GREATER MANCHESTER

PROCEDURE

FOR THE MANAGEMENT OF

SUDDEN UNEXPECTED DEATH

IN CHILDHOOD

(RAPID RESPONSE also known as

Joint Agency Response)

Version 6

Revision Date: **27.09.2019**

Initial Launch: **01.01.2009**
Valid Until: **01.09.2024**

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1. INTRODUCTION

1.1.1 This procedure provides direction for professionals from agencies involved when a child (0-18 years) dies suddenly and unexpectedly.

1.1.2 Together with principles to follow and a definition of cases which require a joint agency response (JAR, previously known as SUDC Rapid Response), the procedure contains general advice and guidance for dealing with a sudden unexpected death and for inter-agency working. Each agency has its own specific guidelines that will complement this procedure (please see the appendices for agency-specific guidance).

1.1.3 All sudden unexpected deaths come within the remit of H.M. Coroner ("the Coroner") who has exclusive jurisdiction and control of the body of the deceased child. Individual circumstances are likely to require individual solutions and the Coroner will always be willing to discuss specific arrangements between the hours of 07.00 and 23.00. Outside these hours the Coroner should only be contacted in cases of absolute urgency.

1.1.4 Families should always be treated with sensitivity, discretion and respect at all times, and Professionals should approach their enquiries with an open mind.

1.1.5 The Greater Manchester SUDC protocol has been in existence since January 2009. This revision is to take into account day to day practise, learning from serious case reviews, and new statutory guidance (Working Together to Safeguard Children 2018, Child Death Review,: Operational and Statutory Guidance).

1.2 Background

1.2.1 One of the Local Safeguarding Children Board's functions, origionlly set out in Regulation 6 of the Children Act 2004, in relation to the deaths of any children normally resident in their area, was as follows:

putting in place procedures for ensuring that there is a coordinated response by the Authority, their Board partners and other relevant persons to an unexpected death.

Whilst the structure of LSCBs may have altered locally, the Children and Social Work Act 2017 Child Death Review requires that procedures are still in place for

ensuring that there is a coordinated response by the Authority, their Board partners and other relevant persons to an unexpected death.

1.2.2 Each unexpected death of a child is a tragedy for the family and community. Subsequent enquiries/investigations should keep an appropriate balance between forensic and medical requirements and the family's and communities' need for support. Children with a known disability or a medical condition should be responded to in the same manner as other children.

1.2.3 A minority of unexpected deaths are the consequence of abuse or neglect, or are found to have abuse or neglect as an associated factor. In all cases, enquiries should seek to understand the reasons for the child's death, address the possible needs of other children in the household and all family members, and also consider any lessons to be learned about how best to safeguard and promote children's welfare in the future. Such cases should be referred for a Rapid Review to occur, following local guidance.

1.2.4 A number of different agencies will become involved throughout the process of establishing the cause of the death.

1.2.5 This procedure provides direction to practitioners who are confronted with the sudden unexpected death of a child. It must be read and implemented in conjunction with agency-specific guidance, protocols and regulations. In most cases the process will be led by the paediatrician for sudden unexpected death in childhood (SUDC) unless there are suspicious circumstances, or the death is seen as a possible suicide, in which case the police will take over the lead role. It is acknowledged that each death has unique circumstances and each professional involved has their own experience and expertise, which will be drawn upon in their handling of individual cases. Nevertheless, there are common aspects to the management of a sudden unexpected death that it is important to share in the interests of good practice and achieving a consistent approach for every child no matter what the circumstances.

1.2.6 This procedure gives an insight into the priorities for those professionals involved, in an attempt to promote a mutual understanding of each agency's roles and responsibilities. Professionals need to strike a balance between the sensitivities of supporting the bereaved family, and securing and preserving anything that may aid in an understanding of why the child died.

1.2.7 When a child dies within the Greater Manchester (GM) Footprint, regardless of their usual area of residence, this Greater Manchester SUDC Protocol should initially be followed. As soon as discussion is possible between professionals it should be decided on a case-by-case basis whether the GM SUDC protocol or the child's local policy, for the area of their usual residence, should then be followed. This should be guided by what is best for the family, and what will be the most effective form of

information gathering. (All Child Death Overview Panel (CDOP) notifications will go to the CDOP *of the child's residence).*

1.2.8 If a child has required resuscitation and is still living, the circumstances of their collapse require a detailed review by the acute paediatric team, the police and childrens care. This is a form of JAR, and should follow recommendations of the Child Death Review: Operational and Statuatory Guidance, but the lead paediatrician will be the lead paediatrician caring for the child in life, not the on call SUDC Paediatrician. Each trust will require a clear plan for the management of such cases.

1.3 AIM

To ensure there is a coordinated multi-agency response for all sudden and unexpected child deaths by:

- Close multi-agency working, with sharing of information between clinical staff, the pathologist(s), police, children's social care, any other relevant agency, and Coroner's services
- Establishing, as far as possible, the cause of death
- Preserving evidence at the place of death
- Documenting fully all interventions by paramedical and medical staff, including resuscitation prior to the certification of death
- Completing a full medical history and examination
- Reviewing all medical records
- An appropriately skilled pathologist (and if necessary a forensic pathologist) investigating the cause of death
- Offering sensitive care and support to all affected by the death
- Identifying and managing any risk to other siblings / children / future siblings
- Preserving all potential evidence in support of a potential prosecution or Public Law (Family Court) proceedings.

2. DEFINITIONS

2.1 Previously (Working Together to Safeguard Children 2008) an unexpected death was defined as the death of a child, in any setting, that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death. Those involved in the response to such deaths were described as the 'Rapid Response Team.'

2.2 The Child Death Review Statutory and Operational Guidance 2018 now refers to the Rapid Response as a Joint Agent Response (JAR).

2.3 The new guidance states that a Joint Agency Response is a coordinated multi-agency response (on-call health professional, police investigator, duty social worker) that should be triggered if a child's death:

- Is or could be due to external causes;
- Is sudden and there is no immediately apparent cause (including SUDI/C);
- Occurs in custody, or where the child was detained under the Mental Health Act;
- Where the initial circumstances raise any suspicions that the death may not have been natural; or
- In the case of a stillbirth where no healthcare professional was in attendance.

2.4 The same guidance also states that "if the death is from external causes, the circumstances are unclear, or safeguarding concerns or problems with care or service delivery are suspected, further investigations will be needed, to understand how the child has died".

2.5 The commissioners of the Greater Manchester SUDC Service have requested that a JAR continues to occur in all cases of Sudden and Unexpected Death as defined in 2.1 therefore, within the Greater Manchester footprint a Joint Agency Response shall be triggered following the **death of any child in the Greater Manchester area, in any setting, that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death.**

2.6 The paediatrician for sudden unexpected deaths in childhood (SUDC on call paediatrician) should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt, this protocol should be followed until the available evidence enables a different decision to be made. In exceptional cases the Coroner should be consulted subject to the provision of paragraph 1.1.3. Where a JAR is not felt to be appropriate, the setting where the child has died will be responsible for following local procedures to ensure a local Child Death Review

Meeting occurs, and all of the necessary notifications take place, and the required support is put into place, following the death.

3. PRINCIPLES

3.1. When dealing with sudden unexpected death all agencies shall follow five common principles, especially when having contact with family members:

- Caring and sensitivity, keeping an open mind and balanced approach
- An inter-agency response
- Sharing of information
- Proportionate response to the circumstances
- Preservation of evidence.

All items on this list are equal in importance.

3.2. In applying the above principles individuals and agencies should ensure that their actions are legal, necessary, relevant and proportionate in order to comply with the Children Act 1989, the Children Act 2004, the Human Rights Act 1998, the European Convention on Human Rights and the Equality Act 2010.

3.3 It is essential that at all times the safety of any surviving siblings and/or other vulnerable people is paramount. This should always include full consideration of the safety of potential future siblings.

3.4 All staff involved in the rapid response/JAR should take appropriate action where any potential signs of abuse or neglect are identified, irrespective of the cause of death, and follow local safeguarding procedures.

4. GENERAL ADVICE FOR ALL PROFESSIONALS WHEN DEALING WITH THE FAMILY

4.1 This is a very difficult time for everyone. The time spent with the family may be brief but actions may greatly influence how the family deals with the bereavement for a long time afterwards. A sympathetic and supportive attitude whilst maintaining professionalism towards the investigation is essential.

4.2 Grief reactions will vary. Individuals may be shocked, numb, withdrawn, angry or hysterical.

4.3 Handle the child with naturalness and respect, as if the child were still alive.

4.4 Always refer to the child by name.

4.5 Deal sensitively with religious beliefs and cultural differences, while remembering the importance of evidence preservation.

4.6 Parents will need to be given time and opportunity to ask questions.

4.7 Give your written contact name and telephone number to the family.

4.8 Practical issues will need to be addressed (where the child will go, what will happen, when they will see the child again) and communicated to parents.

4.9 In suspicious circumstances early arrest of the perpetrator may be essential to secure and preserve crucial evidence for an effective investigation to take place. In such cases, the prompt provision of accurate information and written statements from important witnesses within the family will be necessary.

4.10 In all cases a post-mortem examination (PME) will be performed unless a registered medical practitioner is able to provide a Medical Certificate of the Cause of Death, or H.M. Coroner ("the Coroner") otherwise decides.

4.11 When an unexplained child death occurs it is likely that an investigation and inquest will be opened by the Coroner.

4.12 It is the responsibility of the the trust where the child has died to identify a key worker to support the family, and be a constant point of contact.

5. INTERAGENCY WORKING

5.1 There should be a multi-agency approach involving collaboration of all disciplines and agencies.

5.2 All unexpected child deaths must be treated initially as a multi-agency safeguarding investigation. In the first instance the lead will be the SUDC paediatrician. If at any point the case is deemed suspicious, or a potential suicide, the police will lead. If there are child protection concerns identified then surviving siblings will be the subject of enquiry under Section 47 (S47) of the Children Act 1989 and as such will be managed according to Local Safeguarding Children Board (or the Partnership taking over the LSCBs responsibilities) procedures. At this point the Local Authority has statutory responsibility and will take the lead.

An ongoing SUDC investigation may run alongside a S47 enquiry, or full responsibility may be handed over to the local authority, depending on the stage of the investigation and the nature of the case. The nature of concerns and who has responsibility for leading the case should be reviewed at all stages of the investigation, and all involved should be clear who is leading.

It may not be until the multi-agency meeting that concerns become clear. For this reason children's services should always attend the initial multi-agency meeting. The timing of the initial multi-agency meeting needs early consideration, (**see flow chart 7C**) and at all times the protection of any siblings/vulnerable children or vulnerable adults takes priority.

5.3 Children who die unexpectedly at home should **always** be taken to the nearest Emergency Department with paediatric in patient facilities **not** the mortuary, in accordance with Working Together 2018, Sudden and Unexpected Death in Infancy and Childhood 2016, and 'Child Death Review: Statutory and Operational Guidance. This allows for the earliest possible examination/assessment of the child by a senior clinician. Resuscitation should be attempted unless clearly inappropriate. The only exception to such children being taken to the Emergency Department, rather than the mortuary, is where the police Senior Investigating Officer (SIO) directs otherwise on the grounds of preserving evidence in a suspicious death.

5.4 The police must be informed as soon as possible if any person believed to be under 18 years of age (midnight on the day of birth) dies 'unexpectedly'. No person should 'assume' that the police have been notified. Repeated calls to the police are better than none at all. Early contact with the police enables the prompt recovery of evidence that could otherwise be lost.

5.5 The parents/carers should be allocated a member of staff to care for them on arrival in the Emergency Department and should normally be given the opportunity to hold and spend time with their child while in the Emergency Department, under supervision. If there is suspicion about any particular person(s), the police SIO may

request that access to the child's body be restricted. This request should be facilitated by hospital staff, where it is safe to do so. Without exception, parents/carers who are allowed access to the body should be supervised throughout by a health professional or police officer. Every consideration should be given to the cultural and religious sensitivities of grieving parent/carers. If any person mishandles the child's body in any way, the body should be removed from them, provided it is safe to do so. Details of any mishandling should be recorded in the child's health record. The name(s) of all professionals who supervise in this way should be recorded on the child's health record as they may later prove to be potential witnesses.

5.6 Parents/carers should be prevented from washing the child's body as important forensic evidence could be lost by doing this. Parents/carers could be offered a photograph of their child. They will be offered a lock of hair and hand/foot prints (mementoes) by the SUDC Paediatrician to be taken at the time of PME. Such mementoes should not be taken until the pathologist has fully examined the body at post mortem and agreed they can be taken. At this point, they may be obtained and delivered promptly to the parents/carers by the Police Coroner's Officer (PCO). Pathology should be informed if any request from the parents/ carers for mementoes is made. Responsibility for asking the parents if they wish for mementos to be taken lies with the SUDC Paediatrician, for taking the mementos with the pathology department, and for delivering them with the PCO.

5.7 It should be remembered that babies and children who have been unlawfully killed, can sometimes present without any externally visible injuries.

5.8 The senior Emergency Department clinician is responsible for confirming the fact of death and clearly identifying the time of death in the clinical records. As soon as possible after the child has arrived in the Emergency Department the child should be fully examined by the on-call SUDC paediatrician – usually jointly with the SIO. If there is likely to be a delay of more than one hour in the SUDC paediatrician arriving to the Emergency Department, the child should be examined by the on-call Consultant Paediatrician (or Consultant in Paediatric Emergency Medicine or Consultant in Emergency Medicine if there is no Consultant Paediatrician available within the Trust). Any details given by the parent(s) or carer(s) during or after resuscitation should be carefully recorded. Particular attention should be paid to any apparent changes or inconsistencies in accounts given about the events leading up to the death. Any accounts given should be brought to the early attention of the police. In cases of language difficulty an interpreter must be used rather than English speaking family or friends, to ensure accuracy in the communication of this vital information.

5.9 As soon as death has been confirmed the following will be contacted:

- The police, if not already informed;
- The Coroner by the police and the lead clinician who confirms death (but only in exceptional circumstances should the Coroner be informed between 23:00 and 07:00);
- SUDC paediatrician; and

- Children's Social Care by Police if not already done by Emergency Department staff, or if the child has died elsewhere and has, exceptionally, not been brought to the Emergency Department.

Greater Manchester Police are contactable via 101

The SUDC paediatrician is contactable via Wythenshawe Hospital Switchboard Tel: 0161 998 7070.

5.10 When the child is pronounced dead, the lead clinician in the unit where the child is pronounced dead should break the news to the parents. They will explain the need for police, Coroner and SUDC paediatrician involvement and the need for a post mortem examination.

5.11 In all cases an immediate case discussion should be held as soon as possible between the SIO, the senior clinician dealing with the case (this may be a consultant paediatrician or a consultant in emergency medicine or paediatric emergency medicine) and the SUDC paediatrician – to agree the approach and to ensure continuing close collaboration as frequently as necessary. This will often initially occur by telephone.

5.12 Confirmation of agreed decisions and actions and timescale for completion must be recorded by each party using existing systems. The SUDC paediatrician will ensure all professionals are aware of their agreed roles and responsibilities.

5.13 The lead acute clinician (consultant paediatrician or a consultant in emergency medicine or paediatric emergency medicine) who confirms the fact of death must notify the Coroner in addition to the SIO. Only in exceptional circumstances should the Coroner be called between 23:00 and 07:00. Trust reporting procedures should be adhered to.

5.14 At the earliest opportunity the police should check if the child, family or address are known to Police and Children's services should be contacted to see if the child, family or address are known.

5.15 Usually the child will examined jointly by the SUDC Paediatrician and the SIO. They will then go on to take a detailed history from the carers, having agreed beforehand who will be present at history taking, and whether separate histories should be taken from the parents/carers.

5.16 The Named Nurse for Safeguarding children for the organisation where the child has died should be informed at the earliest convenient moment, and they should assist gathering information. Where there are named nurses for both the acute site and the community, the named nurse at the acute site will be contacted, who can then advise on local procedures for who should be involved.

5.17 When a child dies in a non-hospital setting, the SIO and SUDC paediatrician should decide whether a visit to the place where the child died should be undertaken. This

should almost always take place for children under 2 years of age who die unexpectedly. As well as deciding if the visit should take place, it should also be decided how soon (within 24 hours) and who should attend. It is likely to be the SIO and SUDC paediatrician who will visit, talk with the parents (if this has not already occurred in the Emergency Department) and inspect the scene. They may make this visit together, or they may visit separately and then confer.

5.18 After this visit a multi-agency meeting should be held including the SIO, SUDC paediatrician, GP, health visitor or school nurse, named nurse fr safeguarding children and children's social care representative. Other professionals involved in the child's or siblings care may also be invited. They should review whether there is any additional information that could raise concerns about the possibility of abuse or neglect having contributed to the child's death. If there are concerns about surviving children in the household local procedures for managing child protection enquiries should be followed. The timing of a multi-agency meeting will depend on circumstances (**See flow chart 5.3.1**). This meeting will be chaired by the SUDC paediatrician who will record a summary of the meeting and agreed action points. If there are concerns about abuse or neglect, an initial multi-agency strategy discussion should be convened, chaired and minuted by an appropriately senior representative of Children's Social Care.

5.19 The Coroner, if appropriate, will order a post mortem examination (PME) to be carried out as soon as possible, by the most appropriate pathologist(s).

5.20 The on-call paediatrician, or consultant in emergency medicine or paediatric emergency medicine, for the unit where the child is pronounced dead and the SUDC paediatrician should liaise with the pathologist and provide information on the clinical circumstances of the death, the history and the relevant medical and social records. Ideally a written report will be available prior to PME, but in exceptional cases where this is not possible a verbal report should be given to the pathologist.

5.21 The PCO will inform the SUDC Paediatrician of the provisional PME result and the SUDC paediatrician will ensure GP, hospital staff and relevant community team(s) are informed of the initial post mortem results, unless directed not to by the Coroner. If safeguarding concerns are identified at PM examination they should be directly reported to the SIO and SUDC Paediatrician by the pathologist. In the unlikely event of the Coroner not giving permission to share information and there are safeguarding concerns, it is the responsibility of the SUDC Paediatrician to discuss the case directly with the Coroner. If this still fails to resolve the issue, it should be discussed with the SUDC Lead Clinician, and legal advice sought if necessary. The Police Coroners Officer, or staff from the coroners office will update the family re provisional Post Motem results.

5.22 If a multi-agency meeting hasn't yet occurred this may be held by the SUDC paediatrician after the provisional post mortem examination report is available (**see flow chart 5.3.1**).

5.23 A Child Death Review Meeting (CDRM) (previously referred to as the final case discussion meeting) should be convened and chaired by the SUDC paediatrician as soon as the full post mortem examination report is available, approximately 3 - 4 months after the death, although this may be much later especially when a forensic PME has occurred. This meeting (at the GP surgery, if possible) should involve the GP, health visitor, the key worker, school nurse (if appropriate) midwife (if appropriate), children's community nurse (if appropriate) named nurse and any other paediatrician if involved, pathologist(s), police SIO, police Coroner's officer (PCO), the childs Key Worker, ambulance crew and where appropriate social worker, bereavement support worker, education and Emergency Department staff. All relevant information concerning the circumstances of the death, the child's history, family history and subsequent investigations should be reviewed and the core data set completed. The main purpose is to share information, discuss the final Post Mortem Report findings and plan future care for the family. There must be an explicit discussion of the possibility of abuse or neglect and, if no evidence is identified to suggest maltreatment, this should be documented as part of the summary of the meeting. An Analysis form (previously form C) needs to be completed for CDOP.

5.24 The Analysis form should be sent to the CDOP and to the Coroner, who may take the case discussion information into consideration in the conduct of the inquest and in the cause of death notified to the relevant Registrar or Superintendent Registrar. In addition all attendees at the case discussion meeting should receive a summary which should include

- A brief summary of the case;
- A summary of PM examination findings, the cause of death, and *any* other relevant findings;
- Explicit comment on safeguarding issues for siblings/household contacts and *future siblings*;
- A list of further actions, including management of future pregnancies;
- A full distribution list (including the child's, mother's and father's GP (if known)).

5.25 The SUDC paediatrician should usually, subject to Coroner's and police approval, arrange to meet with the family to give information concerning the cause of the child's death. If a child is well known to a local paediatrician it may be agreed that they will feedback to families. A detailed letter should then be written and sent to the family summarising the meeting.

5.26 If significant concerns are raised at any stage about the possibility of abuse or neglect, a decision may be taken for the police to become the lead agency. The police should be informed immediately if significant suspicion arises so as to ensure any further interviews with the family accord with the requirements of the Police and Criminal Evidence Act 1984. Children's services and police may convene a child protection strategy meeting to decide how to proceed with the child protection investigation.

5.27 If there are grounds for considering a Rapid Review the lead of the local safeguarding partnership should be contacted.

5.28 Managers in all agencies should be proactive in ensuring the well being of their staff, both during and after dealing with child deaths.

6. INFORMATION SHARING and CONFIDENTIALITY

6.1.1 When sharing information, it is the responsibility of the Practitioner to decide what information it is appropriate to share with whom. The rights of individuals to privacy should be protected whilst, at the same time, ensuring sufficient information is shared to allow for the safeguarding of vulnerable children and adults.

Guidance can be found in several documents:

6.2.1 **Section 10 (s10) Children Act (CA) 2004**: the statutory guidance accompanying this primary legislation states that good information sharing is key to successful collaborative working and that arrangements under s10 CA 2004 should ensure that information is shared for strategic planning purposes and to support effective service delivery.

6.2.2 **Section 11 CA 2004**: places a duty of bodies within the NHS to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children.

6.2.3 **Working Together to Safeguard Children (HM Government 2018):** updates the 2015 statutory guidance and sets out the regulations relating to child deaths review functions and this includes collecting and analysing information about each death.

6.2.4 **Human Rights Act 1998 (Article 8):** the right to respect for private and family can be legitimately interfered with where it 'is in accordance with the law and is necessary ... in the interests of … protection of health and morals or the protection of rights and freedoms of others.

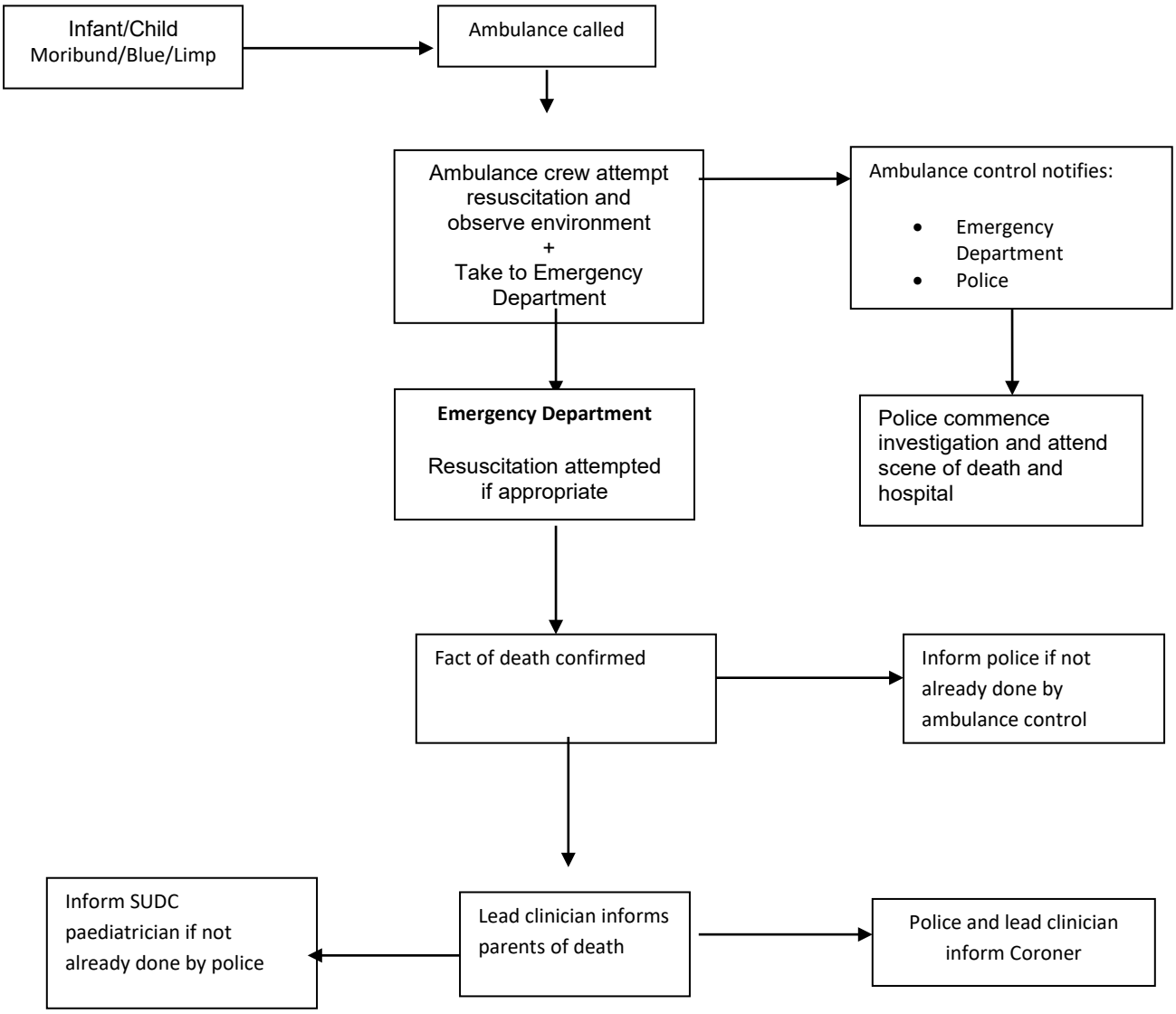
6.2.5 **Data Protection Act 2018**: Information sharing within the Child Death Overview Processes is a statutory function and the Data Protection Act therefore permits the sharing of information for this purpose without express consent of the subjects.

6.2.6 **Caldicott Principles:** These relate to the use of patient identifiable information in the NHS and Social Care and must be followed at all times. Principle 7 states that that '*The duty to share information can be as important as the duty to protect patient confidentiality*' but any information sharing must be done for a legitimate reason and in accordance with the Data Protection Act.

Principles 2 and 3 also state that '*Only use personally identifiable information if absolutely necessary*' and '*Use only the minimum data needed for the specific purpose.*'

6.2.7 General Medical Council (Confidentiality: good practice in handling patient information) Guidance: This guidance provides a framework to help decide when information can be shared. This may be for the direct care or protection of the patient, to protect others or for another reason. The guidance includes a section on managing and protecting information. This has helpful advice on doctors' personal responsibilities for protecting patient information. It also gives advice on when information can be shared after a patient has died. This guidance came into effect 25 April 2017. It was updated on 25 May 2018 to reflect the requirements of the General Data Protection Regulation (GDPR) and Data Protection Act 2018.

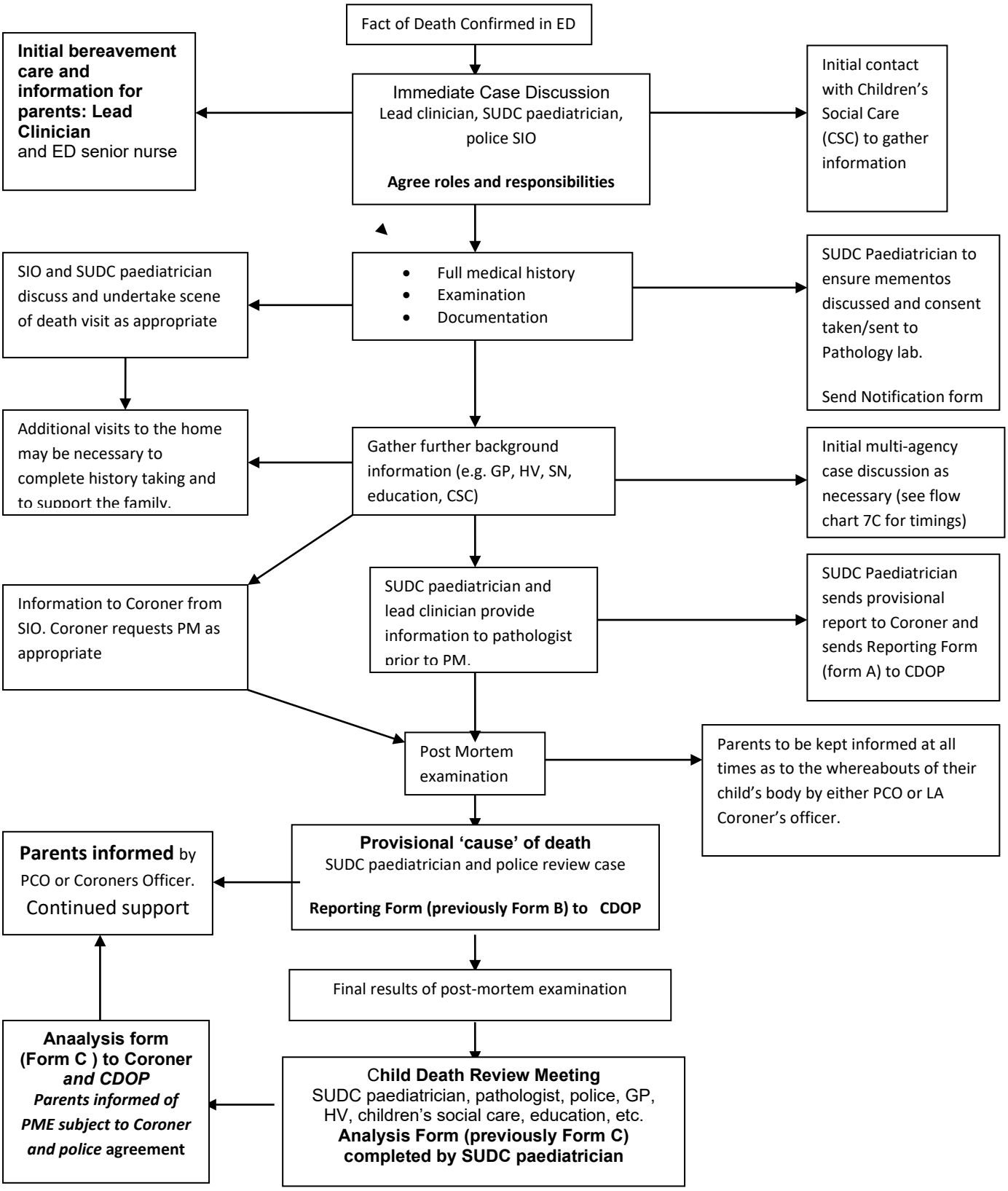
7. RECOMMENDED SEQUENCE OF EVENTS
A: Following ambulance call



NB if there is any uncertainty as to whether or not a Joint Agency Response is indicated, then discuss with on-call SUDC Consultant, considering if they would have a role in:-

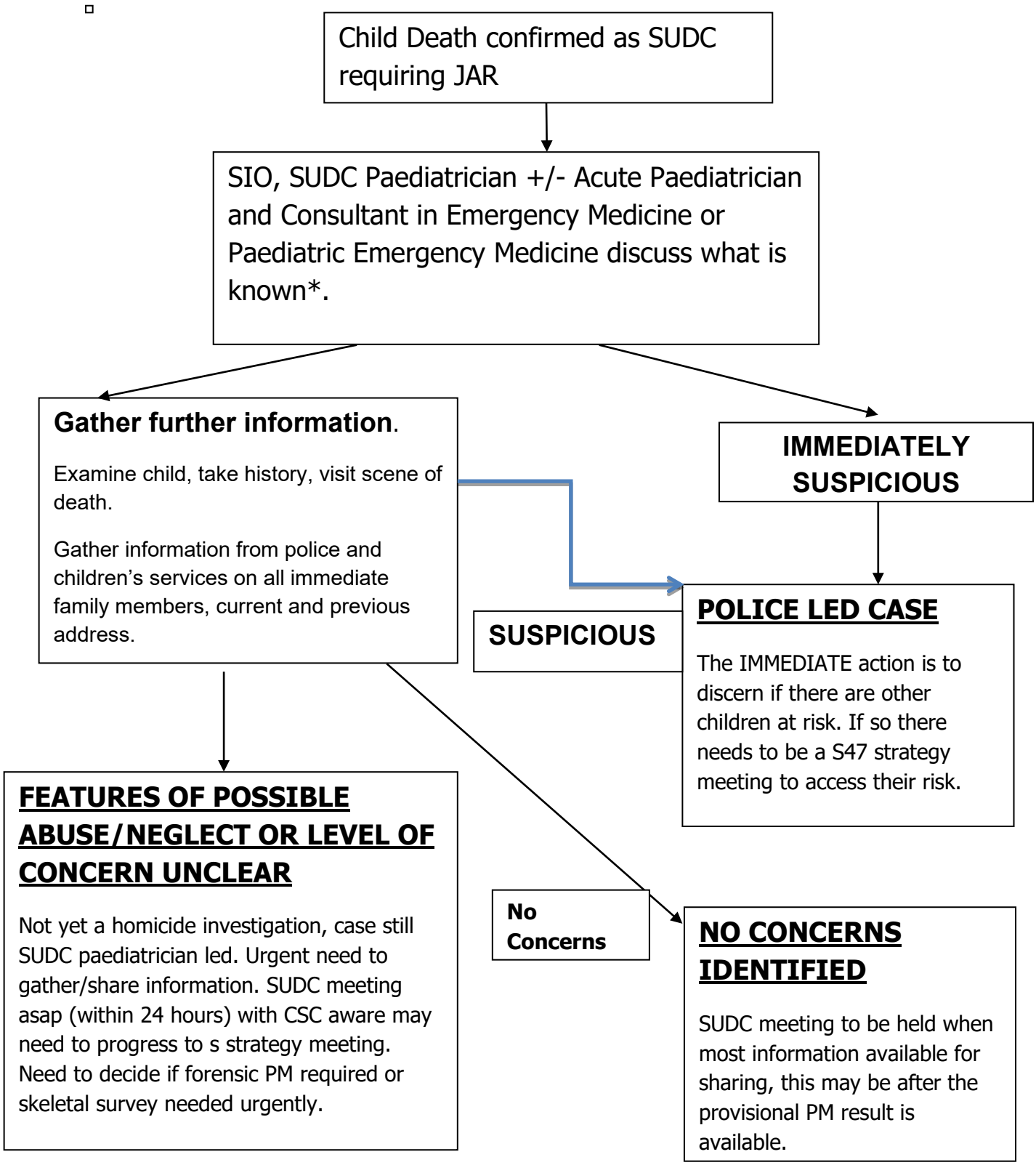
- Establishing the cause of death;
- Identifying modifiable risk factors associated with the death;
- Explicitly considering safeguarding issues for surviving siblings in conjunction with the Local Authority;
- Sign posting to appropriate bereavement support;
- Collecting data for CDOP.

7. A RECOMMENDED SEQUENCE OF EVENTS
B After fact of death confirmed



7. RECOMMENDED SEQUENCE OF EVENTS

C Flow Chart of timings of jar Multi-agency Meetings following Sudden Unexpected Child Death



*This will be referred to as an initial case discussion.

Whilst a 'usual' SUDC meeting would include primary care (e.g. GP, HV, MW etc.) this may not be possible over the weekend. In such cases if concerns have been raised, a meeting should be held including the SIO, SUDC paediatrician and an appropriate representative of children's services as a minimum, and a repeat 'SUDC meeting' will be needed to gather/share more information at a later date.

All cases that have had a JAR will need a final Child Death Review Meeting convened by the SUDC paediatrician.

Throughout the Joint Agency Response professionals must consider the need to initiate a Rapid Review

8 POLICE Appendix 'A'

Introduction

8.1.1. The Primary aim of the police into the report of an unexpected death of a child is to exclude any criminality or third party involvement, on exclusion of that they will gather information to determine how, why and in what circumstance the child/young person died. They will gather and record all enquiries for the purpose of the continuing Coronial Investigation.

8.1.2. The duty of H.M. Coroner is to establish the identity of the deceased and how, when and where he or she died. All police staff should be aware that, once a person has died, the body must not be interfered with in any way, unless authorised by H.M. Coroner either directly or through this protocol.

8.1.3. Throughout their investigation into the report of an unexpected death of a person under eighteen years, the police will take any action necessary to safeguard the wellbeing of any other children or young persons, such as siblings, who are considered to be at risk of harm.

8.1.4. The death of a person under 18 will not be investigated by the police in cases where a doctor is able to issue a 'medical certificate of cause of death'. A 'medical certificate of cause of death' is usually issued in cases in which a doctor has treated the deceased for a diagnosed serious illness or condition from which s/he was expected to die at that time. However there may be circumstances where a cause of death can be supported but the originating circumstances would lead the death to be reportable as unnatural [ie Birth Trauma –leading to complex medical needs] in such cases liaison with the SUDC on call or HMC will assist next action and set proportionate parameters

8.1.5. The police investigation into the unexpected death of any person under 18 in Greater Manchester will be led by a specially trained Detective Inspector (DI) or Detective Chief Inspector (DCI). For the purposes of this protocol, that officer will be referred to as the police 'senior investigating officer' (SIO).

8.1.6. Further guidance for police officers / staff on investigating child deaths is given in:

- 'Working Together to Safeguard Children 2018' – As this is statutory guidance, any deviation from it should be capable of being justified before a judicial or public hearing

- NPCC Homicide Working Group – 'A guide to investigating Child Deaths' 2013

- Dealing with unnatural and unexpected Death 2019

- PCO Standard operating procedures

8.1.7. There are three 'key' features which are central to the multi-agency model of investigation:

- CCGs within Greater Manchester will have access to a consultant paediatrician who is designated to engage quickly with the police and other agencies after the unexpected death of a person under 18 occurs**.** This consultant is known as the **SUDC paediatrician** and will be available 24/7 on a call out basis. A consultant at the hospital where the child is first taken will engage initially in preservation of life procedures, where indicated, initial history taking and on occasion medical examination. Once death is confirmed the SUDC paediatrician will be consulted and hand over of the case agreed. The SUDC paediatrician will then take over responsibility for all medical aspects of the investigation into why the child died and agreed joint liaison with the deceased's family and other agencies.

- The death will also trigger the coming together of a team of professionals from a number of agencies, co-ordinated by the SUDC paediatrician. This process was known as 'Rapid Response', and is now referred to as a Joint Agency Respnse. Key team members will include the SUDC paediatrician, police SIO, Police Coroner's Officer, health visitor or school nurse, GP and others where relevant e.g. midwife, mental health professional, social worker. In essence, this team of professionals will have the knowledge, expertise, information and resources to be able to contribute towards a thorough 'joint' investigation into why the child or young person died. When a person under 18 dies unexpectedly in a non-hospital setting, including Road Traffic Collisions (RTC – See Appendix A1) and suicides, the police SIO and SUDC paediatrician should make a decision about whether a **'joint police/health professional visit'** to the place where the child died should be undertaken. This is the third key element. This should almost always take place for infants (under 2) who die unexpectedly in a dwelling. If the death, trauma or collapse occurred in a place other than the home location, consideration should also be given to visiting and examining the home. Similarly, if the child had been living in different locations in the time leading up to death, consideration should be given to 'joint visits' to them.

  As well as deciding if the 'joint visit(s)' should take place, it should be decided how soon (within 24 hours) and who should attend. Wherever possible the police SIO should take part in any 'joint visit' on behalf of the police. The police and SUDC paediatrician will visit, talk with the parents/carers and inspect/assess the scene. If a 'joint visit' is considered inappropriate, they may visit the location/s separately and then later confer. The purpose of a 'joint visit' is to identify all possible factors (from both a police and medical perspective) that may help explain why the child died.

Railway Deaths [BTP – Non SUDC protocol] GMP assist and BTP have primacy for Investigation, the decision to invoke SUDC must be discussed with the BTP SIO.

Police attendance at the scene – Initial action

8.2.1. The police response should be proportionate and rationalised having regard to the circumstances.

8.2.2. Careful consideration should be given to identify the relevant staff to deploy to such cases , they should have the skills and resilience to deal with the case

8.2.3. When the unexpected death of a child or young person is reported to the police, a detective should be sent to the scene or hospital in an un-liveried vehicle as the first response, unless this would cause any unreasonable delay.

8.2.4. Police attendance at the scene, should be kept to the minimum required, completely avoiding uniformed officers and liveried vehicles where possible.

8.2.5. The officer/s attending the scene should give immediate consideration to the safety of all other children at the location. Depending upon the circumstances of the death and the conditions in which other children may be found, the officer/s may need to take prompt action to secure their safety and wellbeing. In extreme cases, this may require the police to use their powers of removal and protection set out under Section 46 of the Children Act 1989.

8.2.6. All police action should be undertaken in the most low key and least intrusive way possible, and proportionate having regard to the circumstances of the case. If the death has occurred inside a home, it is highly unlikely that police cordon tape will be needed outside.

8.2.7. Upon arrival at the scene or hospital, the SIO should take command and control of the police investigation recording all rationale for decisions and actions.

8.2.8. The Police role is to capture and gather information to assist in determining a sequence of events and whether those events were incidental coincidental or causative of the death. Only post mortem and subsequent examinations will determine the cause of death

8.2.9. All police action should be carried out with empathy, sensitivity and understanding, even when it is suspected that a criminal offence may have been committed. Families will be fully informed that Police and PCO attendance at such deaths is Normal, the gathering of the information is on behalf of the Coroner and to fully inform professionals in an attempt to determine a cause of death

Guidance for dealing with grieving parents/carers

8.2.11 The following advice is offered for consideration in dealing with parents/carers:

- Say who you are, why you are there and how sorry you are to hear what has happened to the child/young person. Establish the child's name quickly and always use this in conversations with those that are grieving.

- If you have a need to handle the child, do so gently and caringly, as if s/he were still alive.

- In the first stages of grief, people may react in different ways, displaying shock, numbness, anger and hysteria. Be patient. Allow the parents/carers space and time to cry, talk together and comfort any other children. These early moments of grieving are very important.

- It is entirely natural for a parent/carer to want to hold or touch the dead child/young person, indeed it is known to help with the grieving process. You should allow this to happen provided it is done with a professional (e.g. police officer,PCO or nurse) being present throughout, as in most cases it is highly unlikely that any important forensic evidence will be lost. You should, however, make a record of all such contact with the Child, together with details of who supervised it, times etc. If however, you consider the death to be suspicious, you should consult the SIO before allowing this to happen. If, for any reason, you are unable to consult the SIO at that time, you should prevent all persons from unnecessarily handling/touching the child /young person until you have done so. Any instructions given by the police SIO in this regard should be passed to the Emergency Department staff immediately if the child/young person is at (or is being taken to) hospital.

- Parents/carers should be prevented from washing the child or changing the clothing or nappy at this stage. You may wish to explain to them that it is your job to try to make sure that no changes are made to the child/young person or his / her clothing until s/he is examined by doctors at hospital. Also explain that this is standard procedure and that it will help to give doctors the best chance of finding out why their child died.

- You should be prepared to answer practical questions such as where the child will be taken and when can they next see him/ her? You should always be certain of the responses you give. Giving inaccurate information could later prove highly distressing to the parents/carers.

  It has been agreed by the coroners that equipment inserted during resuscitation ie ET Tubes ,IO needles can be removed if their position has been documented in the medical records. Any medical interventions that occurred prior to resuscitation must remain in situ.

- Be sensitive to any religious or cultural needs or beliefs. Contact a Cultural Liaison Officer for advice. Ensure that all documentation sent to HMC clearly indicates the Religion

- If you experience any language difficulties whatsoever with parents/carers, you should arrange for the attendance of an interpreter as soon as possible. An English - speaking family member or friend may need to be used initially in urgent cases. In this event, you should consult the appointed SIO about the need to obtain an 'independent' interpreter as soon as possible to ensure accuracy in the conveyance, interpretation and recording of information provided by parents/carers.

- Most parents/carers feel guilty when their child has died. When talking to them try to ask 'open' questions e.g. Tell me what happened? Avoid questions that sound in any way critical such as, 'Why didn't you……?'

- A thorough and successful police investigation is more likely to be achieved if at all times parents/carers are treated with sensitivity and respect by all officers. This applies even if they are suspected of committing a crime against the child or young person.

- Parental Blood samples, if there is an indication that both or either parents or carers has had drink or drugs in the time leading up to the childs death, obtain consent for such samples , they will obtained by Police via contact with the force Duty Officer , proportionate considered approach with rationale should be taken.

Diagnosis of fact of death

8.2.12 North West Ambulance Service (NWAS) paramedics and technicians are now qualified to diagnose 'fact' of death. When necessary, they will do this in every case where they are called to the scene of the death of a child or young person. If the death appears to be suspicious, they will try to minimise contamination of the scene and body whilst performing this function. Obtain a copy of the Patient Report Form [PRF] that will also contain important information in relation to drugs given etc pre admission and will form part of the information forwarded to assist the Pathologist . It is also an exhibit for the Coroners file of evidence

Removal of the body from a scene – Death appears 'suspicious'

8.2.13 If, after 'fact' of death has been diagnosed, the death appears to be 'suspicious', the NWAS crew should remain with the body at the scene until the first police officer arrives. In these circumstances, the SIO should always be consulted before the body is removed from the scene by NWAS.

8.2.14 On average the NWAS crew will be available at the scene for 30 minutes following their arrival time whilst they complete records about the incident. Subject to the exigencies of their service they will transport the body to the Emergency Department, if requested to do so by the police SIO, however where the death is deemed suspicious the deceased will be left in situ

Removal of the body from a scene – Death 'does not appear suspicious'

8.2.15 If, after 'fact' of death has been diagnosed, there do not appear to be any suspicious circumstances; the NWAS crew will (subject to the exceptions' listed below) immediately take the child/young person's body to the local Emergency Department with paediatric facilities.

The following benefits accrue from this action:

- The knowledge that the child/young person is being taken to the Emergency Department rather than a mortuary can soften the early impact on the grieving family/carers
- The grieving family/carers can attend the Emergency Department, with the child, where they may receive immediate medical and social support
- Any perceived risk to a surviving twin or siblings can be assessed & addressed
- Early examination of the child/young person's body by a consultant and/or SUDC paediatrician will inform the early stages of the police investigation.

The only 'exceptions' to the above are as follows:

- If a police officer directs that the body should not be moved
- If the body is considered to pose a health risk
- If 'other exceptional reasons' exist that justify not taking the body to the Emergency Department (e.g. a major incident has occurred involving a high volume of attendances to the Emergency Department)

8.2.16 Where any of these exceptions apply, details should be recorded in police/NWAS records and brought to the attention of the police SIO.

8.2.17 Where the child/young person is not moved to the nearest Emergency Department with paediatric facilities, the police SIO should always be consulted before any arrangements are made for removal of the body by undertakers to the mortuary designated by the local coroner.

8.2.18 Where necessary, the police may be able to arrange transport to the hospital for the immediate next of kin.

8.2.19 Jurisdiction belongs to the coronial area where the death occurred. Where the investigation originates in another Coronial jurisdiction , a discussion between H.M. Coroners the next working day will decide transfer of area. An SIO

cannot make that decision or remove a child into another coronial jurisdiction without Coronial consent

Obtaining information from parents/carers and the scene

8.2.20 As well as basic details for the death report, the officer that initially attends should try to obtain and record the following information:

- Full details of the child/young person who has died,
- Details of the family/carer and contact details
- The circumstances leading up to the death.

In addition, the 'detective' officer should, if relevant, observe/note any features at the scene of the death that may have a bearing on why the child/young person died. This information should be passed to the SIO

No further 'in-depth' questioning should normally take place without the SIO's approval. The SIO will later determine the interview strategy. Repeated questioning of the parent/carer by different officers should be avoided.

When considering the need to question parents/carers in non suspicious cases

8.2.21 When considering the need to question parents/carers, the SIO should discuss the following with the SUDC paediatrician:

- Whether parents are interviewed jointly or separately
- Who will lead the interview

8.2.22 A police coroner's officer [PCO] should also be present when possible during any questioning of parents/carers. This will facilitate creating an antecedents statement without someone having to return to the family later, thus avoiding repetition.

8.2.23 In the event that a case is deemed suspicious, first accounts should be taken from the parents/carers separately. The SUDC paediatrician would not normally be present during these accounts. If any parent/carer becomes a suspect, then a PACE compliant interview by police would be required. The case would be police led, so all subsequent multiagency meetings would be arranged by the police.

Death reported from the hospital

8.2.24 Hospital staff may refer an unexpected death of a person under 18 to GMP, following admittance via the Emergency Department or where the child has died on a ward as an inpatient that may reported via HM Coroner and referred to the Police via that route, the same considerations apply [see page 39]

8.2.25 Upon attendance at hospital emergency department the first officer should liaise with any staff that have examined the child/young person or spoken to parents/carers to establish what is known so far. This is also to ensure that the parents/carers have been informed of the need for police involvement so that the introduction of the officer should not come as a surprise to them.

8.2.26 The officer should deal with family/carers as per guidance given previously in this protocol.

8.2.27 The officer (detective if in attendance) at the hospital should make an early attempt to locate any nappy, clothing or possessions taken from the child by hospital staff that may be important to the investigation. Such items should be brought to the early attention of the SIO. The SIO should discuss with the SUDC paediatrician which items need to be retained for evidential purposes. Items retained should be treated as potential exhibits and packaged separately to avoid any risk of contamination. They may later require forensic examination. Assurances should be given to parents/carers that the items will be returned to them in the best possible condition.

Informing the duty SIO

8.2.28 As soon as the officer (detective if in attendance) is able to confirm the death and obtain basic details of the incident, s/he should communicate these to the Operational Control Room asking for the duty 'divisional' SIO to be informed and requested to attend as soon as possible , during core Hours Mon – Fri 07. 20.00hrs PCO Hubs will also be made aware and will deploy

Formal identification of the body

8.2.29 The detective or Police Coroner's Officer in attendance should, in consultation with the SIO, ensure that formal evidence of identification of the child or young person's body by an 'appropriate' relative/carer is 'sensitively' obtained. In all cases a GMP unique identifying bracelet will be attached to the child prior to removal to the public mortuary and the number recorded for continuity purposes

8.2.30 The releasing of the child's/young person's body at hospital before being taken to the mortuary is often one of the most distressing times for parents/carers and great patience, understanding and empathy is needed,.

8.2.31 It is rare for parents/carers to ask to accompany their child to the actual mortuary and this should <u>not</u> be encouraged. However, if specifically requested, they may be taken into the public reception area. Parents/carers should always be accompanied by Police Staff at all times whilst in the mortuary. They should not be given access to any other part of the mortuary where strict health and safety rules apply.

Responsibilities of the Police Senior Investigating Officer (SIO)

8.3.1. The SIO should assess the circumstances of the death, develop strategy and deploy staff to explore all reasonable lines of enquiry.

8.3.2. Throughout the investigation, the SIO should, wherever possible, follow the guidance contained in 'Working Together to Safeguard Children 2018'.

8.3.3. The SIO must liaise with the Public Protection Departments Child Protection Unit, for early consultation (and in any case within 24 hours). The PCO will forward a copy of the Death report to the GMP serious case review team the next working day serioucase.reviewteam@gmp.police.uk

8.3.4. It is essential that at all times the safety of any surviving siblings and/or other vulnerable people is paramount. This should always include full consideration of the safety of potential future siblings.

8.3.5. All staff involved in the rapid response/joint agency response should recognise the importance of taking appropriate action where any potential signs of abuse or neglect are identified, irrespective of the relationship to the cause of death. This includes conducting a thorough investigation and gathering all potential evidence with a view to consideration of a prosecution for neglect/assault.

8.3.6. All evidence / information / details of concerns (however slight and even if not proven) gathered during the investigation should be documented, retained and indexed in such a way that, where necessary, it can be easily retrieved by staff for child protection / safeguarding purposes in the future.

8.3.7. If at any stage the SIO has grounds to suspect a homicide, arrangements may be made for the Major Incident Team (MIT) to take over the investigation.

8.3.8. Any 'joint visit' to the home by the SIO/PCO and SUDC paediatrician should ideally occur within 24 hours of the death. The SIO should consult the dedicated SUDC paediatrician as soon as possible to determine whether or not this will take place. and a clear action plan must be agreed.

8.3.9. Where the death is being dealt with as suspicious the visit may be delayed pending an agreed Forensic Strategy

8.3.10. The SIO should be present when the SUDC Paed conducts the examination of the infant/child/YP and records the findings .

Detective Chief Inspectors

8.3.11. Where a Detective Inspector is conducting an investigation into any child death (whether considered to be suspicious or not), his or her DCI should

conduct thorough and regular reviews of the investigation and, where necessary, give guidance and instruction.

Informing the Police Coroner's Officer

8.3.12 Between 0700-2000hrs, the police coroner's officer (PCO) for the Coronial area where the death occurred should be notified as soon as possible, to attend the scene. His/her experience and expertise in dealing with sudden deaths and bereaved families should be used to the full. The SIO should maintain close liaison with the PCO throughout his/her investigation. The Police Coroner's Officer must be invited to the rapid response meeting with the family.
The PCO will be responsible for maintaining contact and signposting the family.
Where a death has occurred out of hours a PCO will be allocated the case the next working day and commence a case book in line with Force directives. All contact and communication will be contemporaneous.

Witness / suspect management / interview strategy

8.3.13 The SIO should determine his/her interview strategy in respect of all persons of relevance to the investigation. Police, health and children's services staff should work in close collaboration when planning interviews to avoid all unnecessary repeated questioning of parents/carers. The SUDC paediatrician will wish to obtain a detailed medical history from the parents/carers. The advantages and disadvantages of a 'joint interview' by the police and SUDC paediatrician should be discussed, having regard to the particular circumstances of the case.

8.3.14 If any doubt exists that the parents/carers do not fully understand English, arrangements should be made for the attendance of an interpreter [non famial] as soon as possible.

8.3.15 Even in 'non-suspicious' cases, the SIO could consider the benefits of asking parents/carers to agree to be video interviewed. This could be facilitated at GMP equipped suites. Alternatively, an audio-recorded interview may also be considered.

Intelligence strategy

8.3.16 The SIO should determine his/her intelligence strategy. Where necessary, this should include researching all key persons present around the time of death on police systems.

8.3.17 ~~Information~~ held by partner agencies will be shared to support this process but may require formal Authorities dependant on whom the information relates.

8.3.18 A discussion with the SUDC paed will determine which actions they will lead on , eg in the case of a school they may be the most relevant person torequest information.

8.3.19 The SIO should ensure the dissemination of all useful intelligence gleaned during and at the conclusion of his/her investigation.

8.3.20 Any intelligence gleaned may be useful and even crucial to other agencies and should, if possible, be shared with them on a needs basis.

Scene strategy, evidence recovery and imaging

8.3.21 Where necessary, justified and proportionate, the SIO should determine his/her imaging, scene examination, and search and seizure strategy. If possible, this should be done in consultation with the SUDC paediatrician.

8.3.22 Wherever possible, a Crime Scene Investigator (C.S.I.) should be requested to attend to photograph any injuries, suspicious marks or features on the body .

8.3.23 The SIO where it is considered an ambient temperature is required should liaise with a Crime Scene Manager

8.3.24 If the SUDC paediatrician has not attended the scene, the SIO should consider using the images captured to brief him/her and, in suspicious cases, the 'forensic' pathologist before post mortem.

8.3.25 Any staff member involved in the search should be fully briefed beforehand ~~a~~nd Where items are to be removed from the house, ~~t~~he parents should be told what has been taken and reassured that the items will be returned in due course. A full list should be supplied to the PCO who will manage this aspect until the end of the Coronial /Medico Legal Process The PCO will be responsible for the return of the items to the family

8.3.26 -Preparation and discussion before the joint visit will ensure no further visit will be required
Consideration should be given to the welfare of all staff involved and signposting them for relevant support/Trim process etc

Post Mortem Examinations

8.3.27 If there is any suspicion or concern whatsoever that a criminal act may have been a factor in the child's death, the SIO should ask the coroner to hold a Home Office post mortem using a forensic pathologist. In these circumstances, depending on the age of the child, the coroner may direct that a paediatric pathologist conduct a 'joint' post mortem with the forensic pathologist.

8.3.28 If a 'non-Home Office' post mortem is to be held, the SUDC paediatrician would attend without police. No police involvement or briefing is required. If an SIO wished to attend a non-Home Office post mortem or send a representative, s/he would need to obtain prior authority from the coroner and make early arrangements with the pathologist in question.

8.3.29 Under no circumstances should an SIO seek to delay the start of a non-Home Office post mortem purely so an officer can attend.

8.3.30 If during a non-Home Office post mortem a pathologist uncovered something suspicious, s/he would immediately stop the procedure and contact the coroner. The coroner would then decide whether to continue or re-convene the post mortem with the additional involvement of a forensic pathologist.

8.3.31 Having regard to the circumstances of the death and the age of the child, the pathologist(s) will consider the need for a skeletal survey of the body. If the child is under the age of 2 years, a skeletal survey should be undertaken in most cases. A paediatric radiologist will interpret any survey conducted. The SIO/Coroner will be informed immediately should any concerns be raised from such an examination.

8.3.32 HM Coroner in the first instance will receive a provisional cause of death , the PCO will update the family when confirming with them the next action, Upon receipt of a written post mortem examination report from the pathologist(s), the Coroner will share with the PCO /LA case officer who will update the NOK with the findings, the PCO with HMC permission will share that document with the named SUDC paediatrician and SIO clarifying that the family are aware and HMC has given permission for SUDC to share the results with multi agency partners. Currently 20 wk time frame for receipt of the full document.

8.3.33 Under the requirements of the Human Tissue Act 2004, the next of kin Must be informed of all human tissue samples taken from the child at post mortem. The next of kin must be consulted regarding their wishes in relation to subsequent disposal options which include ;- the retention of the tissue for research purposes, the return to them for burial/cremation or sensitive disposal by other means. Consent from the next of kin in relation to disposal will be obtained by the PCO or HM L/A Staff, families should be given time to reflect before obtaining final decision, that decision will be recorded and the document forwarded via HMC to gmphumantissueteam@gmp.police.uk . If a full organ has been retained for further examination the PCO will attend the family and explain their options again time to reflect must be given, a separate document will be produced for full organs and again that must be sent to HTA team on completion.

Obtaining mementos for parents/carers from the child

8.3.34 The SUDC paediatrician will be responsible for ensuring that parents/carers, in every case, are asked whether or not they would like the following mementoes from the child/young person's body:

- Lock of hair
- Handprints
- Footprints

The SUDC paediatrician will complete the relevant consent form and forward to the Mortuary, ensuring that the PCO and key worker are aware of the request. If that has not been done the SUDC paediatrician will inform the PCO, and request that they will discuss with the family and forward the relevant documentation. This may also be done by a member of the bereavement team.

8.3.35 Once all forensic requirements have been addressed the PCO will be responsible for ensuring that any mementoes requested by the parents/carers are obtained from the mortuary. Mortuary technicians at the Central Manchester & Manchester Children's University hospital, where most child post mortems will take place, have agreed to obtain the mementoes. Separate guidance will be issued to police staff regarding how to arrange the taking of such mementoes and their delivery to parents/carers. Any delay in presentation of them should be avoided.

8.3.36 GMP are responsible for presenting these mementos in an appropriate way. The Police Coroners Officer allocated the case will arrange delivery of the mementos

Informing the coroner of the death

8.3.37 The SIO should ensure that the police coroner's officer formally reports the death to the coroner the next working day'. OOH an SIO update should be forwarded to the relevant PCO hub account as soon as possible,The coroners covering Greater Manchester have stated that they do not require to be routinely notified of a child/young person's death outside office hours. However, if the SIO or a health professional is experiencing any difficulties dealing with such a death and requires the coroner's advice, s/he may contact the coroner at any time (including weekends and public holidays)for contact between the hours of 0700 to 2300.

8.3.38 An Email covering an overview should be forwarded for the Coroners attention as soon as possible in order to inform any decision and avoid unnecessary delays, At the conclusion of the investigation the SIO should, in consultation with the SUDC paediatrician and the Police Coroner's Officer and in accordance with locally agreed timescales, submit a report to the coroner

giving full details of the extent and outcome of the police investigation. The PCO involvement and the file preparation will mean that in the majority of the cases the PCO will give evidence on behalf of the SIO and SUDC paediatrician

Attending multi-agency case meetings

8.3.39 The SIO (or where unavailable his/her nominated representative) and nominated PCO should fully engage in the first and final multi-agency meeting In suspicious cases the police SIO will continue to lead the case meetings. In all other cases, the SUDC paediatrician will lead the meetings.

8.3.40 At these meetings, professionals will agree a co-ordinated action plan. The plan will be delivered by named individuals from the various agencies being tasked with specific responsibilities within a set timeframe.

8.3.41 Any suspicion or concern arising from the police investigation should be shared with senior staff from the other key agencies involved as soon as possible. Full details of the information passed, time/date and to whom should be recorded.

8.3.42 The SUDC paediatrician should review all medical records relating to the Infant/Child/YP and relevant family members. S/he should consult the SIO about any information contained in them that could potentially assist the police investigation. This should include medical records held by the Emergency Department, hospital paediatrician/consultant, community nurses (includes health visitors, school nurses and children's community nurses) in infants the Red Book and the child's general practitioner. Copies of all such documents will be supplied to HM Coroner

8.3.43 Any surviving sibling(s) may be the subject(s) of enquiry under Section 47 (s.47) of the Children Act 1989 (child protection investigation). The police element of any such enquiry would be led by local P.P.I.U staff and managed according to Local Safeguarding Children Board Procedures. If a s.47 enquiry were to be required, this would be discussed at the first joint agency meeting. If circumstances made a s.47 strategy meeting necessary before the initial joint agency meeting the strategy meeting must not be delayed.

8.3.44 During the investigation, SIOs should liaise closely with Children's Services personnel if there is any chance that care proceedings may be commenced in respect of siblings / potential siblings of the dead child/young person. This will help to ensure that any potentially criminal investigation is not inadvertently compromised by the disclosure of information during such proceedings.

8.3.45 All agencies have the same ultimate aim, which is to establish why the child died. As such, the SIO should very much view the investigation as a joint, collaborative enterprise.

Keeping parents/carers informed

8.3.46 Wherever possible, bereaved parents/carers should be kept up to date with all progress made during the investigation, unless this could compromise any intended police action. This is the role of the Police Coroner's Officer and care should be taken to avoid any duplication of effort, particularly in regard to any direct contact with the parents/carers. The communication strategy for parents/carers should be an agenda item at the joint agency meetings. All contact with the parents will be recorded in the PCO case book. It is important to inform the family at each point a child is moved. The PCO can liase with the Key Worker to provide bereavement support to the family.

8.3.47 Important information should only be withheld from parents/carers, if absolutely necessary. In such circumstances honesty and transparency about police actions and intentions form a critical part of winning the respect and cooperation of parents/carers without which an effective and comprehensive investigation may not be possible.

Public Protection Division (PPD)

8.4.1. During their investigation, all SIOs should draw on the knowledge and expertise of staff in the Public Protection Division (PPD).

8.4.2. PPD staff have specialist skills, knowledge and experience within the field of interagency child protection. As such they have a vital role to play in supporting the investigation into the death of any child or young person within the definition of this protocol. The SIO should liaise with his/her divisional PPD at the earliest opportunity.

8.4.3. The PPD staff will address any wider child protection issues including assessing any risk posed to a living sibling or unborn child and taking any action necessary by either invoking police protection procedures or by supporting an application by the Local Authority for an Emergency Protection Order.

8.4.4. The PPD is responsible for attending Child Protection Case Conferences in respect of all children who are the subject of a 'child protection plan' across the force area. When a child who is currently the subject of a 'child protection plan' dies and a multi-agency investigation commences, staff from this unit will contact the police SIO for further information.

8.4.5. The PPD is also responsible for attending and reporting on all child deaths to the Local Safeguarding Children's Board (LSCB) and Child Death Overview Panel (CDOP) in each Local Authority area. Staff from the PPD will complete a Child Notification Form for every child or young person's death coming to the attention of the police. This will include details of the child / young person, the family/carer and the circumstances. This is a requirement on all agencies. The LSCB administrators will then request a second, more detailed form, to be completed. This will also be completed by staff from the PPD.

8.4.6. In cases where a child dies in circumstances where abuse or neglect is suspected to be a feature, the CDOP may decide to hold a Serious Case Review (SCR). Police representation at a SCR will be a PPD Detective Inspector. SIOs should expect contact from this unit following their involvement in such cases.

Road Deaths

8.5.1. The investigation of a road death involving a victim under the age of 18 years will be led by a Road Policing SIO (RPSIO) from within the Serious Collision Investigation Unit. The RPSIO and his/her staff should, as far as possible, follow the relevant guidance contained in 'Working Together to Safeguard Children' and consider the contents of this protocol. [See Appendix A1]

Returning property to bereaved families/carers

8.6.1. Items should be returned in person to parents/carers by the PCO as soon as possible after the Coroner has finished his/her investigation. Parents / carers should first be contacted and sensitively reminded about what items had originally been taken by the police. They should be asked whether they want the items back. If any items are unclean or, for example, still contain feed or juice, the PCO should ask permission to wash them before they are returned. Official labels or wrappings should always be removed. They should be presented back in a sensitive manner,

8.6.2. Where possible, items should be returned in respectful and presentable containers. In many cases, this meeting with parents / carers may represent their final contact with the police concerning the death of their child.

Sources of advice for cultural, religious and diversity issues when dealing with unexpected deaths of children / young people

8.7.1 GMP staff can obtain guidance from the following associations / sources:

- Cultural Liaison Officers
- Black & Asian Police Association
- Christian Police Association
- Disability Support Network
- Jewish Police Association
- Lesbian & Gay Staff Association
- Muslim Police Association
- Diversity Command

Contact details are available on the GMP Force intranet site.

Police Response in Road Traffic Collisions

Appendix A1

A1.1 RTCs are both sudden and unexpected and are due to external causes. A Joint Agency Response is required but in these circumstances all cases will be police led. The common principles of all JAR investigations should be followed. Whilst all deaths following an RTC will have unique features, the following considerations should always apply:

A1.2 In the majority of RTCs some form of resuscitation occurs, and the preservation of life comes first. If, however, death occurs, it must be remembered that the child's body may hold vital evidence, so should not be washed, and all items of clothing, sheeting etc should be saved until discussion with the SIO. This is particularly relevant in collisions where the vehicle has failed to stop. Forensic evidence such as glass and paint flakes can be critical to the investigation and are easily lost or destroyed. Efforts should be made to establish whether or not this is the case at first contact with the SIO.

A1.3 In the event of the death being confirmed at scene the child should be taken to the nearest ED with Paediatric facilities as per protocol (in exceptional circumstances the SIO may request transfer straight to the mortuary).

A1.4 The SIO will contact the SUDC Paediatrician on call at the earliest practical opportunity. It will only be in rare circumstances that the SUDC Paediatrician will be asked to attend the scene of death, this would be following a specific request from the SIO.

A1.5 The SIO and SUDC Paediatrician on call will always discuss the role of the SUDC paediatrician in taking a background history. This may not always be in the ED immediately after death. Unlike the majority of special procedure deaths, a Family Liaison Officer (FLO) will always be deployed following a fatal road traffic collision. The SIO, following discussions with the SUDC Paediatrician on call and the FLO, will decide when and where such a history is most appropriate.

A1.6 If there are forensic considerations an external examination should be deferred till the forensic post mortem examination (PME). In other cases the ED consultant will have greater experience of trauma victims that the SUDC Paediatrician on call and could be asked to comment on injuries. If there is any evidence of injury not thought to be associated with the RTC the SUDC Paediatrician should be asked to examine and the SIO informed

A1.7 The SIO will ensure all usual CSC and GMP checks occur.

A1.8 The SUDC Paediatrician on call shall collate medical background information, including any factors that may have increased the child's vulnerability (vision, hearing, behaviour etc), and will review the medical records including

community health records. If such factors exist, then the SIO must be informed as soon as possible so that they can consider the information for the purposes of the Criminal Procedures and Investigation Act 1996 (Disclosure)

1. In some cases (particularly fail to stop cases) a forensic PME will be requested, although this is a coronial decision. The SUDC Paediatrician on call should attend the PME if not attending another case. If the child hasn't already been externally examined then the SUDC Paediatrician should be present for the external examination. In the event that the SUDC paediatrician is unable to attend, if there are any concerns about injuries not associated with the RTC, the SIO should arrange for the SUDC Paediatrician on call to review photographs taken at PME.

A1.9 Following provisional PME findings the SUDC Paediatrician will organise a Child Death Review A meeting should be held with the support of the SIO. At this point a key worker can be confirmed if not already identified. The SIO and FLO will attend or send a representative.

A1.10 Once Police involvement is coming to an end, the SIO will inform the SUDC Paediatrician so they can reconvene a Child Death Review Meeting to complete analysis forms for CDOP, and review support given to the family.

A.11 Road Death Investigations are often led by a Roads Policing Lead Investigator or RPLI. These officers perform the same function as an SIO.

9 AMBULANCE PROTOCOL Appendix B

9.1 Initial call

9.1.1 When the ambulance service is called to the scene of a sudden unexpected death or collapse/cardiac arrest of a child (0-18 years) the attending Ambulance Crew ("NWAS Crew") must notify the Paramedic Emergency Operations Centre (EOC) at the first available opportunity without delaying patient treatment.

It is then the responsibility of the Emergency Operations Centre to notify the police in ALL such cases.

9.2 Resuscitation

9.2.1 When resuscitation is indicated:

- Full resuscitation must be performed according to local protocol.
- The receiving Emergency Department must be contacted via the Emergency Operations Centre with information on the child's clinical condition and the estimated time of arrival (ETA)
- All the information including history, observations of the scene and resuscitation details must be documented on the patient report form and passed onto the staff at the receiving unit.
- If circumstances allow, any other information will be passed on to the receiving doctor or police; i.e. background history, living conditions, comments made by those at scene.
- Anything suspicious will be reported directly to both police and the receiving doctor at the hospital.
- It may be necessary to make a safeguarding vulnerable child referral, depending on the circumstances of the case
- A copy of the patient report form will be left with a senior nurse or doctor dealing with the child.

9.3 Conformation of Death

9.3.1 The Ambulance Crew will confirm death in every case in which they are called to the scene of the death of a child or young person where resuscitation is not indicated. They will try to minimise contamination of the scene and body whilst performing this function provided doing so does not adversely affect any viable resuscitation attempt.

9.4 Removal of the body from a scene – Death 'does not appear suspicious'

9.4.1 If, after conformation of death, there do not appear to be any suspicious circumstances, the NWAS crew will (subject to exceptions listed below)

immediately take the child's body to the nearest local Emergency Department with Paediatric facilities with the agreement of the Police.

In such circumstances, the attending ambulance crew will contact Emergency Operations Centre and inform them of confirmation of death. Ideally this should be prior to the child being transferred into the ambulance. The ambulance Emergency Operations Centre will make it clear to the receiving Emergency Department that death has been diagnosed and that resuscitation is not being attempted and that the child is being transferred to the Emergency Department as per GM SUDC protocol.

If the Police or the SUDC pediatrician are already involved this information should also be conveyed to the Emergency Department staff.

9.4.2 The only exceptions to the above are as follows:

If any police officer directs that the body should not be moved (the officer should be told that once the ambulance has left it cannot return and the body will need to be moved by undertakers arranged by the police).

If the body is considered to pose a public health risk.

If *other exceptional reasons* exist that justify not taking the body to the nearest Emergency Department with Paediatric facilities e.g. major incident in progress. Details should be recorded in police and NWAS records and brought to the attention of the police SIO.

9.5 Removal of the body from a scene – Death appears 'suspicious'

9.5.1 If after confirmation of death, the death appears to be 'suspicious', the NWAS crew should remain with the body at the scene until the first police officer arrives. In these circumstances, the SIO should be consulted before the body is removed from the scene by NWAS. The first police officer at the scene should have the means to identify and contact the duty police SIO for this purpose.

9.5.2 On average the NWAS crew will be available at the scene for 30 minutes following their arrival time whilst they complete records about the incident. Subject to the exigencies of their service they will transport the body to the nearest Emergency Department with paediatric facilities, if requested to do so by the police SIO, within that timeframe. If the child requires to be transported to the Emergency Department out-with this timeframe the Police and NWAS should agree if this is possible with the NWAS Emergency Operations Centre.

9.6 Travelling to the Emergency Department

9.6.1 If a relative or carer wishes to travel to the hospital with the child, this should be permitted. Where necessary, the police may arrange transport to the hospital for any other immediate next of kin who wish to attend.

9.7 On arrival at the emergency department

9.7.1 On arrival at the ED, the ambulance should be met by a senior emergency medicine or paediatric doctor. This will allow for transfer into the department in the most appropriate manner.

9.8 Other actions to be taken after death has been established

9.8.1 As far as possible make arrangements for the support of the bereaved (contact relatives, neighbours, priest etc).

9.8.2 Obtain police PIN or collar number from the officer attending and record on the appropriate documentation.

9.8.3 Complete all documentation as comprehensively as possible and provide a copy to the police.

9.8.4 The NWAS attending crew or representative will be invited to the SUDC multi-agency rapid response meeting. This will be via contact with the NWAS Safeguarding Practitioner via 07812 304 236, or 01204 498400 and asking for the NWAS Safeguarding Practitioner or the NWAS Safeguarding Team.

The NWAS Safeguarding Practitioner will co-ordinate who is available to attend the meeting and feedback to the original attending crew. The NWAS Safeguarding Team can also be contacted by email: safeguarding.team@nwas.nhs.uk

10 THE GENERAL PRACTITIONER (GP)

Appendix C

10.1 Rarely the GP may be called to the scene first. In such cases they should adhere to the same principles as the Ambulance crew (Appendix B).

10.2 In the unlikely event of being first to the scene the GP will confirm death and will inform the police, via Police Control. The police and GP will inform HM Coroner ("the Coroner"). The GP ill inform the Emergency Medicine consultant or consultant paediatrician at the hospital to which the child will be taken. The child should not go directly to the mortuary. The GP will carefully record (verbatim) any account given by parents/carers of the circumstances leading up to the death and bring this to the attention of the police SIO.

10.3 Usually the GP will not be notified until after death is confirmed at the hospital and the Joint Agency Response Team has become involved. GP involvement is vital to support the grieving family and to provide background information on the child, the child's siblings, parents and wider family. (See 5.23 - 5.31 on confidentiality and information sharing).

10.4 The GP will be asked to attend a multiagency meeting to discuss the case (usually within 24-48hours of death). To facilitate the GP attending these meetings they may be held at the GPs surgery. It is extremely useful to have access to the health records of the child and family. The purpose of this meeting is to consider the potential cause of death, specifically consider safeguarding issues for surviving siblings, review support for the family and complete data collection for CDOP Reporting form (previously form B). Individual roles and responsibilities will be decided at this meeting. It is the SUDC Paediatrician's role to summarise this meeting and distribute an action plan.

10.5 The GP should offer appropriate support to the family.

10.6 The GP will also be invited to a final professionals meeting, the Child Death Review Meeting (CDRM) (once more usually held at the GP's Surgery) when the final post mortem examination report is available. The purpose of this meeting is to consider the cause of death, specifically consider safeguarding issues for surviving siblings, and future siblings, review support for the family and complete data collection for CDOP Analysis Form (previously form C).

10.7 Additional guidance for GPs, particularly in relation to the longer term care of the family, can be obtained from the following:

10.7.1 Lullaby Trust:
https://www.lullabytrust.org.uk/professionals/supporting-bereaved-families/

10.7.2 Child Bereavement UK:

https://www.childbereavementuk.org/supporting-bereaved-children-and-young-people and https://www.childbereavementuk.org/supporting-bereaved-adults

https://www.childbereavementuk.org/supporting-bereaved-adults

10.8 Mother's, sibling's and, where possible, father's records should highlight that a child has died in the family. Any safeguarding concerns raised during the Joint Agency Response investigation should also be highlghted irrespective of their relevance to the cause of death and any relevant information shared.

11 HOSPITAL STAFF Appendix D

EMERGENCY DEPARTMENT

11.1 As soon as the emergency department is notified that the ambulance crew is attending the scene of child cardiac arrest/death the nurse in charge must notify:

- The on-call paediatric resuscitation team
- The on-call paediatric consultant
- The on-call emergency department consultant.

11.2 Full resuscitation should normally be commenced unless clearly inappropriate.

11.3 The identities of people present and their relationship to the child must be ascertained and recorded in the medical records.

11.4 To identify the possible cause of death a detailed history should be obtained (using the proforma below as a guide). This will usually be taken by the SUDC paediatrician accompanied by the SIO, however if a family gives information to the hospital team this should be documented carefully and discussed with the SUDC paediatrician/SIO on arrival. The comments of parents/carers at all stages must be recorded in detail (verbatim if possible) in case of discrepancies or if suspicious circumstances develop.

11.5 The site and route of any interventions during resuscitation e.g. venepuncture, failed cannulation, intraosseous needle, should be documented on a body chart and may be removed. Any interventions which took place pre-collapse (eg tracheostomy tube, central line, chest drain etc) should remain in situ. An endotracheal tube may be removed altogether (if the death is not suspicious) but only if there is documented clinical evidence of correct placement of the tube. If there is doubt that the endotracheal tube is not correctly placed, the fact must be noted and the tube left in situ.

11.6 A full general examination should be undertaken by the paediatrician/emergency medicine consultant noting any rashes, injuries on the child, signs of dehydration etc, and state of any clothing or bed linen. The examination should include a retinal examination if possible.

11.7 All items of clothes and personal possessions should be placed in plastic bags and retained. They may not be returned to the family without prior consultation with the police and HM Coroner (“the Coroner”). They should be kept safe from any contamination and brought to the attention of the police as soon as possible. Staff should be aware that some or all of the items could later be sent for forensic examination.

11.8 **Do not wash the body**. Photographs may be taken and given to the parents according to the local protocol. Where requested by the family locks of hair, and hand/foot prints will be taken after the post mortem and **must not** be taken in the Emergency Department. This will be arranged by the SUDC Paediatrician.

11.9 Prior to death, blood, urine and CSF specimens may have been taken for toxicology, metabolic and septic work-up. The hospital notes must accurately record which tests have been obtained. The paediatrician/lead clinician must ensure that all results of pre-mortem tests are forwarded to the Coroner and pathologist.

11.10 If the child is dead on arrival at hospital or when the fact of death is certified, the attending doctor should inform the police as soon as possible on **101.** It will be the dual responsibility of the police and senior clinician (emergency medicine or paediatric) to inform the Coroner's office of the death. Only in exceptional circumstances should the Coroner be contacted between 11pm at night and 7am in the morning.

11.11 If initial history suggests the possibility that metabolic disease may contribute to the death then the lead clinician should consult with a paediatric metabolic consultant. If specimens are to be taken this should only be with specific agreement of the Coroner.

11.12 When death is confirmed the senior clinician should contact the SUDC paediatrician and discuss the immediate case management and arrangements for hand over.

The SUDC paediatrician is contactable via Wythenshawe Hospital Switchboard Tel: 0161 998 7070.

11.13 Children's social care should be contacted to ascertain if the child, parents, any siblings or the address are known, and in what capacity.

11.14 Other professionals also need to be informed. This should be done in consultation with the NHS Trust's 'child death' checklist.

11.15 The parents/carers will need time to accept the information. Staff should be prepared for a range of reactions from bereaved individuals.

11.16 Explain that the police, the Coroner and SUDC paediatrician must be informed and that a post-mortem examination will be necessary to try to ascertain the cause of death.

11.17 Explain that the child's, and any sibling's medical records will be reviewed and that the SUDC paediatrician will contact the parent's GP to ascertain if there is any relevant family history.

11.18 A record should be made at every stage of contact with the family. This should include which health professionals were present at each contact. Careful documentation is required to include the full history and the verbatim comments and demeanour of the parents/carers. In addition to NHS Trust ID bracelets, the police will require a unique Police ID bracelet identifying the child.

11.19 The parents/carers/family members should be encouraged to see and hold the child whilst discreetly accompanied by a professional. However, if the death appears suspicious, the police SIO should be consulted before allowing this. At no stage should staff place themselves at risk in this situation.

11.20 A member of staff should accompany the child to the appropriate mortuary. The child should not be left unattended until in the mortuary.

11.21 The trust's hospital checklist should be completed according to local practice.

UNEXPECTED DEATH OF A CHILD ON A WARD, INCLUDING NEONATAL UNITS AND POST NATAL WARDS

11.22 All child deaths should be referred to the coroner. If the clinician is unable to issue a medical certificate of the cause of death following this discussion then the SUDC procedure should be followed. **The SUDC paediatrician is contactable via Wythenshawe Hospital Switchboard Tel: 0161 998 7070.**

11.23 The investigation of newborn baby deaths has been the subject of debate both regionally and nationally. Nationally it is the norm that SUDC Joint Agency Response doesn't investigate newborn deaths. However there are circumstances where a Joint Agency Response is clearly appropriate (for example, if a newborn baby has been identified as healthy and then dies suddenly after being given to his/her parents for routine care even if still on labour ward, or on the postnatal ward). When a hospital specialist is unsure whether or not a case should trigger a Joint Agency Response this should be discussed with the SUDC Paediatrician (and the SIO when appropriate, for example if there are concerns about the care given by carers or health professionals).

11.24 When a child dies on the ward and, if the collapse leading to their death was sudden and unexpected 24 hours prior to that collapse, then a Joint Agency Response should be instigated.

11.25 The role of the Joint Agency Response is to

- ascertain cause of death
- address safeguarding/criminal issues
- offer support to the family
- collect information for CDOP (Child Death Overview Panel).

In cases where a thorough history has already been taken, the social background of the child considered, safeguarding issues/unnatural death explicitly addressed and the child and family are already well known to the acute team it *may* be that a Joint Agency Response has nothing further to add. However the SUDC paediatrician should be informed of the death and a three-way discussion between Acute Lead, SUDC Paediatrician and SIO should occur. The reasons for not instigating a Joint Agency Response should be documented in the hospital notes and by the lead consultant.

12 SUDC PAEDIATRICIAN Appendix E

12.1 The SUDC Paediatrician will provide telephone advice and attend the emergency department promptly when on call once they have been informed of a sudden unexpected child death (see definitions). If the child is not in the emergency department, the SUDC paediatrician will agree with the referrer what actions are required next.

In the rare circumstances of two deaths occurring at the same time a discussion will take place between the SUDC paediatrician and the SIOs involved to decide on the most appropriate management of each case.

12.2 The SUDC paediatrician will take the lead in the medical investigation in communication with other health care professionals and in communication with other agencies (police, police coroner's officer, coroner's office and children's social care).

12.3 There are rare occasions when a child dies and they do fulfil the criteria for a joint agency review but the SUDC paediatrician does not feel a full response is necessary (usually because key aspects of the service have already been covered by hospital staff). In these circumstances there should be a careful discussion with the referrer and hospital staff to review the key aims of the joint agency review – to establish the cause of death, to ensure safeguarding has been fully considered and to support the family – to ensure these have been met and this discussion should be documented and then a letter written to CDOP and the coroner to explain why a joint response was not undertaken and with details of who to contact with any further queries. There would need to be an agreement as to who would organise the final Chid Death Review Meeting.

12.4 The SUDC paediatrician will ensure all necessary multi-agency strategy discussions/meetings take place in non-suspicious cases. In suspicious cases and cases of potential suicide the police will lead and organise these multi agency discussions. At all meetings it should be considered if criteria for a Rapid Review have been met.

12.5 On arrival in the Emergency Department the SUDC paediatrician will meet with the senior acute physician and SIO to discuss what is already known about the child's death. They will then agree who will be present to examine the child. If the child is a patient on a ward or PICU, then the SUDC paediatrician will meet with the senior acute physician on the ward.

12.6 The SUDC Paediatrician will fully examine the child with the SIO and document all findings. If there are any findings that raise the possibility of a suspicious death, these will be immediately communicated to the SIO.

12.7 The SUDC paediatrician will take a full history from the family, usually accompanied by the SIO and Police Coroner's Officer (PCO).

12.8 The SUDC paediatrician will ask the family if they would like mementos to be taken at post mortem examination. They will complete the consent form and fax it to the pathology department. It should be remembered that some individuals may potentially find the idea of taking mementos to be upsetting and offensive. All families should be asked, although it may be helpful to make it clear that what is comforting for some families may be extremely distressing for others. Also be careful of the offer for older children where hand and foot prints may not be so easy to take.

12.9 Following history taking the SIO and SUDC paediatrician will discuss if there should be a visit to the scene of death**.** It would be unusual not to visit the scene in a child under 2 years.

12.10 If the family are not present in the Emergency Department, (or ward) the SIO and SUDC paediatrician will agreed when/where will be the most appropriate setting to take a history.

12.11 After examination, history taking and home visit, the SUDC paediatrician will discuss with the SIO (and where possible the duty SW) an immediate plan for onging investigation of the death and support of the family. A key worker should be identified as soon as possible.

12.12 The SUDC paediatrician will make contact with the named nurse for the acute site at the earliest convenient moment. If the child's death is outside PCO working hours, they will contact the PCO at the earliest convenient moment.

12.13 The SUDC paediatrician will review the Emergency Department records, the ambulance call out sheet and any other hospital records available.

12.14 The SUDC Paediatrician will collate information from all relevant medical records, including sibling's health records, notes of previous hospital, community, Obstetric, A&E Department attendances must be reviewed including records of the use of NHS facilities in other areas. They will seek information on any relevant parental health problems from GP.

12.13 Together with the hospital paediatrician, where appropriate, the SUDC paediatrician will provide information for the pathologist prior to the post mortem examination. This should take the form of a written report wherever possible. It is the responsibility of the PCO to inform the parents of any movements of the child's body, timings of PM examination (PME) etc.

12.14 The SUDC Paediatrician will complete a Death Notification Form (Previously Form A) for CDOP within 48 hours of the childs death.

12.15 The SUDC paediatrician will arrange and chair a multiagency meeting. They will summarise the meeting and distribute to all present as well as ensuring the

hospital staff, CSC, GMP and CDOP and the coroner are updated. If it is predictable that a strategy meeting will be required, the SUDC paediatrician should discuss with a senor manager in CSC so they can chair the meeting. IN this case, CSC will be responsible for taking minutes and distributing them.

12.16 Unless working on another case the SUDC Paediatrician will attend the PM examination **or hand over to a colleague if their on call period has finished**. *After the PME they will ensure that the family are aware of the result by liasing with the PCO.* If an initial multiagency meeting has already occurred they will ask permission to share the provisional results with other professionals. If a meeting hasn't already occurred then they will request to inform others at the meeting.

12.17 If it becomes clear that a child's death is the result of natural causes it will usually be appropriate for the police role to be reduced although the SIO should continue to be informed of the progress of the case.

12.18 The SUDC paediatrician will complete the Reporting Form (Form B) for CDOP within 40 days of the child's death.

12.19 The SUDC paediatrician will organise a final Child Death Review Meeting as soon as the final results of the post mortem examination along with coronial permission to share information have been provided by the PCO. (All attendees should receive a summary which should include

- A brief summary of the case
- A summary of PM examination findings, the cause of death, and *any* other relevant findings.
- Explicit comment on safeguarding issues for siblings/household contacts and *future siblings.*
- A list of further actions, including management of future pregnancies.
- A full distribution list (which should always include the child's, Mother's and where possible Father's GP and any other professionals felt to be relevant during the meeting. GMP and CSC must be aware of the final PME result).

An analysis Form (form C) should be completed at the meeting and sent to CDOP

If no final meeting is held the SUDC Paediatrician should write to CDOP to explain why a final meeting was not held, and cc all the attendees from the early meeting. The letter should include an option to call a meeting if further information sharing is felt by any professional to be helpful. This should almost never be the case, and should only occur if the analysis form was completed at the initial meeting and no further no information was available.

12.20 After the Child Death Review Meeting, the SUDC paediatrician should offer to meet the family to explain the outcome of the case discussion and post mortem examination, including the cause of the child's death, and following this send the family a letter documenting what was discussed in accessible language.

12.21 The SUDC Paediatrician should ensure in liaison with the Police Coroner's Officers that the family is fully notified and supported at all stages.

13 Role of the Named Nurse Appendix F

13.1 If the Named Nurse is aware of a SUDC death before being contacted by the SUDC paediatrician they will start to request records and ascertain health and safeguarding background.

13.2 The SUDC Paediatrician will telephone the Named Nurse* for Safeguarding children at the earliest opportunity following the child's death after history taking, examination and home visit.

13.3 The SUDC paediatrician will inform the Named Nurse of the child's details, a brief summary of the child's death and together they will agree who will be responsible for

i. Contacting the child health recorder holder (HV or SN) to request records and ascertain health and safeguarding background (if not already done). This may lead to further notes/information being requested.
ii. Agree who will invite other professionals to SUDC meeting (this will usually be the named nurse). This may include HV/SN/MW/Allied Health professionals/education.
iii. Contacting Children's Services if the police are not arranging children's services to attend the SUDC meeting.

13.4 At the end of the initial contact between SUDC paed and Named Nurse, it should be clear what is the immediate plan, and when a multiagency SUDC meeting will occur (a specific date will depend on other professionals attending, but a timeframe can be agreed, see flow sheet 5).

13.5 The Named Nurse will update other named and designated professionals as per local agreement.

13.6 The Named Nurse will usually attend the SUDC multiagency meeting. In cases where the Named Nurse doesn't attend this will be following discussion between the Named Nurse and SUDC paediatrician, and the reason for not attending will be clearly documented.

13.7 Following the initial multiagency meeting the Named Nurse will complete any actions agree from the meeting.

13.8 The SUDC Paediatrician will summarise the meeting and send out an action plan, unless the case has been handed over to the police as lead in suspicious cases, or children's services have taken the lead where there are wider safeguarding concerns. They will then be responsible for updating all professionals re actions.

13.9 When the final post mortem (PM) examination report is available, the SUDC paediatrician will decide in conjunction with the SIO whether a final multiagency meeting will be called (this will usually be the case). If a final meeting isn't held, the SUDC paediatrician will inform the Named Nurse. If the Named Nurse has information that would require a final meeting they will request the SUDC paediatrician hold one. If there is a meeting the Named Nurse will be invited and decision to attend will be on a case by case basis, and if not attended the reason for not attending will be clearly documented.

*Different areas have hospital based and/or community Named Nurses. The SUDC paediatrician will initially contact the Named Nurse for Safeguarding Children at the hospital where the child has been brought to. It will be the responsibility of this professional to ensure the correct named professionals are involved.

14 ROLE OF THE KEYWORKER APPENDIX G

14.1 As described in the Child Death Review Statutory and Operational Guidance England 2018, appendix 5 Page 63 the keyworker must meet certain criteria in order to support the family appropriately.

If you are not comfortable to complete this role it is important to discuss this with your line manager and the SUDC lead.

14.2 If at all possible meet the family with the SUDC paediatrician as part of the rapid response. If that is not possible, as soon as is feasible contact the family to offer your condolences, explain your role as keyworker, ensure the family have contact details and offer the opportunity for the family to ask questions.

14.3 Initial support

Where possible arrange to meet with the family as soon as possible

- Have keepsakes been offered and consent completed?
    - If the family said no previously give the opportunity again
    - Memory Boxes (we source ours from 4louis charity who give boxes for free. Please be mindful of the contents and know what you are giving but the family can make/buy their own).
    - Offer to book another visit (all families are different and they may not want another visit). Remind them how they can contact you if this changes and offer to call in a weeks' time.
    - Ensure families are aware of helplines they can contact especially out of work hrs (https://www.thegoodgrieftrust.org/need-know-info/from-us-to-you/for-newly-bereaved/ scroll to the bottom for a list of helplines) . The lullaby trust is often given to families as a point of support at this point, from experience, be aware the main page can be quite upsetting for a family newly bereaved and I would advise they access the website via this page https://www.lullabytrust.org.uk/bereavement-support/

14.4 Preparing for the funeral

- Families may have questions around how to plan a funeral. Most of the basics around a child's funeral is free under the age of 15 sometimes 18 years (I would advise talking to different funeral directors, remembering they are a business to make money). When using a minister to perform the service they will often waive their fee when it is a child death.

- Families can apply to the DWP for a bereavement payment and if they don't want too or don't qualify there is the child funeral charity who will also help with funeral costs https://www.childfuneralcharity.org.uk/
- It is not expected that you attend the funeral. If you are going to the funeral remember you are going as part of your job as keyworker, not as a family mourner. Going to the funeral can have a positive impact on your relationship with the family and can give insight into the support of their family and friends.
- Where possible try to arrange another visit after the funeral to check in

14.5 After the funeral

- This can be a natural low point for families, up until this point the family have been kept busy with organising the funeral, and visitors , with people are openly contacting and wanting to support. After a funeral there is often a lull in activity and often families describe the reality hits at this point.
- Suugest that a monthly visit leading up to inquest is offered. Often families will go through waves of being ok and then needing support. You may find some months you will have increased contact with the family compared to the next. Every family is different and they may not engage at all, remember to document and let the SUDC team know.
- Speak to the coroners about potential date for inquest and where possible pencil this date in your diary to attend and support (the coroners will often inform the family)

14.6 Lead up to the inquest

- If you have never been to a coroner's inquest I would advise to go and observe one (this way you can have a better understanding of how the court works, how to get there, facilities available to the family and overall be able to support the family with more confidence). Each coroners should have details on how you can do this through the local council.
- Reports are often late coming to the family due to the unascertained nature of most of these deaths. The Police Coroners Officer (PCO) will often arrange to meet with the family to go through the reports and answer any questions before the inquest (you may need to call the PCO to get regular updates as the inquest date approaches). Where possible liaise with the PCO to join this meeting so that you can understand and repeat the messages to the family
- Families will naturally start to question their responsibility for their child's death. You may find yourself regularly repeating key messages e.g. 'that coroner's court is not about blaming anyone but instead about trying to ascertain how your child died'.

- Families may benefit from a visit to the courts beforehand. This can be arranged with the PCO.

14.7 After Inquest and beyond

- After inquest a final meeting is arranged.
- After this, suggest that instead of offering a monthly visit let the family lead contact, each family is different. I would advise seeking regular supervision to explore any dependency the family may develop over your support and think about how you can refer and signpost to other services or identify support networks already within the family.
- Remembrance days- many hospitals have a remembrance service annually. – you might want to attend this to offer support if you know any families attending. Contact the local hospital chaplaincy for further information
- Referrals to charities for ongoing support : Some which I can suggest there are many more
    - Reuben's Retreat- based in Glossop, they will offer respite, therapy and remembering activities for all the family
    - Gaddum- Couselling for adults, there is a waiting list and a minimal £10 charge
    - Once upon a smile- Great for sibling support
    - Compassionate Friends- Advice, retreats

14.8 Lastly and most importantly: Looking after yourself

- Keep the relationship professional, Use work contact numbers, visit in work time. Inform a family when you are off on leave and who they can contact in your absence
- Adhere to local lone worker policy when visiting. If you do not have one I would advise you visit in 2's or arrange the contact at your workplace if suitable, highlight to management and continue this practice until process are in place
- Seek regular supervision
- Reflect on your own wellbeing and if you are struggling to support talk to your line manager and/or the SUDC lead.
- Document all contacts
- Be kind to yourself (you can't pour from an empty cup)

Please do get in contact if you would like any further support from our team

Swan Bereavement Team

Salford Royal Hospital

0161 206 5175

15 CHILDRENS SOCIAL CARE Appendix H

15.1 In the first instance Emergency Department staff will check with Children's Social Care (within the local authority that the child is currently residing) whether the deceased or any child within the same family or address is or has been known to children's services and if so, in what capacity.

15.2 Children's Social Care staff will check whether the child and or siblings are known in any capacity, or any other child in the family, parents or address is known. It will be necessary for the Emergency Department to check with other local authorities where the child has previously lived, if this is not already known by the current local authority where the child is residing. Such information will be given to the Emergency Department and/or SUDC paediatrician in confidence.

15.3 If the family of the deceased child are existing or recent clients of Children's Social Care, the Assistant Director and Head of Safeguarding for Children's Social Care will be notified and the child's social worker informed or consideration will be taken regarding the need for a social worker to be allocated to the family by the social care duty and assessment service.

15.4 If concerns about abuse or neglect are evidenced / suspected, a multi - agency strategy discussion should be convened by children's services, taking the place of the initial SUDC meeting.

15.5 Children's services should attend all SUDC multi agency meeting/s even if no safeguarding concerns have yet been identified. It is at this meeting that it can become clear if there are safeguarding issues/child protection or family support needs. If the SUDC meeting needs to progress to a strategy meeting, the SUDC Paediatrician should discuss this with Childrens Social Care so that a chair and minute taker can be provided for the meeting.

15.6 If the family is not known to Childrens Social Care, the primary support to the family will be given by all involved agencies, including health workers and the police. Should these agencies assess that children's Social Care support or services is required, a referral to Childrens Social Care should be completed.

15.8. Following the referral to Childrens Social Care, if further assessment is required and an Early Help / Social worker is allocated to the child, contact will be made with the family first and liaison will take place with the Senior Investigating Officer and SUDC paediatrician to ensure all relevant information is shared.

15.9 If the death appears to be suspicious and there are other children in the family, a Child Protection Investigation (Section 47 of the Children Act 1989) will take place.. This will be done in accordance with statutory requirements and the local authorities Safeguarding Partnership Arrangement procedures. The immediate protection of any other children in the family will take priority.

15.10 If a Child Protection Investigation is required this will be agreed via a multi agency strategy meeting within the SUDC rapid response process to ensure timings, roles and responsibilities are clear (see point 15.4). If due to the urgency of the matter it is not possible to have a strategy meeting a strategy discussion between Childrens Services and the police will take place. A strategy meeting will all relevant professionals will then be held as soon as is practicable to ensure all strands of the investigation, roles and timescales are pulled together and next steps are clear.

15.11 Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the National Child Safeguarding Practice Review Panel and Local Safeguarding Partnership Arrangement within five working days of being aware of the incident, if –

(a) the child dies or is seriously harmed in the local authority's area, or
(b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.

Within 15 working days, a Rapid Review of the case should be completed and the nation Practice Panel informed of the outcome. Please refer to your local Safeguarding Partnership Arrangements for your Rapid Review Pathway.

The SUDC meeting should consider if a Rapid Review meeting is required.

15.12 All attendees should receive a copy of the SUDC/Joint Ageency Review (JAR) meeting minutes ideally within 5 working days. A copy can be obtained by contacting the SUDC administration team on:

0161 537 0405
Tracey.cliffe@nhs.net or loren.francis@nhs.net

16 COMMUNITY PRACTITIONERS: HEALTH VISITING, SCHOOL NURSING AND CHILDREN'S COMMUNITY NURSING GUIDELINES

APPENDIX I

16.1.1 The gathering of relevant information from community practitioners such as health visitors, school nurses and children's community nursing staff following a sudden unexpected child death is required to aid the investigative process by the coroner.

16.1.2 The need to support the professionals involved with the family prior to the death of the child must be recognized.

16.1.3 The community practitioner will make the child's community health record available to the SUDC paediatrician and discuss any concerns e.g. failure to thrive, neglect, parental problems such as substance use, domestic abuse, mental ill health and learning difficulties.

16.1.4 The community practitioner will contribute to any multi-agency meetings and will provide written reports as requested.

16.1.5 The community practitioner involved with the child/family should work closely with the GP to provide bereavement support for the family.

16.1.6 It is essential that at all times the safety of any surviving siblings and/or other vulnerable people is paramount. This should always include full consideration of the safety of potential future siblings.

16.1.7 All staff involved in rapid response should recognise the importance of taking appropriate action where any potential signs of abuse or neglect are identified, irrespective of the relationship to the cause of death.

16.2 In the very rare cases where the community practitioner is first on the scene:

16.2.1 Dial 999 and ask for an ambulance to attend the scene immediately stating "cardiac arrest".

16.2.2 Attempt resuscitation or procede as instructed by the ambulance service. If the indications are that the child is clearly dead and no active resuscitation has been attempted, the body should remain in situ pending the arrival of the police.

16.2.3 The position of the child and the condition in which it was found must be recorded together with any comments/explanations from any person present. Bring this explanation to the notice of the police or SUDC paediatrician. Try not to disturb the scene, i.e do not touch or move anything.

16.2.4 When the paramedics arrive, spend time listening to the parents and offering support.

16.2.5 If the parent/carer goes to the hospital with the child, ensure that appropriate arrangements are made for the care of siblings. Record details of who is caring for the children.

16.2.6 If the parent is alone, ensure that he/she has the appropriate family support. Give the parents a work telephone number where you can be contacted.

16.2.7 Inform your line manager and the named nurse for safeguarding children of the action taken.

16.2.8 As soon as possible after the incident (within 24 hours) make a precise and thorough record of the event in the child's record, making particular reference to:

a. Any inappropriate delay in seeking help,
b. The position of the child, its surroundings and the condition in which it was found,
c. Inconsistent explanations - accounts should be recorded verbatim in quotes where appropriate,
d. Evidence of high risk behaviour eg domestic abuse, drugs/alcohol use,
e. Parent's reaction/demeanour,
f. Unexplained injury e.g bruises, burns, bites, presence of blood,
g. Neglect issues.
h. General condition of the accommodation

NB: If the records have already been secured, record on a continuation sheet which can be added to the child's records.

16.3 When a child has died

16.3.1 Check to ensure that all known agencies working with the child have been informed of the child's death eg, paediatric allied health professionals (AHPs), audiology, midwifery servcies, community paediatricans, Children's Centres etc so as to avoid appointments being sent.

16.3.2 Inform the Child Health Department to avoid appointments being sent.

16.3.3 Contact the family to acknowledge the death of their child, and offer support as required.

16.3.4 In the case of an infant death ensure that the parents/carers have a copy of the infant death booklet and the help line number of the Lullaby Trust (previously the Foundation for the Study of Infant Death, FSID), freephone 08088 026868.

16.3.5 Assess the support that the parents/carers/siblings/grandparents require. Where the family is in need of intensive support consider alternatives, e.g. Lullaby Trust Befriender Service.

16.3.6 If the mother was breast feeding, discuss and advise on the suppression of lactation and refer to the GP where necessary or ask advice directly from labour ward.

16.3.7 Ensure that the parents/carers have your work contact number.

16.3.8 Ensure that community health records are available to the SUDC paediatrician; be available to attend any subsequent multi-agency meetings and to provide written reports as requested.

16.4 <u>In the months following the death:</u>

16.4.1 Arrange a home visit again after the funeral and during the following weeks, in consultation with the family.

16.4.2 Make sure that the parents have your work contact number.

16.4.3 Assess whether additional support is required to assist parents/siblings cope with their grief and arrange as appropriate.

16.4.5 Remember the first anniversary of the child's birth and death and consider a visit at those times.

16.4.6 In the case of Sudden Unexpected Infant Deaths offer support with the subsequent babies via the Care of the Next Infant (CONI) Scheme.

16.4.7 Access any support you may require for yourself, eg staff counselling service/ supervision.

17. MIDWIFERY SERVICE APPENDIX J

Introduction

17.1.1 These guidelines inform midwives of the procedures in the event of the unexpected death of a child. This can be a difficult time for everybody. Additional support can be obtained from the designated/named professionals and CONI Coordinators.

17.1.1 Nationally it is the norm that SUDC Rapid Response doesn't investigate newborn deaths. However there are circumstances where a Joint Agency Response (JAR) is appropriate

- if a baby has been born healthy and then dies suddenly a JAR shall be triggered(even if still on labour ward on the antenatal wards)
- in the case of a stillbirth where no healthcare professional was in attendance a JAR shall be triggered

When a hospital specialist is unsure whether or not a case should trigger a JAR this should be discussed with the SUDC Paediatrician (and the SIO when appropriate, for example if there are concerns about the care given by carers or health professionals).

17.1.2 It is essential that at all times the safety of any surviving siblings and/or other vulnerable people is paramount. This should always include full consideration of the safety of potential future siblings.

17.1.3 All staff involved in SUDC Joint Agency Response should recognise the importance of taking appropriate action where any potential signs of abuse or neglect are identified, irrespective of the relationship to the cause of death.

17.1.4 Records will be secured by the named professionals as soon as the death has been notified. A copy will be made available for the midwives. This is a precautionary measure until the situation is clarified.

- Midwives should also refer to their own organisation's procedures/protocols
- All midwives should be competent to deal with the issues of bereavement and should access support from the specalist bereavement team if avaiable.
- On-going care and support will be provided by the midwife until the end of the postnatal episode of care unless the family specifically request another member of the team or the midwife is a witness and the employing organisation advises against a particular person visiting. In this event, check with your line manager/legal department and make careful notes of the events.

17.2 If the midwife is first on the scene

17.2.1 When an unexpected fresh stillbirth or sudden unexpected death has occurred without the presence of a health professional, or if the birth has been concealed, the midwife must assess the baby and the mother's medical condition and immediately dial 999 and request an amulance. The ambulance service will inform the police. The midwife should not complete the medical certificate of stillbirth and the GP should be informed (Northwest Local Supervising Authorities Guidance for Supervisors of Midwives (NLSAGSM) 2005).

17.2.2 Resuscitation (CPR) should be attempted if appropriate. If the indications are that the baby is dead and no active resuscitation has been attempted, the body and placenta (if delivered) should remain where they were found pending the arrival of the police. If the placenta is undelivered this should be done as per midwifery guidelines, and then retained.

17.2.3 The position of the baby and the condition in which it was found must be noted together with any comments/explanations of the mother or any other person at the scene. Try not to disturb the scene, i.e. do not touch or move anything.

17.2.4 When the paramedics arrive, spend time listening to the parents and offer support.

17.2.5 If the parent/carer goes to the hospital with the baby, ensure that appropriate arrangements are made for the care of the siblings.

17.2.6 If the parent/carer is alone, ensure that he/she has the appropriate family support.

17.2.7 Give the parents/family a work telephone number where you can be contacted.

17.2.8 If the mother's condition requires obstetric intervention, she should be transferred with a midwife to the nearest maternity unit, whether she is booked there or not.

17.2.9 If the baby is not resuscitated the body will be taken to the nearest hospital Emergency Department with paediatric facilities (see Appendix B and D).

17.2.10 Parents and family members may have access to the baby's body. An appropriate professional **MUST ALWAYS** be present however.

17.2.11 If the midwife has any relevant information about the pregnancy or the family, this should be reported directly to the police and Emergency Department staff as soon as possible.

17.2.12 As soon as possible and within 24 hours, make a precise and thorough record of the event in the baby's record, making particular reference to:

a. Any inappropriate delay in seeking help,
b. The position of the baby and the condition in which it was found.
c. Inconsistent explanations - accounts should be recorded verbatim in quotes,
d. Evidence of drugs/alcohol abuse,
e. Parents reaction/demeanour,
f. Unexplained injury e.g bruises, burns, bites, presence of blood,
g. Neglect issues.
h. Position of the baby and its surroundings
i. General condition of the accommodation
j. Evidence of high risk behaviour eg domestic violence

NB if the records have already been secured, use a continuation sheet which can be added to the child's records at a later date.

17.2.13 Midwifery staff involved in the case should be offered support and the opportunity to speak to their line Manager or Modern Matron.

17.2.14 The family GP and health visitor must be informed as soon as possible

17.2.15 In the case of a death on the maternity unit, also contact : coordinator on delivery suite and Head of Midwifery and the bereavement midwives if available.

17.3 If you learn later that a baby has died

17.3.1 Check that the following agencies/professionals are informed of the infant's death.

a. Medical records department/maternity/children's hospitals to avoid follow up appointments being sent.
b. Child health department to avoid appointments /reminders being sent
c. The family GP in case s/he has not already been contacted by the police/hospital
d. Health visitor
e. Audiology department if the infant has been referred for follow up or has not yet had neonatal screening.
f. Named midwife safeguarding children and the relevant line manager
g. School Nurse if there are older siblings in the family
h. Any other department to which the infant has been referred/seen if follow up appointments are possible, e.g. Sure Start, Social Care

i. Known research projects in the area, which might result in a questionnaire being sent to parents/carers.
j. Local Supervising Authority and Modern Matron
k. CEMACH Office

17.3.2 The midwife holding case responsibility for mother and baby should contact the family to acknowledge the death, offer condolences and answer any question.

17.3.3 Discuss the support the parents/carers/extended family require. If there is inadequate support, consider more intensive midwifery support or alternatives/ Lullaby Trust Befriender Service.

17.3.4 Ensure that the midwifery records are available to the SUDC Paediatrician and be available to attend any subsequent multi-agency meeting. If still visiting the mother photocopy the hand held records and take the originals to the meeting.

17.3.5 Be prepared to provide a Statement of Evidence if requested and seek advice from the designated nurse / named midwife.

17.4 The next pregnancy:

17.4.1 Ensure that the C.O.N.I. co-ordinator has been notified as soon as possible.

17.4.2 In the ante-natal period ensure that the family Health Visitor and GP are aware of the pregnancy and forthcoming delivery.

17.4.3 Scrutinise previous records to ascertain whether it is necessary to inform any other professional/agency of the pregnancy. e.g social worker. If the cause of death is available following a post mortem examination, please ensure this is known before seeing the woman / family.

17.4.5 Ensure that the family receives appropriate support during the pregnancy, delivery, and post-natal period.

17.4.6 Ensure evidence based practice is shared with carers in respect of the following specific risk factors:

- co-sleeping
- ingestion of prescribed medication/ substances
- sleeping positions
- smoking
- temperature control.

Use your local C.O.N.I. Co-ordinator for advice, support, guidance and for up to date research.

18 THE ROLE OF THE CORONER,POLICE CORONER'S OFFICER [PCO], LOCAL AUTHORITY CORONERS OFFICER AND PATHOLOGIST

Appendix K

18.1 After the fact of death is confirmed, the Coroner has control of the body. Medical samples should only be taken by the pathologist.

18.2 In most cases of children under 2 years old, prior to the post mortem examination, a full skeletal survey will be conducted and interpreted (in accordance to royal college for radiology guidelines). Skeletal surveys in older children will be considered on an individual case basis.

18.3 The decision as to mode of and venue of Post Mortem will be taken by the Coroner on each case

18.4 Where a post Mortem is stopped by the conducting Pathologist it will immediately be halted pending notification and discussion with the authorising Coroner , next action will be directed following consultation with the SIO and may revert to a Home Office pathologist also being present

18.5 If the circumstances of the death are deemed as suspicious from the outset, the SIO will consult the coroner who may direct a joint Post Mortem by a forensic and a paediatric pathologist. In such circumstances the coroner, or other interested parties may require a subsequent PM examination to take place.

18.6 The SIO, the Police Coroners Officer and the SUDC paediatrician or on call paediatrician will liaise to ensure that as much information as possible is provided to the Coroner and the pathologist before the PM. This should include the SUDC coroners/pathology report , an SIO update, a copy of the ED episode where appropriate and any medical records available

18.7 The Lead Consultant at the acute hospital is responsible for ensuring that the results of any pre-mortem samples are forwarded to the coroner and the pathologist. Where samples are available and untested the Coroner should be notified by the Trust and they are secured pending decision

18.8 Notification of time and venue of the Examination will be communicated via the Paed Pathologist, only those persons authorised by Coroner may attend. In all cases the PCO is responsible for ensuring the family are fully apprised with all movement of the child and all updates

18.9 In the event of a "suspicious death", the SIO together with the Pathologist will have agreed a Forensic Strategy that will be followed.

18.10 The PM shall be carried out as soon as practicable. All persons involved with this protocol will co-operate to this end. All investigations are required to be carried out expediously to support

- The prompt release of the infant/ child/yp to their family.
- The conclusion of the inquest or criminal proceedings into the death of the child.

18.11 "In children under 2 years old (and in some cases, older, to be considered on an individual case basis) some radiological imaging is necessary prior to the post mortem. This will include a full skeletal survey in those under 2 years but may include further imaging, including scans. These will be carried out in accordance to Royal College of Radiologists guidelines and may require agreement of the Coroner if further imaging is needed. Radiological images will be reported by consultant radiologists in accordance with Royal College of Radiologists guidelines.

18.11 A paediatric PM~~)~~ in most cases will involve the taking of material for additional investigations (such as histology, microbiology, metabolic studies, toxicology and biochemistry or immunology), In some cases full organ/s may be required for further examination to assist in establishing the cause of death.~~-~~In circumstances where Histology and /Or organs are retained the pathologist will record all samples on the post Mortem result form and send that direct to Coroner.

As soon as possible the pathologist will provide to the coroner in writing the following information:

- Any significant preliminary Post Mortem pathological findings.
- The preliminary cause of death.
- Details of material retained for further examination (if any).

Police Coroners officers are responsible for updating families and completion of the HTA consent. Police Coroners officers must ensure families are fully apprised as to provisional cause of death and the ongoing process.

Where a full organ has been retained contact by the PCO with the family should be face to face and include time for them to decide their options Where parents are estranged signatures off both where possible should be obtained.

18.12 All samples taken at PM are under the control of the coroner and must be labelled, identified.

18.13 Mementoes requested by the family ie Hand/foot prints and locks of hair will only be taken after the PM (not in ED). Currently RMCH on receipt of the Memento request form will obtain the prints, they will notify the Serious Crime Division that they are available and ready for collection, the Police Coroners Officer is responsible for formatting those prints and delivery to the family

18.16 any preliminary report or findings resulting from the examination may only be shared to relevant interested parties with Coroner permission and dealt with in line with all confidentiality processes.

On receipt of the final Post Mortem report , the PCO will update the next of kin with the conclusion, they should additionally seek permission from Coroner for the SUDC paed to have a copy and to allow dissemination of the information to relevant parties, that decision should be communicated and documented. The SUDC paed will offer/signpost a more detailed review of the report where required by the family, the document should be forwarded by the PCO with permission to the SIO to inform their decisions

18.18 In the unlikely event, however, of the coroner not giving permission to share information, it is the responsibility of the SUDC Paediatrician on call to discuss the case directly with the coroner. If this still fails to resolve the situation, the on call SUDC paediatrician will inform the SUDC lead paediatrician that there are safeguarding concerns. The SUDC Lead will then speak directly with the coroner concerned. In the unlikely event that this does not lead to agreement to share information legal advice should be sought.

18.19 In non suspicious cases, the police Coroner's Officer will review and collate all the required reports and statements relating to the death so as to formulate an inquest file for the coroner's attention. In "suspicious" cases the actions of this officer will be directed by the police SIO.

18.20 The PCO (police coroner's officer) should be invited (by the SIO / SUDC paediatrician) to attend all meetings of the rapid response team, whether chaired by the police SIO (for suspicious deaths) or SUDC paediatrician (for non-suspicious deaths). The strategy for effective communication with the parents/carers of the child will be a key agenda item at such meetings. The PCO will have an important role to play in communicating information to the family.

18.21 Notwithstanding a death has been dealt with as Suspicious the PCO will be updated from the outset and work alongside the FLO ensuring the Coronial and HTA aspects are fully communicated, at the stage the death is determined as non suspicious the PCO will continue with the family and an exit strategy put in place for the

18.22 The Police Coroners officer allocated the case will maintain a detailed case book which will include time and dates updates to the family, they will ensure that both the SUDC Paed and SIO are aware of decisions at each stage

18.23 The PCO (or FLO where appointed) will also specifically be responsible for explaining to parents/ carers that it may be possible for them to visit their child's body both before and/or after post - mortem examination, whilst in mortuary facilities However where a visit is required before post mortem that must be accompanied by PCO/FLO and agreed by the SIO, the mortuary where the deceased lies will allocate an appropriate time the visit can be facilitated.

Royal Manchester Children's Hospital mortuary

18.24 The opening hours for the Royal Manchester Children's Hospital Mortuary are 09:00am – 17:00pm Monday to Friday. For any advice, please contact the main hospital switchboard (0161 276 1234) and ask to be put through to the Paediatric Mortuary, if the call is out of hours, please ask to be put through to the Paediatric APT on call.

Parents / carers attending the Royal Manchester Children's Hospital the mortuary to view their child's body MUST always be accompanied by the PCO/FLO.

In suspicious cases the need for another police officer to attend alongside the PCO/FLO is at the discretion of the Senior Investigating Officer

Viewings at the Royal Manchester Children's Hospital mortuary are between 2pm and 4pm on weekdays. Such 'weekday' viewings can be arranged by contacting the Royal Manchester Children's Hospital mortuary via the main hospital switchboard **(0161 276 1234).**

The Mortuary department is not manned during weekends. Any viewings by parents/carers that cannot wait until the next working day may be arranged via the Clinical Co-ordinator at the Royal Manchester Children's Hospital, this can be done via the hospital switchboard (0161 276 1234).
Due to the demanding role of the Clinical Co-ordinator (e.g. Cardiac arrest supervision) you may experience a delay when trying to contact the Clinical Co-ordinator to arrange a viewing. Please note that this is for Mr Meadows' cases only. For any other Coroners cases, the Paediatric on call APT should be contacted via switchboard (0161 276 1234) to facilitate a viewing.

If a situation arises where a child needs to be urgently transferred to the Royal Manchester Children's mortuary out of hours (for urgent Forensic cases only), the paediatric on call APT should be contacted via the Hospital switchboard (0161 276 1234) to facilitate this transfer.

Other hospital mortuaries

18.25 Different rules may apply for other hospital mortuaries. These will need to be identified on a case by case basis.

19. Death in secure accomodation including while under escort Appendix L

Deaths in Young Offenders Institute (YOI)

19.1 Since April 2004 the Prisons Probation Ombudsman's Fatal Incidents Investigation Team has been responsible for investigations into deaths in YOIs.

19.2 When a young person dies in a YOI the Prisons and Probation Ombudsman will be the lead agency in the investigation into the death.

19.3 The YOI must provide the Local Safeguarding Partnership and the Youth Justice Board (YJB) with a copy of any initial incident report and any relevant documentation in connection with the care that person received while in that establishment.

19.4 It is expected that the investigation led through the Prisons Probation Ombudsman's Fatal Incidents Investigation Team will be multi-agency in gatherng the relevant information to decide on the appropriate course of action. Their procedure will supersede the procedure outlined for the rapid response team.

Death in a Local Authority Secure Children's Home (LASCH)

19.5 When a young person dies in a LASCH, the LSCB rapid response team for the area in which the LASCH is located will lead the investigation into the death.

19.6 The manager of the LASCH and the Youth Offending Service (YOS) where the young person was living at the time of sentence or remand will prepare a local management report (LMR) for the YJB. The report should contain:

- An analysis of events surrounding the incident
- A chronology of the young person's time under the care of the provider
- Documentary and supporting evidence
- Recommendations for operational practice and or training

Death of a young person while under the care of an escort

19.7 If a young person dies while being escorted to secure accommodation then the LSCB for the area in which the accommodation is located will be the lead agency for the investigation into the death. The rapid response team for that area will lead the invetigation.

19.8 The YJB will commission a LMR from the service provider and if there are any practice implications beyond specific escorting issues then the YJB will also request a LMR from the secure establishment and the relevant YOS.

*YJB serious incidents guidance

20 SOURCES OF SUPPORT FOR FAMILIES Appendix M

THE LULLABY TRUST
www.**lullabytrust**.org.uk

The Lullaby Trust has a help line offering support and information to anyone who has suffered the sudden death of an infant. A card for parents to use the help line free of charge is provided by the trust. Requests for the card can be made by parents or professionals. The help line is also available for family, friends, and those professionals involved with the death. The telephone advisors personally answer the telephone every day of the year.

The Lullaby Trust has a wide range of leaflets and information for bereaved families and professionals. It also has a network of befrienders, who are previously bereaved parents. Arrangements can be made for befrienders to contact the bereaved family to offer additional support

Lullaby Trust Helpline

bereavement support: 0808 802 6868

information & advice: 0808 802 6869

Open 9am to 11pm, Monday to Friday and 6-11pm on weekends and Bank Holidays

CHILD BEREAVEMENT UK

http://www.childbereavement.org.uk/

Child Bereavement UK provide confidential support, information and guidance to families and professionals. Professionally trained bereavement support workers are available to take calls 9am - 5pm Monday-Friday. Tel: 0800 02 888 40.

Winston's Wish

www.**winstonswish**.org.uk

Winston's Wish is the leading childhood bereavement charity in the UK. They offer support & guidance to bereaved children, families and professionals.

Helpline 08452 03 04 05 *(Monday – Friday 9am to 5pm and Wednesday evenings 7pm to 9.30 pm)*

Cruse Bereavement Care

Central Hall, Oldham Street,
MANCHESTER, M1 1WT

0161 236 8103

Compassionate Friends National Helpline

Understanding, support and encouragement to parents after the death of a child or children
Helpline open every day of the year: 10am - 4pm & 6.30pm - 10.30pm
0845 123 2304
www.tcf.org.uk

SOBS Survivors of Bereavement By Suicide

uk-**sobs**.org.uk/

SOBS (**Survivors Of Bereavement by Suicide**) is a self-help, voluntary organisation. Many of those helping have, themselves, been bereaved by suicide
0115 944 1117

sobs.admin@care4free.net

Victim Support and Witness Service for Greater Manchester

National Victim Support line: **0845 30 30 900**

www.victimsupport.org.uk

21 USEFUL CONTACTS FOR PROFESSIONALS Appendix N

On call SUDC Paediatrician: via Wythenshawe Hospital Switchboard
0161 998 7070

SUDC Clinical Lead **Dr E J Dierckx**
0161 537 0410

SUDC Administrator **Mrs T Cliff**
0161 537 0405

GMP **0161 872 5050**

Rebecca Rice, Information Access Team Leader
Greater Manchester Police HQ,
Chester House, Boyer Street, Stretford, M60 ORE
0161 856 2668

Children's Social Care, Emergency Duty Teams	**Telephone**
Bolton	01204 337407
Bury	0161 253 6606
Manchester	0161 255 8250
Oldham	0161 770 6936
Rochdale	0845 121 2975
Salford	0161 603 4500
Stockport	0161 718 2118
Tameside	0161 342 2222
Trafford	0161 912 5199
Wigan	0161 834 2436

Coroner's Offices	**Coroner**	**Telephone**
Manchester	Mr NS Meadows	0161 830 4338
Bury, Rochdale, Oldham	Mr SR Nelson	01706 924815
Trafford, Stockport, Tameside	Mr JS Pollard	0161 476 0971
Wigan, Bolton, Salford	Mrs J Leeming	01204 338799

PCO HUB Contacts :

Crown Prosecution Service. Complex Casework Unit: 5th Floor Sunlight House, Quay Street Manchester M60 3PS. Tel 0161 827 4700

Ambulance safeguarding contact
NWAS safeguarding practitioner is contactable via 07812 304 236, or 01204 498400.

21 Glossary

Appendix O

AHP	**Allied Health Professionals**
Child	**An individual under 18 years of age**
CONI	**Care of the Next Infant**
CPR	**Cardio Pulmonary Resuscitation**
DCI	**Detective Chief Inspector**
DI	**Detective Inspector**
ED	**Emergency Department**
FSID	**Foundation for the study of Infant deaths**
GMP	**Greater Manchester Police**
GP	**General Practioner**
JAR	**Joint Agency Response**
LSCB	**Local Safeguarding Children Board**
MIT	**Major Incident Team**
NWAS	**North West Ambulance Service**
PCO	**Police Coroner's Office**
PICU	**Paediatric Intensive Care Unit**
PME	**Post Mortem Examination**
PPD	**Public Protection Division**
PPIU	**Police Protection and Investigation Unit**
SCR	**Serious Case Review**
SIDS	**Sudden Infant Death Syndrome**
SIO	**Senior Investigating Officer**

SUDC **Sudden Unexpected Death in Childhood**