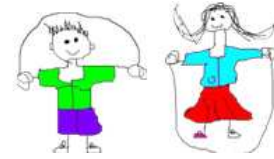




*Working Together
to Safeguard Children*



LUTON LOCAL SAFEGUARDING CHILDREN BOARD

Bedfordshire and Luton Local Safeguarding Children Procedure Child Death Overview and Rapid Response Arrangements

**Working Document
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1. INTRODUCTION

STATUTORY BASIS OF CHILD DEATH OVERVIEW ARRANGEMENTS

1.1 The Local Safeguarding Children Board Regulations 2006 places a requirement on the Bedfordshire & Luton LSCBs to include within its function, in relation to the deaths of children normally resident in Bedfordshire and Luton;

(a) collecting and analysing information about each death with a view to identifying—

(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e) [*Serious Case Review*];

(ii) any matters of concern affecting the safety and welfare of children in the area of the authority; and

(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

(b) putting in place procedures for ensuring that there is a co-ordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

1.2 In this connection an unexpected death is one which was not anticipated as a significant possibility 24 hours before the death or where there was similarly unexpected collapse leading to or precipitating the events which lead to the death. This definition is adopted throughout this procedure.

1.3 Statutory guidance on the fulfilment of this requirement is contained in Chapter 7 of Working Together to Safeguard Children (2006) and these procedures are consistent with that guidance.

1.4 Within Bedfordshire and Luton the functions specified in the regulations and guidance will be undertaken by the Child Death Overview Panel (CDOP) on behalf of the LSCBs. CDOP will meet on a bi monthly basis.

CHILD DEATH OVERVIEW PANEL TERMS OF REFERENCE

Purpose

1.4 Through a comprehensive and multidisciplinary review of child deaths, the Bedfordshire and Luton CDOP aims to better understand how and why children in Bedfordshire and Luton die and use our findings to take action to prevent other deaths and improve the health and safety of our children.

1.5 In carrying out activities to pursue this purpose, the CDOP will meet the functions set out in paragraph 7.4 of *Working Together to Safeguard Children* in relation to the deaths of any children normally resident in Bedfordshire and Luton namely collecting and analysing information about each death with a view to identifying –

- (i) any case giving rise to the need for a Serious Case Review
- (ii) any matters of concern affecting the safety and welfare of children in Bedfordshire and Luton
- (iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in Bedfordshire and Luton

Objectives

1. To ensure, in consultation with the local Coroner, that local procedures and protocols are developed, implemented and monitored, in line with the guidance in Chapter 7 of *Working Together* on enquiring into unexpected deaths.
2. To ensure the accurate identification of and uniform, consistent reporting of the cause and manner of every child death.
3. To collect and collate an agreed minimum data set of information on all child deaths in Bedfordshire and Luton and, where relevant, to seek additional information from professionals and family members.
4. To evaluate data on the deaths of all children normally resident in Bedfordshire and Luton, thereby identifying lessons to be learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children.
5. To evaluate specific cases in depth, where necessary to learn lessons or identify issues of concern.
6. To improve agency responses to child deaths through monitoring the appropriateness of the response of professionals to each unexpected death of a child, reviewing the reports produced by the rapid response team and providing the professionals concerned with feedback on their work.
7. To identify significant risk factors and trends in individual child deaths and in the overall patterns of deaths in Bedfordshire and Luton, including relevant environmental, social, health and cultural aspects of each death, and any systemic or structural factors affecting children's well-being to ensure a thorough consideration of how such deaths might be prevented in the future.

8. To refer to the chairs of the LSCBs any identified safety or public health issues for consideration, with the Director of Public Health or any other relevant agency, of how best to address these and their implications for the provision of services and training.
9. To identify any public health issues and consider, with the Director(s) of Public Health and other provider services how best to address these and their implications for both the provision of services and for training.
10. To increase public awareness and advocacy for the issues that affect the health and safety of children
11. Where concerns of a criminal or child protection nature are identified, to ensure that the police and coroner are aware and to inform them of any specific new information that may influence their inquiries; to notify the Chair of the LSCB of those concerns and advise the chair on the need for further enquiries under section 47 of the Children Act, or of the need for a Serious Case Review
12. To provide relevant information to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family
13. To monitor the support and assessment services offered to families of children who have died
14. To monitor and advise the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths
15. To organise and monitor the collection of data for the nationally agreed minimum data set and the arrangements for providing data to bodies commissioned by the DCSF (Department for Children, Schools & Families).
16. To co-operate with any regional and national initiatives – e.g. the Confidential Enquiry into Maternal and Child Health (CEMACH) – in order to identify lessons on the prevention of child deaths.
17. To make recommendations to the LSCBs for any additional data to be collected locally.
18. To inform the chairs of the LSCBs where specific new information should be passed to HM Coroner or other appropriate authorities.
19. To monitor the appropriateness of the response of professionals to unexpected deaths of children.

20. To prepare an annual report to the LSCBs on the work of the CDOP.

Scope

1.6 The CDOP will gather and assess data on the deaths of all children and young people from birth (excluding those babies who are stillborn) up to the age of 18 years who are normally resident in Bedfordshire or Luton. This will include neonatal deaths, expected and unexpected deaths in infants and in older children. Where a child normally resident in another area dies within Bedfordshire and Luton, that death shall be notified to the CDOP in the child's area of residence. Similarly, when a child normally resident in Bedfordshire or Luton dies outside of these areas the Bedfordshire and Luton CDOP should be notified. In both cases an agreement should be made as to which CDOP (normally that of the child's area of residence) will review the child's death and how they will report to the other.

Confidentiality and Information Sharing

1.7 Information discussed at the CDOP meetings will not be anonymised prior to the meeting, it is therefore essential that all members adhere to strict guidelines on confidentiality and information sharing. Information is being shared in the public interest for the purposes set out in Working Together and is bound by legislation on data protection.

1.8 CDOP members will all be required to sign a confidentiality agreement before participating in the CDOP. Any ad-hoc or co-opted members and observers will also be required to sign the confidentiality agreement. At each meeting of the CDOP all participants will be required to sign an attendance sheet, confirming that they have understood and signed the confidentiality agreement.

1.9 Any reports, minutes and recommendations arising from the CDOP will be fully anonymised and steps taken to ensure that no personal information can be identified.

Accountability and Reporting arrangements

1.10 The CDOP will be accountable to the chairs of Bedfordshire's and Luton Local Safeguarding Children Board.

1.11 The CDOP is responsible for developing its work plan, which should be approved by the LSCB. It will prepare an annual report for the

LSCB, which is responsible for publishing relevant, anonymised information.

1.12 The LSCB takes responsibility for disseminating the lessons to be learnt to all relevant organisations, ensures that relevant findings inform the Children and Young People's Plan and acts on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.

1.13 The LSCB will supply data regularly on every child death as required by the DCSF to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of these deaths.

1.14 Inevitably some of these deaths will also be subject of the child death review processes in other LSCB areas. This does not detract from the value of their inclusion within the LSCBs Panel remit.

1.15 These procedures include provision for cooperation with other LSCBs in collecting information and providing a coordinated response to unexpected child deaths in these circumstances

CHILD DEATH OVERVIEW PANEL MEMBERSHIP

1.16 The Panel will be chaired by the Independent Chair or nominated Person not directly involved in the provision of services to children. Director of Public Health has been identified as the Chair for Bedfordshire and Luton CDOP.

1.17 The Panel will comprise a core membership of senior professionals from the following:

- Director of Public Health (Chair)
- Coroner or Coroner's Officer
- Lead Paediatrician (s)
- Designated Doctor for Safeguarding (s)
- Children's Social Care
- Police Child Abuse Investigation Unit
- Designated Nurse for Safeguarding
- Midwifery (co-opted)
- Bereavement Counsellor (to be identified)

- Lay representative (to be developed)

Other professionals may be co-opted to attend one or more meetings of the panel at the discretion of the chair.

CHILD DEATH OVERVIEW PANEL MEETINGS

1.18 The Panel will meet bi-monthly. Meetings will be supported and minuted by the CDOP Administrator.

1.19 The minutes of Panel meetings will be circulated to the chairs of the LSCBs, all core members of the Panel and to any co-opted members attending the relevant meeting.

2. CHILD DEATH OVERVIEW ARRANGEMENTS

NOTIFICATION OF DEATHS

2.1 The CDOP Administrator will be notified of the death of any child, aged less than 18 years, normally resident in Bedfordshire or Luton or the death of any other child in, or consequent to an unexpected event in, Bedfordshire or Luton by:

- The senior police officer in Bedfordshire or Luton attending the unexpected death of a child or similarly unexpected event consequent to which a child had died, wherever the death occurred
- The medical practitioner or paramedic confirming the fact of death of a child in Bedfordshire or Luton, whether the death was unexpected or not, unless the Police are involved in the investigation of that death
- The coroner's officer to whom any death of a child in Bedfordshire or Luton, or of a child normally resident in the county, is reported
- Any professional made aware of the death, outside of Bedfordshire or Luton, of a child normally resident in one of the authorities. (This is particularly relevant to children receiving medical treatment at specialist centres, in out of county respite hospice or foster care placements or on holiday, including abroad)
- Any other professional or member of the public learning of a relevant death who suspects that it may have not been previously notified to the CDOP
- The head of the PCT Child Health Records Department on receipt of notification that a child has died from the Registrar of Births, Deaths and Marriages

2.2 The CDOP Administrator will also accept details of a relevant child death occurring outside of Bedfordshire or Luton from another LSCB or representative of a LSCB partner agency.

2.3 Notification of a child death to the CDOP Administrator should be made or confirmed in writing, by Secure FAX or by email, within 48 hours of becoming aware of the death and include the information specified in Appendix1.

2.4 These procedures along with the notification form for notifying a child death to the CDOP is available for downloading on both Bedfordshire & Luton LSCBs' websites www.bedfordshirelscb.org.uk or www.lutonsafeguarding.gov.uk

2.5 On receipt of notification that a child has died the CDOP Administrator will check the child death database for previous notification of the death. If not previously notified, a record on the database will be made of deaths within the remit of the Panel. Where details supplied suggest that the death is outside of the remit of the Panel, are incomplete or there is variance between any duplicate notifications of the same death the CDOP Administrator will make any necessary enquiries to ensure that relevant, accurate and complete details are held.

2.6 All notifications to the CDOP that a child has died will be acknowledged in writing.

2.7 If a child whose death is notified to the CDOP is normally resident outside of Bedfordshire or Luton the CDOP Administrator will provide immediate notification of that death to the appropriate LSCB in writing.

DATA SET COLLECTION

2.8 The CDOP Administrator will arrange for the Core Data Collection form to be completed, this form can be downloaded from the websites above. In most cases this will be the health professional with overall responsibility for the care of the child at the time of their death but occasionally it might be the Police where a crime has been committed. **(Different sections of the Core Data Collection Form can be sent to the relevant agencies who are most likely to have requisite information for completion and these could be compiled by the Administrator).**

2.9 For unexpected child deaths occurring in Bedfordshire or Luton, or consequent to an event in the county, completion of the form is part of the CDOP unexpected child death response procedure and only

verification with the Lead Paediatrician that the response arrangements have been initiated is required.

2.10 For some children, particularly those normally resident or who have died consequent to an incident outside of Bedfordshire or Luton, another CDOP will also be collecting information on the death. In these cases the CDOP Administrator should liaise with the CDOP Administrator for the other CDOP regarding collection of the data set to avoid duplication of requests to professionals. A reciprocal arrangement for the sharing of information obtained following such liaison should be agreed.

2.11 In normal circumstances, where the death is not sudden or unexpected, the professional requested to provide the data set information should do so **within 14 days** of the death. If all information is not available within that time frame, the missing data should be flagged on the Core Data Collection form and arrangements made for this to be provided to the CDOP Administrator when available.

2.12 For sudden or unexpected deaths the Lead Paediatrician will forward the Core Data Collection form to the CDOP Administrator after the multi-agency Case Discussion Meeting, or sooner if all required information is available.

2.13 If an incomplete Core Data Collection form is received or there is variance between the information provided and that already held the CDOP Administrator will make any necessary enquiries to ensure that relevant, accurate and complete details are held

2.14 On receipt of a completed Core Data Collection form the CDOP Administrator will add the information provided to the record of the death on the CDOP database.

DATA SET REPORTING AND ANALYSIS

2.15 For each meeting of the Panel the CDOP Administrator and a representative from the Coroner's office and the Lead Paediatrician for child deaths from each PCT will prepare a summary and statistical report, to include information on recent child deaths, the longer term pattern of child deaths, and the effectiveness of the child death review process. This, supported by copies of all Core Data Collection forms completed since the previous meeting will be forwarded to all members attending the meeting.

LEAD PAEDIATRICIAN REPORTS ON UNEXPECTED CHILD DEATHS

2.16 The CDOP Administrator will collate all final reports on unexpected child deaths received from the Lead Paediatrician. At least one week in advance of the Panel meeting copies of these reports with any accompanying documents, including the relevant Core Data Collection forms, will be forwarded to all members attending the meeting

CASES FOR IN-DEPTH REVIEW

2.17 Immediately following a meeting of the Panel the CDOP Administrator will identify at least two child deaths, where a full Core Data set is available, for in-depth review at the following meeting. This selection will be in accordance with parameters set by the Panel.

2.18 The CDOP Administrator will thereafter obtain copies of all relevant information held by agencies in respect of the child. Appendix 3 provides a checklist of relevant information. Panel members may need to facilitate this process by advising the Administrator how and who to approach for such information, if need be.

2.19 All information requested should be provided to the CDOP Administrator at least two weeks before the following meeting of the Panel. The CDOP Administrator will advise on this date when making the requests for information.

2.20 Where an agency holds a large amount of information in respect of the child this may be abridged and summarised with only copies of information relating to the period immediately prior to the child's death and to any other key events in the child's life being provided.

2.21 The identity of the professional's providing the copy of information or third parties will be anonymised for the panel presentation but noted separately.

2.22 At least one week in advance of the Panel meeting copies of all documents received by the CDOP Administrator in relation to each child death to be appraised by the CDOP Administrator with the help of other relevant professionals (ref: 2.15) in depth, including the relevant Core Data Collection forms, will be forwarded to all members attending the meeting.

2.23 The CDOP Administrator will seek advice from the Chair to decide on which member of the Panel will arrange preparation of a synopsis of each case to be reviewed and to present this at the meeting (ref: 2.15).

2.24 Professionals should prepare the cases to provide a synopsis of, at most, 2 sides of A4 paper and a presentation of, at most 10 minutes.

2.25 The CDOP Administrator will ensure that all professionals attending the Panel meeting are provided with a copy of the LSCBs Assessment of Contributory Factors form as a briefing on the review process to be followed – this form can be downloaded from the LSCB websites details on page 10.

CHILD DEATH OVERVIEW PANEL MEETING

2.26 Each meeting of the Panel will:

- Review all new completed child death data sets together with the Analysis Report of the CDOP Administrator
- Review all new reports arising from the unexpected child death response arrangements
- Review any new child deaths, maximum of two in depth
- Consider the effectiveness of the LSCBs Child Death Response and Overview arrangements and other services provided to the families of children who have died
- Consider whether any matter should be referred to the chairs of the LSCBs or other action taken in compliance with the panel's terms of reference. Explicit consideration will be given to the provision of information to the family of each child whose death is reviewed.
- Agree parameters for the selection of cases to be reviewed in depth at subsequent meetings and identify any professionals who should be co-opted to attend the meeting where the cases are to be reviewed

2.27 To review a case in depth the Panel will complete an assessment of factors that contributed to the death and agree a classification of it according to avoidability. The LSCBs Assessment of Contributory Factors form should be used to record this assessment (see 2.25).

REPORTING

2.28 The chair of the Panel is responsible for referring to the chairs of the Bedfordshire & Luton LSCB's any matter as agreed by the Panel and for monitoring completion of any other action agreed by the Panel within their terms of reference.

2.29 The Panel will decide on a case by case basis the information that should be shared with the family of each child whose death is reviewed and the means by which this will be provided.

2.30 An annual report from the Panel will be provided to both LSCBs in a format that did not reveal the identity of individuals in the case but contains a summary outlining trends, comparative data, and main issues emanating from cases reviewed in-depth that year.

2.31 The CDOP Administrator is responsible for the compilation of any data returns required by the DCSF or the bodies operating on behalf of that Department.

2.32 Information on individual cases will only be provided to any body outside of the CDOP as specified in these procedures or with the explicit agreement of the Panel.

ADMINISTRATIVE ARRANGEMENTS

2.33 The CDOP child death database is managed by the CDOP Administrator. This need to be compliant with relevant legislations like Data Protection Act, Freedom of Information Act etc.

2.34 Complaints received regarding the actions of an individual professional or agency will be directed to the relevant agency and dealt with under that agency's complaints procedure. Any other complaints regarding the application of these procedures by the CDOP or a professional operating on their behalf will be referred to the chairs of the LSCBs.

3. UNEXPECTED CHID DEATH RESPONSE ARRANGEMENTS

INTRODUCTION

3.1 The following procedures detail the CDOP multi-agency response to the sudden or unexpected death of a child. They should be followed by all professionals in conjunction with any relevant policies, procedures and protocols of their own agency.

APPLICATION

3.2 These procedures are applicable to the sudden or unexpected death of a child, aged less than 18 years, of any natural, unnatural or unknown cause, at home, in hospital or in the community.

3.3 A sudden unexpected death is defined as one which 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 which led to the death. This includes the death of a child with an existing medical condition or disability whose death at

the time it occurred was not expected as a natural consequence of that condition (e.g. died at a time or of a cause or event not normally associated with the medical condition).

3.4 Where there is any doubt about whether a death is unexpected these procedures should be followed.

3.5 It is advised that professionals responsible for end of life care to children with terminal conditions identify, document and regularly review the circumstances to be able to ascertain when death occurred, was it unexpected for the purpose of this procedure. It should be ensured that the child's family and all staff involved in the care are aware of these actions.

3.6 These procedures are primarily applicable to deaths occurring in Bedfordshire or Luton but will also be applied to deaths occurring elsewhere consequent to a sudden unexpected event in Bedfordshire or Luton. It will, however, normally be most appropriate for the CDOP child death arrangements where the death occurred to provide the initial response.

3.7 Similarly, it will normally be appropriate for the initial response to a death occurring in Bedfordshire or Luton consequent to a sudden unexpected event elsewhere to be provided by the CDOP, under these procedures, with the further management of the response being undertaken by the CDOP for the area where the event occurred.

3.8 In such cases close liaison and cooperation between the child death response arrangements of the respective CDOP is essential to ensure a coordinated approach and agree appropriate management of the response. The place where the child is normally resident and any agreement between the respective Coroners on jurisdiction should be considered in deciding which CDOP should have primacy.

FRAMEWORK FOR THE RESPONSE TO A SUDDEN OR UNEXPECTED CHILD DEATH

3.9 These procedures contain general guidance for all professionals involved in the response to the sudden or unexpected death of a child, information about individual agency responsibilities and details of the multi-agency arrangements for the longer term management and assessment of the death.

3.10 Multi-agency working will always involve at least HM Coroner, Police, Health and Social Care professionals. Other agencies involved with the family also have a contribution to make.

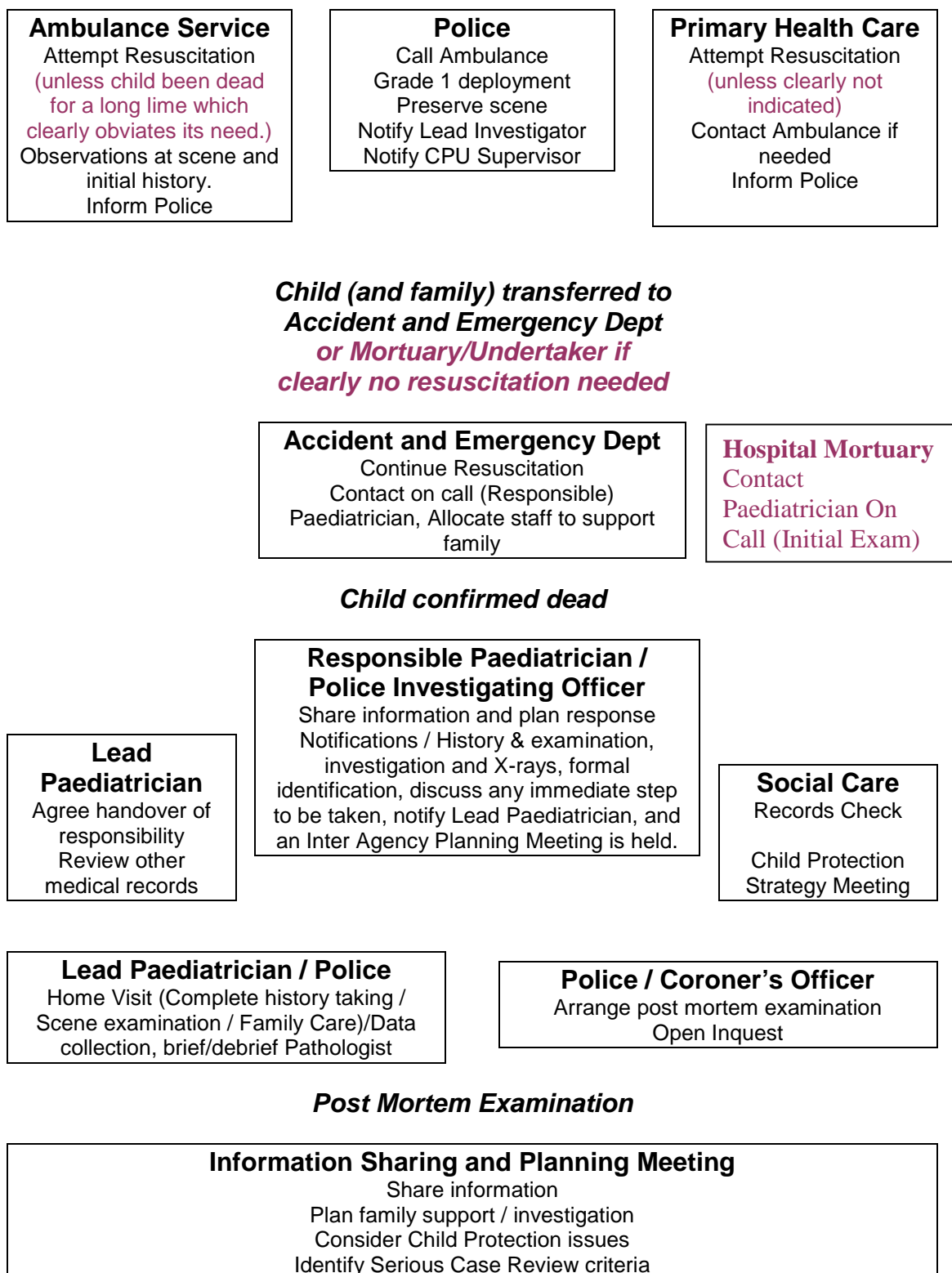
3.11 Each professional must be fully conversant with both their own agency's responsibility and the responsibilities of the other agencies. There should be collaborative and coordinated working at all levels from the earliest call to the emergency services.

3.12 The key events described in these procedures are:
Transfer of the child to an Accident and Emergency Department **unless the child is found dead for quite some time (e.g. days) so that need for resuscitation is clearly out of question. In latter case trans the body to the mortuary.**

- Initial response and early investigation
- Early inter-agency information sharing and planning
- Hospital procedures
- Lead Consultant Paediatrician/ Police home visit
- Liaison with HM Coroner and Post Mortem examination arrangements
- Multi-agency review and planning arrangements

3.13 The pathway through these events is shown in Figure 1.

Figure 1. FLOWCHART OF RESPONSIBILITIES



Complete LSCBs Data Set

Case Review Meeting

Review circumstances of death / response / investigation / family support
Complete CDOP Data set and Assessment of Contributory Factors
Identify further action required (including plan for communicating outcome to family / Child
Protection / Serious Case Review / plan for future pregnancy)
Report to HM Coroner and CDOP

RELATIONSHIP TO OTHER PROCEDURES

3.14 These procedures are complimentary to and will operate in parallel with or contribute to a number of other processes. These may include:

- Coroner's inquests
- Criminal investigations
- Serious Case Reviews
- Child Protection (Section 47) investigations
- Health and Safety Executive Investigations
- Health Service Serious Untoward Incident investigations
- Provision of Social Care services to family members
- Provision of primary care and/or hospital treatment to family members
- LSCB Child Death Overview arrangements (see above in procedures)
- Prison Service investigations
- Independent Police Complaints Commission investigations

3.15 Following the sudden or unexpected death of a child the Police, acting on behalf of HM Coroner or in the investigation of a crime have primacy in the investigation. Notwithstanding this, all professionals should work within these procedures and ensure that the interface between them and other processes is appropriately managed.

PRINCIPLES

3.16 The following principles should be adhered to by professionals from all agencies:

- Ensuring that bereaved families are treated with sensitivity and respect, offered appropriate support and kept fully informed
- Adopting an open minded, proportionate and professional approach to the circumstances
- Effectively working together and sharing information within a multi-agency response
- Ensuring that evidence is preserved and that the death is thoroughly investigated
- Providing a prompt response and ensuring that the investigation is completed expeditiously

GENERAL GUIDANCE

3.17 The unexpected death of a child is a traumatic time for everyone involved. The family will be experiencing extreme grief and shock. Professionals will need to support the family and although the time spent with them may be brief, actions may greatly influence how the family experiences the bereavement for a long time afterwards.

3.18 It is the right of every child to have their death properly investigated. Families also desperately want to know what happened, how the event could have occurred, what the cause of death was and whether it could have been prevented. If another child death occurs in the family, a carefully conducted investigation of an earlier death is extremely helpful.

3.19 The majority of child deaths occur as a result of natural causes or accidents. Some of these will however have medical implications for other family members or have been contributed to by potentially avoidable factors. In addition, a minority of child deaths are the consequence of, or associated with, abuse or neglect.

3.20 The response of all agencies to the death of a child must therefore keep a sensitive balance between a sympathetic and supportive approach to the family and maintaining professionalism towards the investigation.

3.21 Unless there are clear and compelling reasons to the contrary, it is inherent in these procedures that all children who die suddenly or unexpectedly in the community are transferred to a hospital Accident and Emergency Department **unless they are discovered dead for hours or days, in which case they can be taken to a hospital mortuary and attended by Paediatrician On Call there.** This is regardless of whether the chances of successful resuscitation are thought to be negligible, and specifically so that the response to the death may be effectively managed in accordance with these procedures.

3.22 When the Police are concerned that a death may be due to intentional harm, it is important that these procedures are still applied and that all agencies co-operate closely and jointly to determine how best to proceed with the investigation and support of the family.

3.23 All professionals must record any information provided by parents, carers or other family members in as much detail as possible. The initial accounts about the circumstances, including timings, must be recorded accurately, contemporaneously and preferably verbatim.

3.24 Where the use of any recording equipment is contemplated to assist in the later recall and documenting of information provided by the family, this should only be carried out with the knowledge and agreement of all persons present and the Police Investigating Officer. Any recordings made must be preserved and once used for their primary purpose retained by the Police.

3.25 All entries on medical records and other documents relating to the

deceased child must be legibly signed, timed and dated, include role or designation and be and clearly attributable to their author.

3.26 The following advice is provided for professionals dealing with the family of a child who has died, particularly in the early stages of their bereavement.

- When you arrive always say who you are, why you are there, and how sorry you are about what has happened to the child
- The family will be in the first stages of grief and may react in a variety of ways, such as shock, numbness, anger or hysteria. Allow the family members space and time to cry, to talk together and to comfort any other children. These moments of grieving are very important
- It is normal and appropriate for a parent to want physical contact with their dead child. In all but exceptional circumstances, such as when crucial forensic evidence may be lost or interfered with, this should be allowed, albeit with observation by an appropriate professional
- In talking about the baby preferably use the first name, or, if you don't yet know the name, say 'your baby/son/daughter'. Don't refer to the child as 'it'
- Have respect for the family's religious beliefs and culture. Such issues must be handled sensitively but not to the detriment of the investigation
- If English is not the family's first language an interpreter should be arranged
- Take things slowly, allowing the family members to gather their thoughts and tell the story in their own way
- The parents should be allowed time to ask questions about practical issues. This includes telling them where their child will be taken and when they are likely to be able to see them again. They may also need advice and assistance with funeral arrangements and what to do with their other children
- Most parents feel guilty when their child has died. When talking to them try to ask questions in a neutral way, e.g. 'Would you like to tell me what happened?' Avoid questions that sound critical, such as 'Why didn't you?'

- At all times be sensitive in the use of mobile phones and other communication equipment. Whenever possible, whilst remaining contactable, such equipment should be turned off when with the family
- Don't use such phrases as 'suspicious death' or 'Scenes of Crime Officer', and try to avoid comments that might be misunderstood by, or distressing to, the family
- Parents need to understand the role of the coroner, and the need for a detailed multi-disciplinary investigation, which will include obtaining a comprehensive medical history, a visit to the place where the collapse or other event leading to the death occurred, post mortem examination and meetings between the professionals involved
- Do not ask their permission for a post mortem but explain sensitively what is involved
- Parents should be told that they will be informed of the initial post mortem result and other information as it becomes available, but that the final cause of death may not be established for a few weeks or even months
- Parents need to know to whom they can turn for help and support in their bereavement
- Written contact names and telephone numbers should be given to the parents

FACTORS THAT MAY AROUSE CONCERN

3.27 Certain factors in the history or examination of the child may give rise to concern about the circumstances surrounding the death. If any such factors are identified, it is important that the information is documented and shared with senior colleagues and relevant professionals in other key agencies involved in the investigation. The following list is not exhaustive and is intended only as a guide.

- Previous child deaths in the family. Two or more unexplained child deaths occurring within the same family is unusual and should raise questions both about an underlying medical or genetic condition as well as possible unnatural events
- Inconsistent information. The account given by the parents or

carers of the circumstances of the child's death should be documented verbatim. Inconsistencies in the story given on different occasions or to different professionals should raise suspicion, although it is important to be aware that inconsistencies may occur as a result of the shock and trauma of the death

- Inappropriate delay in seeking help
- Evidence of drug, alcohol or substance misuse, particularly if the parents are still intoxicated or sedated
- Evidence of parental mental health problems
- Previous episodes of unexplained illness, such as cyanotic episodes or acute life threatening events Acute Life Threatening Event (ALTE).
- Previous and current child protection concerns within the family relating to this child or any siblings.
- Neglect. Observations about the condition of the accommodation, cleanliness, adequacy of clothing, bedding and the temperature of the environment in which the child is found are important. A history of previous concerns about neglect may be relevant.
- Evidence of physical abuse/unexplained injuries, e.g. unexplained bruising/burns/bite marks. However, it is very important to remember that a child may have serious internal injuries without any external evidence of trauma.
- Presence of Blood. The presence of blood must be very carefully noted and recorded. It is found occasionally in cases of natural death. A pinkish frothy residue around the nose or mouth is a normal finding in some children whose deaths are due to the Sudden Infant Death Syndrome. Fresh blood from the nose or mouth is less common, but does occur in some natural deaths. Bleeding from other sites is very uncommon in natural deaths.

3.28 However the following should be noted and are present in many infant deaths:

- Froth emerging from the mouth and nose. This froth results from the expulsion of air and mucus from the lungs after death. Sometimes the froth may be blood- stained – this does not mean that the death was unnatural

- Small quantities of gastric contents around the mouth. This does not mean that death was caused by inhalation of vomit. Often there is slight regurgitation after death
- Purple discoloration of the parts of the face and body that were lying downwards. This is not bruising, but is caused by the draining of blood in the skin after death. For the same reason the parts that were lying upwards may be very pale
- Covering of the child's head by the bedclothes. This has often been a feature of cot death in the past, and probably contributes to death through accidental asphyxia or overheating
- Wet clothing or bedding. This is usually caused by excessive sweating before death
- If the child looks as though he/she has been roughly handled, remember that this may be the result of attempts at resuscitation

4. AMBULANCE

4.1 This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies.

4.2 Following receipt of a call to the Ambulance Control Centre the nearest available emergency response will be sent to the scene, supported by a second emergency response if possible.

4.3 The recording of the initial call to the ambulance service should be retained in case it is required for evidential purposes.

4.4 The Ambulance Control Centre will immediately notify the Police Force Control Room when there is a call to the scene of an unexpected child death or this is reported by the attending ambulance staff. The member of staff calling should specify that the child death response procedures are being initiated and provide details of the child and circumstances.

4.5 Ambulance staff should not assume death and unless clearly inappropriate they should clear the airway and apply full cardiopulmonary resuscitation **except for situations where child is found dead for hours or days.**

4.6 All children should be taken to the Accident and Emergency Department, unless they have obviously been dead for some time and the circumstances of death present a clear and compelling reason for the body to remain at the scene for forensic examination.

4.7 A child must be taken to the Accident & Emergency Department **unless found dead for hours or days, in which case the child could be taken straight to the hospital mortuary.**

4.8 The Accident and Emergency Department should be informed, giving an estimated time of arrival and the child's condition (**and the mortuary where relevant**).

4.9 The family should also be taken to the hospital to ensure receipt of appropriate medical and social support.

4.10 The first professional on the scene should note the position of the child, the clothing worn and the circumstances of how the child was found.

4.11 Any persons remaining at the scene should be asked not to disturb or move items around where the child was found until it has been seen by the Paediatrician and/or Police. It should be stressed that this can be extremely important in helping the family to understand why the child

has died.

4.12 If the circumstances allow, any comments made by the carers or others present, any background history, any possible drug misuse and the conditions of the living accommodation should be noted.

4.13 The patient clinical record is to be completed in full as a record of attendance and treatment of the patient. Printouts from any monitoring equipment used should be retained with the record. All information from the scene and any concerns should be reported directly to the Police and to the receiving doctor at the hospital as soon as possible.

4.14 If the child's body is to remain at the scene the ambulance staff should await the arrival of the Police Investigating Officer.

4.15 There will be times when a GP, Health Visitor or Community Nurse is the first professional to attend. In such circumstances that professional should adhere to the same general principles as the ambulance staff and an ambulance should be called as an emergency.

4.16 A representative of the Ambulance Service will always be invited to the multi-agency Information Sharing and Planning Meeting and Case Review Meeting.

5. GENERAL PRACTITIONERS / HEALTH VISITORS / COMMUNITY NURSING STAFF

5.1 This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies.

5.2 Occasionally the GP, Health Visitor or Community Nurse will be the first professional to attend the scene of the unexpected death of a child. In general the same guidance applies to these professionals as the Ambulance Service.

5.3 Primary healthcare professionals should not assume death and unless clearly inappropriate they should clear the airway and apply full cardiopulmonary resuscitation. An emergency ambulance should always be called to the scene.

5.4 It is important that if a health professional is the first at the scene that they take responsibility for contacting the Police. They should specify that the child death response procedures are being initiated and provide details of the child and circumstances.

5.5 The professional should ensure that ambulance staff take the child to the Accident and Emergency Department rather than to the mortuary, even when the fact of death has been confirmed at home or elsewhere. It is preferable that verification of death is deferred until the child is transferred to the local Accident and Emergency Department.

5.6 Primary healthcare staff are very important in supporting the family following the death of a child. They should visit the family at home as soon as is convenient and will be involved in providing ongoing advice, support and counselling for the family, in collaboration with other professionals. This process will be coordinated as detailed below in the inter-agency working section of these procedures.

5.7 Additional guidance for primary healthcare staff, particularly in relation to the longer term care of the family, is available from the Foundation for the Study of Infant Deaths.

5.8 Primary healthcare staff should make notes available to the professionals involved in the investigation of the child's death.

5.9 Those involved with the family will always be invited to the multi-agency Information Sharing and Planning Meeting and Case Review Meeting and should attend wherever possible

6. HEALTH/ RESPONSIBLE PAEDIATRICIAN / LEAD PAEDIATRICIAN

This section deals with the roles of health professionals. Since arrival of the child at the hospital, initial response will be from hospital staff. Thereafter, others will take over. For the purpose of clarity the term '**Responsible Paediatrician**' is used for Consultant Paediatrician on call who would attend the child at the hospital. Subsequently, the '**Lead Paediatrician**' with wider remit, who would be a Community Paediatrician will take over and will remain connected with the process. For this reason the role of the 'Lead Paediatrician' is further elaborated in section 7.

Introduction

6.1 This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies.

6.2 These procedures will be followed when a child dies unexpectedly within a hospital in Bedfordshire or Luton or is brought to an Accident and Emergency Department having died in the community. In addition to procedures for hospital staff, there are those which may be undertaken by other health service staff in the initial response to the death of a child.

6.3 Procedures detailed here relate to:

- The initial hospital response to the death of a child
- Inter-agency liaison, discussion and planning
- Agency notification and information gathering
- Care of the child's family
- History taking from the family
- Examination of the child's body and obtaining early samples and x-rays

6.4 The management of the health service response to the death of a child must be undertaken by a Consultant Paediatrician. In case of an unexpected death occurring outside or within the hospital, a Consultant Paediatrician on call on that day will assume the role of 'Responsible Paediatrician' under this procedure who will make initial response as per protocol, available to download at LSCB websites, details on page 10. Later, at an appropriate time the case will be handed over to the 'Lead Paediatrician' who will be another Consultant Paediatrician specifically designated for this role.

6.5 Notwithstanding the central role of the Responsible Paediatrician,

each professional needs to know their role and the role of others in the investigation of the death and the provision of support to the family.

6.6 The on-call Consultant Paediatrician undertaking the Responsible Paediatrician role at the hospital and the nurse allocated to support the family will be invited to the Inter Agency Liaison & Planning Meeting.

Initial Response

6.7 On arrival at the hospital the child should be taken to an appropriate area in the Accident and Emergency Department. Should the unexpected death of a child occur elsewhere in the hospital (e.g. in a children's ward or maternity unit) these procedures should be followed at that location.

6.8 The family should be provided with privacy. A nurse should be allocated to look after the family and to keep them informed about what is happening. The nurse should record any medical or other information provided by the family.

6.9 The child should immediately be assessed and unless it is clear that the baby has been dead for some time (for example when rigor mortis or blood pooling are evident), resuscitation should always be initiated and death confirmed when appropriate.

6.10 Subject to the approval of the medical staff involved, the parents should be given the option of being present during resuscitation. The allocated nurse should stay with them to explain what is happening.

6.11 The On Call Consultant Paediatrician should be immediately notified who will assume the role of 'Responsible Paediatrician' and will thereafter be responsible for management ensuring that procedures are followed until this is taken over by the Lead Paediatrician.

6.12 At the same time the Police will be notified, if already not involved, by telephone call to the Police Control Room. The member of staff calling should specify that the unexpected child death response procedures are being initiated and provide details of the child and circumstances. A Child Abuse Investigating Unit Supervisor will attend in response and will liaise with the Responsible Paediatrician.

6.13 Once the fact of the child's death has been confirmed, any IV cannulae, ET tubes and other equipment may be removed from the child after checking that tubes have been correctly placed. This should be documented clearly in the medical notes and necessary investigations with chain of evidence and X-rays organised. (Refer to 6.57 – 6.63).

6.14 Any clothing removed and any items of clothing or bedding brought in with the child should be placed in labelled specimen bags and given to the Police Investigating Officer. The clothing may assist the pathologist and occasionally be required for forensic examination. A record must be made of who removed the items and handed them to the Police. Clothing may not be returned to the parents until the Coroner agrees.

6.15 The child's body should not be washed or "cleaned up" as this may interfere with the pathologist's investigation. The child may be wrapped in a clean blanket. Where cleaning of the child's body is considered essential the Police Investigating Officer and Responsible Paediatrician must be consulted as it may be appropriate for the body to be photographed and / or swabbed before being cleaned.

6.16 The Responsible Paediatrician will contact the Lead Paediatrician and agree an appropriate point for that doctor to assume responsibility for management of the case. The Police Investigating Officer will be informed of this transition.

Inter-agency liaison and planning

6.17 The Lead Paediatrician, Responsible Paediatrician and the Police Investigating Officer will liaise as early as feasible to ensure following arrangements are made. In the mean time any medical issue can be clarified with the Responsible Paediatrician by the Police or by other professionals if needed.

The Purpose of the Inter-agency Liaison & Planning Meeting is to –

- Share all currently available information on the death
- Plan the urgent review of all records held at the hospital
- Agree responsibility for notifying other agencies and professionals of the death and obtaining relevant information from their records
- Plan initial actions to be undertaken jointly by health and Police professionals including:
- Maintain the chain of evidence
 - Obtaining a full history from the family
 - Provision of care and support to the family
 - Review what is done and what else needs to be done at the hospital
 - Any other action following conclusion of hospital involvement
 - If clear indicators of abuse or neglect discuss with social care representative about course of action e.g. s47

Strategy meeting.

- Plan a visit to the home address or other place where the child died
- Agree arrangements for liaison with the pathologist
- Identify and coordinate any other actions required by the agencies own policies and protocols
- Agree the point at which responsibility for multi-agency management of the case will be handed over to the Lead paediatrician, unless the case is being dealt as a suspicious death.

6.18 There should be a clear agreement in each case on specific roles and responsibilities.

6.19 The liaison process should be ongoing as new information is received.

6.20 If any child protection concerns arising from the circumstances of the death are identified the appropriate Social Care professional should be requested to attend the hospital and a formal Strategy Meeting should be held under LSCBs Safeguarding Procedures

6.21 If there are indications that the death is suspicious and an immediate forensic post mortem examination is to take place, the examination of the child's body, skeletal survey and taking of samples should be deferred for the Pathologist to carry out. In such cases the on call Consultant Paediatrician will need to brief the Pathologist on whatever information has been obtained up to that point.

6.22 At the conclusion of their actions at the hospital the Responsible and Lead Paediatrician, Police Investigating Officer and, if present, Social Worker should agree a record of what has been done, what actions are outstanding and who is responsible for their completion.

Agency notification and information gathering

6.23 The sharing of information between agencies at an early stage following the report of a sudden unexpected infant death is vital to the planning of the multi-agency response.

6.24 The following should be notified by the CDOP Administrator of the child's death, requested to check their records for relevant information relating to the child or other family members and to ensure that any appointments for the deceased child are cancelled:

- Designated and Named Health Professionals for Safeguarding Children are informed (who will notify, obtain information from and

- facilitate liaison with the GP, Health Visitor and School Nurse)
- Social Care for the area where the child is normally resident, or Out of Hours Team (who will notify and obtain information from the Bedfordshire or Luton Review and Conference Service)
 - Other relevant health professionals involved in the previous care of the child
 - Police Child Abuse Investigation Unit (to include all Police databases)
 - Education establishments, if relevant (including any nursery or other provision attended by the child)

6.25 Where the child is normally resident outside of Bedfordshire or Luton the corresponding professionals in the home area should be notified and asked to check their records in addition to the Bedfordshire and Luton professionals.

6.26 All records held by the hospital in respect of the child and any siblings should be obtained and reviewed by the Responsible Paediatrician. The original records will be required by the pathologist and a copy should therefore be produced for retention by the hospital. Additional copies will be required by the Lead Paediatrician and may be requested by the Police.

6.27 As a minimum any relevant information held by Social Care and the hospital should be obtained whilst the child and family are still at the hospital. The urgency with which checks of other records should be requested will be dependent upon the circumstances of the death. They should however be completed as far as is possible prior to the post mortem examination taking place.

Care of the child's family

6.28 When the child has been pronounced dead, the Responsible Paediatrician should break the news to the parents, having first reviewed all the available information. The interview should be in the privacy of an appropriate room. The allocated nurse should also be present.

6.29 The family should be treated with respect and honesty. They should be allowed to ask questions at any stage. Unless there is an obvious cause of death, it is usually best to say that an opinion cannot be given at that stage.

6.30 Parents should, in all but exceptional circumstances, be allowed to hold and spend time with their child. Professional presence should be discreet but vigilant during parents' time with their child.

6.31 Mementos should be offered routinely. If there are marks on the child's body which might be masked by taking mementos these areas must be avoided. Details must be recorded in the medical notes (e.g. lock of hair cut or palm or sole prints taken). If mementos are not taken in the Accident and Emergency Department the Coroner's Officer should be notified and a request made to arrange these after the post mortem examination.

6.32 The family should be informed that the death must be notified to HM Coroner and that formal identification of the child's body to the Police and a post mortem examination will be required. It should be sensitively explained to the family what this involves and that tissue samples will be taken for examination under the microscope. They should be told where this will be done and that if it is to be at a specialist centre, that the child will normally be returned to the hospital afterwards. They will usually be able to spend time with their baby after the post mortem examination.

6.33 The family should also be informed that to ensure that the investigation into the death of a child is as effective as possible and that the family are properly supported a number of agencies, including the Police, Health Service, Social Care, Education will be involved and will meet to plan any further actions that each will take. Details should be provided of any action planned, including any visit to the home address and of the need to obtain a comprehensive history from the family.

6.34 It is important to ensure that someone is looking after any other young children in the family. The family should be offered help in contacting other family members or close friends, employers, the hospital chaplain or other religious leader if the parents wish.

6.35 The Care of Next Infant (CONI) scheme operates to support families with children born following a cot death. The programme offers a flexible approach with supportive measures including weekly health visitor home visits, apnoea monitors, weighing scales/charts and symptom diaries. If there are other young children in the family and especially if the dead child is from a multiple birth, urgent institution of the CONI scheme should be considered.

6.36 If the child is a twin the other twin should be assessed immediately and admitted for a period of observation and investigation. It must be emphasised to the family that the admission of the surviving twin is because of the possibility of a natural medical condition. If the family decline the offer of admission, this should prompt an urgent reconsideration of the family's needs and the health needs of the surviving twin.

6.37 The family should be given a copy of the Foundation for the Study of Infant Deaths (FSID) booklet “When a baby dies suddenly and unexpectedly”, the Department of Health leaflet “Guide to the post-mortem examination: brief notes for parents and families who have lost a baby in pregnancy or early infancy”, and the FSID helpline number (see Appendix 2). An offer should be made to inform the (FSID) who provide counselling for affected families and professionals. Any health staff involved in an unexpected child death can also contact the FSID.

6.38 Further support for the family should be provided in accordance with existing hospital policies.

6.39 Before they leave the hospital the family should know where their child will be, and the contact details for the relevant co-ordinator whom they can contact if they wish to visit their child.

6.40 They should also be provided with contact details for the Lead Paediatrician, the Police Investigating Officer (or Family Liaison Officer if appointed) and the Coroner’s Officer.

History taking from the child’s family

6.41 Initial history would be taken by the Responsible Paediatrician at the time of presentation at the hospital. Subsequently, the Lead Paediatrician should take history in a way to fill in the gaps. The identity of the people present and their relationship to the child needs to be ascertained and detailed records made of who was present and what was said.

6.42 It will normally be appropriate to undertake the history taking in conjunction with the Police present to avoid duplicating the task

6.43 Unless there are indications that the death may be suspicious it will not be appropriate to separate the parents / carers to obtain the history from them, although note should be made of who provides the information. If the death is suspicious the Police Investigating Officer will take this into account when planning the taking of the history.

6.44 Appendix 3 is provided as a guide to areas which should be covered in the history taking. It cannot be regarded as comprehensive, as additional specific questions may arise as a consequence of information provided by the family. Some parts of the checklist are applicable to all children who have died. Others will be relevant only for children under the age of 2 and older children where there is no readily identifiable external cause of death or the child had a chronic medical condition or disability.

6.45 Discretion is needed as to the amount of detail that should be sought in the first instance and the immediate history should be obtained first. If a visit to the home address is planned, a lot of the background information can be obtained from the medical records or during that visit. If, however, such a visit is not feasible, it will be necessary to cover as much ground as possible whilst at the hospital.

6.46 Encouraging the parents to talk spontaneously with prompts about specific information is likely to be better than trying to collect a structured history. In recording the accounts of parents / carers it is important to use their own words as far as possible. Ideally, information should be recorded verbatim.

6.47 Much of the information is very sensitive. Parents may feel very vulnerable when asked about their sleeping arrangements, alcohol intake or drug use, so great skill is needed in asking the questions in a non-threatening way, with no implication of value judgement or criticism.

Examination of the child's body

6.48 Unless there are indications that the death is suspicious and an immediate forensic post mortem examination is to take place, the Responsible Paediatrician should undertake a full general examination of the child's body. A consultant in emergency medicine may also need to be involved and for children over 16 years, may be more appropriate.

6.49 This examination should be conducted with the Police Investigating Officer present.

6.50 Any marks and injuries should be documented on a body chart. This should include the site and route of any intervention in resuscitation, for example, venepuncture or intra-osseous needle insertion.

6.51 The examination should include the genitalia for any signs of injury and fundoscopy for retinal haemorrhage (preferably by a Consultant Ophthalmologist).

6.52 An ear temperature should be taken immediately on presentation, using a low reading thermometer if necessary. Care should be taken to examine the ear and record the findings before the temperature is taken.

6.53 Full growth measurements (length, weight and head circumference) should be taken and plotted on centile charts. The child's general appearance, cleanliness and descriptions of any blood or secretions around nose or on clothes should also be noted.

6.54 The child's body should not be washed or "cleaned up" as this may interfere with the pathologist's investigation.

6.55 Any visible marks and injuries should be photographed by a Police Forensic Investigator.

6.56 Any clothing removed should be placed in labelled specimen bags and given to the Police Investigating Officer. The clothing may assist the pathologist and occasionally be required for forensic examination. A record must be made of who removed the clothing and handed it to the Police. Clothing may not be returned to the parents until the Coroner agrees.

Obtaining samples

6.57 If any laboratory investigations were taken during resuscitation, these should be clearly documented.

6.58 Unless there are indications that the death is suspicious and an immediate forensic post mortem examination is to take place, samples for medical investigations should be taken routinely as soon as possible after death. The recommended samples for children under 2 years are detailed in Appendix 4. For older children the Paediatrician should consider which of the investigations detailed at Appendix 4 are indicated on the basis of the medical history. If there is definite external evidence of injury early samples should only be taken after discussion with the Police and Pathologist, as this could interfere with the interpretation of injuries at post mortem examination. However, the only opportunity to identify or exclude some medical conditions is by taking samples at or shortly after death and this should not be unnecessarily missed.

Skeletal survey

6.62 Unless there are indications that the death is suspicious and an immediate forensic post mortem examination is to take place a full skeletal survey needs to be performed in all children under 2 year age and a clinically targeted X-rays in older children . It should be reported before the post mortem examination by a consultant Radiologist experienced in interpreting paediatric X-rays. If the surveys have to be performed and reported out of hours, the X-rays should be reviewed by a specialist Paediatric Radiologist before the post mortem examination.

6.63 The radiology must be a full skeletal survey not a 'babygram'. The British Society of Paediatric Radiology, have developed standards for skeletal surveys in suspected non-accidental injury (NAI) in children and these should be followed.

Home Visit

6.64 Consideration will be given to a joint visit to the home address (or to the place where the child collapsed / died if different) by the Lead Paediatrician (or alternative senior health professional experienced in responding to unexpected child deaths) and the Police Investigating Officer. Where it is not possible for Lead Paediatrician to accompany the Police on a home visit, any medical query could be put to the Responsible Paediatrician who would have attended the child in the hospital at the time of death and would have collected preliminary information.

6.65 Where the death is considered suspicious at the outset, the arrangements for the visit will be considered by the Police in the context of the police investigation and particularly the forensic strategy for the scene.

6.66 Arrangements should be made to ensure that the scene of the child's collapse and / or death is left undisturbed and the Police Investigating Officer may have visited the scene of death immediately and be maintaining a presence there.

6.67 If it is not possible for the Lead Paediatrician to undertake the visit at this stage, the Police or the Responsible Paediatrician will fully brief the Lead Paediatrician as soon as possible afterward who will then arrange to visit when feasible.

6.68 If a joint visit is impossible within this time frame, separate visits should occur. If separate visits are arranged, then the Lead Paediatrician and the Police Investigating Officer should confer soon afterwards to share their findings and discuss their interpretation.

6.69 It must be explained to the family that this is a routine part of the investigation to help identify and understand the factors that have contributed to the death and provide information for the pathologist, prior to the post mortem examination.

6.70 The purpose of the visit is to:

- Explore the circumstances of the death, relevant events and previous history, filling any gaps in and supplementing the information which was obtained at the hospital or from agency records.
- Carry out a systematic examination of the site of the child's death
- Ensure that the family are fully informed about the multi-agency approach to the death of the child and the support available to them

6.71 The Police Investigating Officer will arrange for the scene to be photographed by a Police Forensic Examiner. This should normally take place towards the end of the home visit when the Police Investigating Officer is in a position to set parameters for the Forensic Investigator.

6.72 There may also be a need to remove items from the scene. This will be undertaken by the Police Forensic Investigator and the decision to take items will be made by the Police Investigating Officer in conjunction with the Responsible Paediatrician.

6.73 The home interview and visit to the place where the child died can be very difficult, but may also be of great value in understanding the sequence of events leading to the death. Parents commonly find this home interview, whilst stressful and sometimes painful, very helpful. The fact that the Paediatrician is willing to spend this time with them, helping to understand what has happened to their child may in itself be very important to the family.

6.74 The preliminary home visit should essentially just involve the Lead Paediatrician (in some instances nominated senior nurse) and Child Abuse Investigating Supervisor. They will consider if it would be appropriate at that time to invite the Coroner's Officer to either the preliminary visit, or at a subsequent home visit. If the Coroner's Officer attends he/she should explain direct to the parents the post mortem procedure, how they will be informed of the preliminary results, and answer any questions they may have.

6.75 Time will also be needed for the paediatrician to help the parents deal with the very powerful emotions that are commonly brought out by this discussion.

7. LEAD PAEDIATRICIAN

7.1 The Lead Paediatrician for Child Deaths will be notified by the Responsible Paediatrician of the death of a child in hospital or who has been brought to an Accident and Emergency Department having died in the community.

7.2 The Lead Paediatrician will thereafter have responsibility for ensuring a coordinated health service response to the death is in accordance with these procedures and should agree with the Responsible Paediatrician the point at which he/she will take over that role the operational management of the response. In most circumstances this will be when the initial response at the hospital is completed.

7.3 The Lead Paediatrician will also be notified by the Police Investigating Officer if the body of a child who has died is not removed to hospital and by the Coroner's Officer if the body of a child has been conveyed directly to the mortuary. In such cases the lead Paediatrician will liaise with the Police Investigating Officer to coordinate a subsequent response which complies with these procedures as closely as possible.

7.4 The Lead Paediatrician will, if appropriate, either conduct the joint visit to the home address (or to the place where the child collapsed / died, if different) with the Police Investigating Officer, or arrange for an alternative senior health professional experienced in responding to unexpected child deaths to do so.

If the Lead Paediatrician does not undertake the visit he/she should ensure that they are fully briefed by the health professional concerned as soon as possible afterwards.

7.5 The Lead Paediatrician will obtain from the 'Responsible Paediatrician' (on call Paediatrician) a full report on the initial response to the child's death. This should include details of any outstanding actions and the Lead Paediatrician should, in conjunction with the Police Investigating Officer, arrange for these to be completed. .

7.6 The Responsible Paediatrician would have reviewed available hospital records and summarised that in a report. The Lead Paediatrician will receive Responsible Paediatrician's report and add information from reviewing other available health records.

7.7 The Lead (or Responsible) Paediatrician should provide the Pathologist with all medical records relating to the child and details of any x-rays and tests carried out. The original x-ray films, test results and any unexamined samples should also be provided to the Pathologist. These should be transferred in such a way that their evidential integrity

is maintained.

7.8 Copies of the original records should be retained by the Paediatrician to facilitate management of the investigation and review process and provided to the original record holder and the Police Investigating Officer.

7.9 The Lead or Responsible Paediatrician will, in conjunction with the Police Investigating Officer, fully brief the Pathologist and should include all information obtained during the initial investigation, a full medical report based on the history given by the parents in hospital, examination of the child immediately after death, information obtained during the home visit and examination of all relevant medical and social records. In very young babies this might include obstetric records. Any photography of the scene or of the child at presentation or in the Accident and Emergency Department should be provided to the Pathologist prior to starting the post mortem.

7.10 Inadequate briefing may result in failure to carry out the tests that might lead to the identification of a cause of death.

7.11 The Lead or Responsible Paediatrician may attend the post mortem examination. Where this does not occur there must be adequate discussion between the Lead & Responsible Paediatrician and the Pathologist both before and after the post mortem examination.

7.12 Thereafter the Lead Paediatrician will ensure that the CDOP Administrator is aware of the child's death and is responsible for managing the multi-agency planning and review arrangements, as detailed on page 26 of these procedures.

7.13 The interim findings of the post mortem examination should be provided in writing by the pathologist to HM Coroner, the Police Investigating Officer and the Lead Paediatrician immediately after the post mortem examination is completed.

7.14 The final report on the post mortem examination should be similarly provided to HM Coroner, the Police Investigating Officer and the Lead Paediatrician.

8. POLICE

Introduction

8.1 This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies.

8.2 In respect of the sudden or unexpected death of a child the Police have a number of inter-related responsibilities:

- To investigate the circumstances of the death on behalf of HM Coroner
- To establish if a crime has been committed and if so, to investigate that crime
- To participate in the CDOP response to the death as described in these procedures including contributing to any action required to protect other children in the family from any identified child protection risks.

8.3 Procedures detailed here relate to:

- Investigative Responsibility
- Receipt of call and deployment
- Child deaths at hospitals outside of Bedfordshire and Luton
- Initial attendance
- Inter-agency liaison and planning
- Agency notification and information gathering
- Care of the child's family
- History taking from the child's family
- Examination of the child's body and obtaining samples and x-rays
- Identification
- Home visit
- Reporting the death to HM Coroner
- Post mortem examination
- Multi-agency arrangements

8.4 These should be followed in conjunction with and additional to any other procedures applicable to the circumstances of the death (e.g. Road Traffic Collision SOP; ACPO Murder Investigation Manual).

Investigative Responsibility

8.5 Lead responsibility for the investigation of the sudden or unexpected death of a child will be the undertaken by:

- If at the outset or subsequently there any indications that the death of a child is suspicious, a Senior Investigating Officer
- If the child is under 2 years of age and the death is not the result of a road traffic collision, a Senior Investigating Officer
- If the death results from a Road Traffic Collision, a Road Policing

Unit Investigator.

- In all other cases a Child Abuse Investigation Unit Supervisor

8.6 If a Child Protection Unit Supervisor is not the lead investigator, one will work with the lead investigator to provide advice and assistance, particularly in relation to the application of these procedures.

8.7 The Lead Investigator, or Child Abuse Investigation Unit Supervisor if delegated by the Lead Investigator to undertake responsibilities under these procedures, is referred to as the Police Investigating Officer.

8.8 If at any point in the investigation there are indications that the death is suspicious the duty Senior Investigating Officer will be contacted and will assume lead responsibility for the investigation.

Receipt of call and deployment

8.9 The Force Control Room will be responsible for the initial deployment of resources to the death of a child, irrespective of the origin of the notification or the circumstances of the death.

8.10 For any child death occurring outside of a hospital, the Ambulance Service will be notified and requested to send an emergency ambulance if not already in attendance.

8.11 If a road traffic collision is involved, the initial deployment will be in accordance with the Road Traffic Collision SOP. In addition the duty Child Abuse Investigation Unit Supervisor will be contacted to assist the lead investigator.

8.12 In all other circumstances an immediate deployment will be made to the place where the incident occurred and the hospital where the child has been taken. Police attendance should be kept to the minimum required and consideration should be given to the initial response being from plain clothed officers. Officers maintaining the integrity of any scene should use unmarked cars where possible.

8.13 The duty Lead Investigator (see above) will then be contacted to assume management of the investigative response. If not the Lead Investigator, the duty Child Abuse Investigation Unit Supervisor will also be contacted.

8.14 In normal circumstances it will be appropriate for the Child Abuse Investigation Unit Supervisor to attend the hospital where the child has been taken and to there liaise with the Responsible Paediatrician regarding implementation of these procedures.

Child deaths at hospitals outside of Bedfordshire and Luton

8.15 If, following an incident in Bedfordshire or Luton, the child has been taken to a hospital outside of Bedfordshire or Luton, the relevant Police force will be contacted and requested to initiate their CDOP procedures for an initial response to the death of a child at the hospital.

8.16 In these circumstances the Child Abuse Investigation Unit Supervisor will be responsible for:

- Liaison with Police force and other agencies where the hospital is located to ensure a coordinated initial response
- Notification, as soon as possible, to the Lead Paediatrician for Child Deaths of the circumstances of the death and the response provided.

Initial attendance

8.17 If an ambulance is not present one must be called immediately, and consideration given to attempting to revive the child. The first police officer to arrive, or any other professional, may be expected by the parents to try and revive the child, even if it is hopeless, and should be prepared for this. **However, attempt to revive the child will not be practicable if the child has been dead for quite some time (e.g. days).**

8.18 Police officers need to be aware of and coordinate their actions with the responsibilities and roles of other professionals, e.g. resuscitation attempts, taking details from the parents, examination of the child and looking after the welfare needs of the family.

8.19 The first officer attending the scene of a child's death or the hospital where the child has been taken will assume control of the situation, commence a scene log and preserve the scene. The preservation of the scene will be appropriate to presenting factors and as directed by the Lead Investigator. An explanation should be given to the parents/carers that this is routine in order to assist in determining how the child died. Unless the death is clearly suspicious, there is no reason why parents cannot hold their dead child. This should however take place under the discreet observation of a Police officer.

8.20 The first officer at the scene should note the position of the child, the clothing worn and the circumstances of how the child was found. Any comments made by the carers or others present, any background history, and the conditions of the living accommodation should also be noted.

8.21 Children under 2 years of age should always be taken to the Accident and Emergency Department by ambulance and older children

will usually be, unless obviously dead for some time and the circumstances of death require the body to remain at the scene for forensic examination. If the parents / carers wish to accompany the child to hospital this should be facilitated. They should however be accompanied by a Police officer. **However, if the child is dead for quite some time (e.g. days) and retaining body at the scene for forensic purposes is not required, body can be transferred to mortuary/undertaker instead of A&E department.**

8.22 At the hospital it will only in exceptional circumstances be necessary to evidentially preserve technical equipment, the ambulance or whole areas of the hospital. Setting realistic and appropriate parameters will prevent unnecessarily tying up facilities that may be required for the treatment of others.

Inter-agency liaison and planning

8.23 If the child's body is not removed to hospital the Police Investigating Officer will contact the Lead Paediatrician for Child Deaths and coordinate subsequent action which complies with these procedures. In any other case the Police Investigating Officer will liaise with the Responsible Paediatrician.

8.24 At the hospital the Police Investigating Officer and the Responsible Paediatrician will liaise at an early stage to:

- Share all currently available information on the death
- Plan the urgent review of all records held at the hospital
- Agree responsibility for notifying other agencies and professionals of the death and obtaining relevant information from their records
- Plan initial actions to be undertaken jointly by health and Police professionals including:
 - Examination of the child's body, obtaining urgent post mortem samples and a skeletal survey
 - Obtaining a full history from the family
 - Formal identification of the child's body
 - Provision of care and support to the family
- Plan a visit to the home address or other place where the child died
- Agree arrangements for liaison with the Pathologist
- Identify and coordinate any other actions required by the agencies own policies and protocols
- Agree the point at which responsibility for multi-agency management of the case will be handed over to the Lead Paediatrician

8.25 There should be a clear agreement in each case on specific roles

and responsibilities.

8.26 The liaison process should be ongoing as new information is received.

8.27 If any child protection concerns arising from the circumstances of the death are identified the appropriate Social Care professional should be requested to attend the hospital and a formal Strategy Meeting should be held under LSCB Safeguarding procedures.

8.28 If there are indications that the death is suspicious and an immediate forensic post mortem examination is to take place the examination of the child's body, skeletal survey and taking of samples should be deferred for the Pathologist to carry out. This may also affect the manner in which the history is obtained and the briefing of the Pathologist by the Responsible Paediatrician.

8.29 At the conclusion of the initial liaison process at the hospital the Responsible Paediatrician, Police Investigating Officer and, if present, Social Worker should agree a record of what has been done, what actions are outstanding and who is responsible for their completion.

Agency notification and information gathering

8.30 The sharing of information between agencies at an early stage following the report of a sudden unexpected death of a child (0 –18) is vital to the planning of the multi-agency response.

8.31 The following should be notified of the child's death, requested to check their records for relevant information relating to the child or other family members and to ensure that any appointments for the deceased child are cancelled:

- General practitioner
- Designated Child Protection Professionals
- Health visitor and/or school nurse
- Social Care for the area where the child is normally resident (or Out of Hours Team)
- Bedfordshire and Luton Review and Conference Service (this will be done by Social Care)
- Other relevant health professionals involved in the previous care of the child
- Police Child Abuse Investigation Unit (to include all Police databases)
- Education, if indicated (including any nursery or other provision attended by the child)
- CDOP Administrator

8.32 Where the child is normally resident outside of Bedfordshire or Luton the corresponding professionals in the home area should be notified and asked to check their records in addition to the Bedfordshire and Luton professionals.

8.33 All records held by the hospital in respect of the child and any siblings should be obtained and reviewed by the Responsible Paediatrician. The Police Investigating Officer should request copies of these and any obtained from other agencies, for the information of HM Coroner.

8.34 The originals of medical records will only be seized by the Police where the circumstances of the death are such that there are concerns over preserving the evidential integrity of the records

8.35 As a minimum any relevant information held by Social Care and the hospital should be obtained whilst the child and family are still at the hospital. The urgency with which checks of other records should be requested will be dependent upon the circumstances of the death. They should however be completed as far as is possible prior to the post mortem examination taking place.

Care of the child's family

8.36 Initial care of the family will normally be undertaken by hospital staff. The Police should however assist with this wherever possible and where a Family Liaison Officer has been appointed it will normally be appropriate for that officer to work closely with the relevant health service professional.

8.37 Parents should, in all but exceptional circumstances, be allowed to hold and spend time with their child. Professional presence should be discreet but vigilant during parents' time with their child.

8.38 Mementos should be offered routinely. If mementos are not taken in the Accident and Emergency Department the Coroner's Officer should be notified and a request made to arrange these after the post mortem examination.

8.39 The family should be informed that the death must be notified to HM Coroner and that formal identification of the child's body to the Police and a post mortem examination will be required. It should be sensitively explained to the family what this involves and that tissue samples will be taken for examination under the microscope. The family should be informed where this will be done and that if it is to be at a specialist centre, that the child will normally be returned to the hospital

afterwards. They will usually be able to spend time with their child after the post mortem examination.

8.40 The family should also be informed that to ensure that the investigation into the death of a child is as effective as possible and that the family are properly supported a number of agencies, including the Police, Health Service, Social Care, Education will be involved and will meet to plan any further actions that each will take. Details should be provided of any action planned, including any visit to the home address and of the need to obtain a comprehensive history from the family.

8.41 It is important to ensure that someone is looking after any other young children in the family. The family should be offered help in contacting other family members or close friends, employers, the hospital chaplain or other religious leader if the parents wish.

8.42 Before they leave the hospital the family should know where their child will be, and the contact details for the relevant co-ordinator whom they can contact if they wish to visit their child.

8.43 They should also be provided with contact details for the Lead Paediatrician, the Police Investigating Officer (or Family Liaison Officer if appointed) and the Coroner's Officer.

History taking from the child's family

8.44 Often medical staff interview parents before the police arrive at hospital in an effort to establish the circumstances surrounding the child's collapse. This account should be obtained by the Police Investigating Officer.

8.45 The Lead Paediatrician will normally take a detailed history from the parents / carers and a Police Officer should be involved in this to avoid duplicating the task. Repeat questioning of the parent by different police officers or other professionals should be avoided.

8.46 The identity of the people present and their relationship to the child needs to be ascertained and detailed records made of who was present and what was said.

8.47 Unless there are indications that the death may be suspicious it will not be appropriate to separate the parents / carers to obtain the history from them, although note should be made of who provides the information. If the death is suspicious the Police Investigating Officer will decide whether any interviews with the parents / carers need to be carried out under the Police and Criminal Evidence Act, 1984 and how this may fit into the overall investigation plan.

8.48 Appendix 3 is provided as a guide to areas which should be covered in the history taking. It cannot be regarded as comprehensive, as additional specific questions may arise as a consequence of information provided by the family. Some parts of the checklist are applicable to all children who have died. Others will be relevant only for children under the age of 2 and older children where there is no readily identifiable external cause of death or the child had a chronic medical condition or disability.

8.49 Discretion is needed as to the amount of detail that should be sought in the first instance and the immediate history should be obtained first. If a visit to the home address is planned, a lot of the background information can be obtained from the medical records or during that visit. If, however, such a visit is not feasible, it will be necessary to cover as much ground as possible whilst at the hospital.

8.50 Encouraging the parents to talk spontaneously with prompts about specific information is likely to be better than trying to collect a structured history. In recording the accounts of parents / carers it is important to use their own words as far as possible. Ideally, information should be recorded verbatim.

8.51 Much of the information is very sensitive. Parents may feel very vulnerable when asked about their sleeping arrangements, alcohol intake or drug use, so great skills is needed in asking the questions in a non-threatening way, with no implication of value judgement or criticism.

Examination of the child's body and obtaining samples and x-rays

8.52 Unless there are indications that the death is suspicious and an immediate forensic post mortem examination is to take place the Responsible Paediatrician should undertake a full general examination of the child's body. A consultant in emergency medicine may also need to be involved and for children over 16 years, may be more appropriate.

8.53 The Police Investigating Officer should be present when this is conducted and ensure that all marks and injuries are recorded along with the Responsible Paediatricians opinion on their cause.

8.54 The child's general appearance, cleanliness and descriptions of any blood or secretions around nose or on clothes should also be noted. The child's body should not be washed or "cleaned up" as this may interfere with the pathologist's investigation.

8.55 Any visible marks and injuries should be photographed by a Police Forensic Investigator.

8.56 Any clothing removed should be appropriately packaged and retained by the Police. Care should be taken to ensure the evidential integrity and continuity of all exhibits and samples, including any taken during attempts at resuscitation, and the Police Investigating Officer or Forensic Investigator should advise hospital staff on these issues.

Identification

8.57 The Police Investigating Officer should ensure that wherever possible the child body is formally identified at the hospital, or at least prior to the post mortem examination taking place, and that continuity of identification is maintained through to the post mortem examination.

8.59 At each stage in the chain of continuity, appropriate witness statements must be obtained.

Home Visit

8.60 Consideration will be given to a joint visit to the home address (or to the place where the child collapsed / died if different) by the Lead Paediatrician (or alternative senior health professional experienced in responding to unexpected child deaths) and the Police Investigating Officer. Where it is not possible for Lead Paediatrician to accompany the Police on a home visit, any medical query could be put to the Responsible Paediatrician who would have attended the child in the hospital at the time of death and would have collected preliminary information.

8.61 A joint visits should take place within 24 hours of the death if possible. Arrangements should be made to ensure that the scene of the child's collapse and / or death is preserved until the visit takes place and this may, at the discretion of the Police Investigating Officer, involve maintaining a Police presence there.

8.62 If a joint visit is not possible within this time frame, separate visits should occur. If separate visits are arranged, then the paediatrician and the police officer will confer soon afterwards to share their findings and discuss their interpretation.

8.63 It must be explained to parents that this is a routine part of the investigation to help identify and understand the factors that have contributed to the death and provide information for the pathologist, prior to the post mortem examination.

8.64 The purpose of the visit is to:

- Explore the circumstances of the death, relevant events and

previous history, filling any gaps in and supplementing the information which was obtained at the hospital or from agency records.

- Carry out a systematic examination of the site of the child's death
- Ensure that the family are fully informed about the multi-agency approach to the death of the child and the support available to them

8.65 Where the death is considered suspicious the arrangements for the visit will be considered by the Police in the context of the overall investigation and particularly the forensic strategy for the scene.

8.66 The Police Investigating Officer will arrange for the scene to be photographed by a Forensic Examiner. This should normally take place towards the end of the home visit when the Police Investigating Officer is in a position to set parameters for the Forensic Investigator.

8.67 There may also be a need to remove items from the scene. This will be undertaken by the Police Forensic Investigator and the decision to take items will be made by the Police Investigating Officer in conjunction with the Lead Paediatrician.

8.68 Bedding will only be taken if there are obvious signs of forensic value such as blood, vomit or other residues. The routine collection of bedding is neither necessary for any investigative purpose, nor appropriate for the family. Items such as the child's used bottles, cups, food or medication together with any used nappies will normally be taken. There is no need to retain any other clothing unless the child's clothes have been changed prior to the arrival of the police.

8.69 If any medical equipment has been used for the child (e.g. syringe drivers, portable ventilators) these should be taken after advice is obtained on how to preserve any internal records settings.

8.70 If it is necessary to remove items from the house, this should be done with consideration for the parents. It should be explained that this may help to find out why their child has died. Parents / carers should be asked if they want the items returned.

8.71 At the earliest opportunity after the investigation is completed, any items the family wish to have returned, should be returned to them. All police documentation will be removed and the property will be returned if appropriate in new/clean wrapping/bags. If soiled articles were taken, parents/carers should be asked about their return, and if they would like them cleaned prior to return. An appointment should be made with the parents/carers to return any property, remembering that this could be a significant event for them

Reporting the death to HM Coroner

8.72 In all cases the Coroner's Officer must be notified of the death as soon as possible in accordance with normal Police procedures. The Coroner should be provided with full details of the circumstances of the death and any special considerations relative to the post mortem examination in order that HM Coroner can be briefed and appropriate arrangements can be made.

8.73 The statements relating to identification of the child's body should be forwarded to the Coroner's Officer as soon as possible to enable an Inquest to be opened.

8.74 The Police Investigating Officer and the Coroner's Officer should continue close liaison throughout the investigation.

Post mortem examination

8.75 The Police Investigating Officer, in conjunction with the Lead Paediatrician should ensure that the Pathologist is provided with full details of the circumstances. including all information obtained by their initial investigation, a full medical report based on the history given by the parents in hospital, examination of the child immediately after death, information obtained during the home visit and examination of all relevant medical and social records. In very young babies this might include obstetric records. Any photography of the scene or of the child at presentation or in the Accident and Emergency Department should be provided to the Pathologist prior to starting the post mortem.

8.76 Inadequate briefing may result in failure to carry out the tests that might lead to the identification of a cause of death.

8.77 The Police Investigating Officer should attend the post mortem examination. If this is not possible, then they must send a representative who is aware of all the facts of the case. A Forensic Investigator must attend all post mortem examinations conducted by a Home Office pathologist.

Multi-agency arrangements

8.78 The Child Abuse Investigation Unit Supervisor and, if different, the Lead Investigator should attend the multi-agency Information Sharing and Planning Meeting and Case Review Meeting.

8.79 The Police Investigating Officer will notify the Administrator of the child's death in accordance with (page 41) of these procedures.

9. SOCIAL CARE

9.1 This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies.

9.2 Social Care (adult or children's services) may hold information in respect of a child who has died or their family. The duty social worker for the area where the child lived or the Out of Hours Team will be

contacted by either the Police or the Responsible Paediatrician as part of the initial information gathering procedure and should share any information held.

9.3 Any child death notified to a social worker must then inform their Deputy Team Manager and Team Manager, the Head of Service must notify the Assistant Director for Children Social Care and in their absence the Director of Children Services. The Social Worker must notify Bedfordshire or Luton Conference and Review Service of the circumstances and establish whether or not the child is subject to a Child Protection Plan.

9.4 Social Care may become more directly involved in the initial response to the death of a child either where there are specific support needs of the family, especially if there are other children, or where there are child protection concerns arising from the circumstances of the death.

9.5 Any child protection concerns will be addressed in accordance with LSCBs Safeguarding procedures and Social Care has lead responsibility for these issues which is shared jointly with the Police if there is a concern that an offence has been committed. If any action is considered necessary in advance of the multi-agency Information Sharing and Planning Meeting the Social Worker should coordinate this with the Health and Police professionals responding to the child death. In all but exceptional circumstances this should be through convening a formal child protection strategy meeting.

9.6 A senior Social Care representative e.g. Head of Intake/Assessment and Family Support and or a representative on their behalf will always be invited to the multi-agency Information Sharing and Planning Meeting and Case Review Meeting.

10. CORONER'S OFFICER AND PATHOLOGIST

10.1 This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies.

10.2 Any child whose death is sudden or unexpected should be taken to the Accident and Emergency Department, unless there are concerns that the child has been murdered. If, for any reason, a child's body is taken directly to the mortuary, the mortuary or Coroner's Officer will immediately inform the duty Child Abuse Investigation Unit Supervisor and the Lead Paediatrician. Those professionals will thereafter coordinate subsequent action which complies with these procedures.

10.3 The Coroner's Officer will be notified of a child's death in accordance with existing Police policies by the Police Investigating Officer.

10.4 The Coroner's Officer is thereafter responsible, on behalf of HM Coroner for:

- Arranging for a post mortem examination
- Informing all relevant professionals of the time and place of the post mortem examination, including the Police Investigating Officer and the Lead Paediatrician
- Informing the family of the time and place of the post mortem examination
- Liaising with the family about mementos if these have not been taken in the Accident and Emergency Department
- Liaising with family regarding retention of tissue and organs and obtaining necessary signatures
- Ensuring, in liaison with the Lead Paediatrician, that all medical records, x-rays and test results are forwarded to the paediatric Pathologist prior to the post mortem examination
- Ensuring parents are aware of available support organisations
- When interim and final post mortem reports are received from the Pathologist, forwarding copies of these to the Lead Paediatrician, Police Investigating Officer and GP
- Ensuring effective communication between those professionals involved in the multi-agency response to the child's death and HM Coroner
- Ensuring that the family's wishes regarding disposal of any body tissues retained from the post mortem examination are made known to the Pathologist and HM Coroner.
- Ensuring that the child's body is released for burial or cremation as soon as possible

10.5 Where a Police Family Liaison Officer has been appointed it may be appropriate for some of these responsibilities to be undertaken by that Officer.

If possible the post mortem examination should be completed as soon as possible of the child's death. In all cases, the post mortem examination should be carried out by a Paediatric Pathologist.

10.6 If there are any concerns that the death may be suspicious nature, a Home Office Pathologist will be used in conjunction with a Paediatric Pathologist. Where a Pathologist is qualified as a Forensic Pathologist they may complete the post mortem examination on their own.

10.7 If during the post mortem examination a Pathologist becomes at all concerned that there may be suspicious circumstances, they must halt the post-mortem and inform the Coroner's Officer who in turn will inform the Police Investigating Officer.

10.8 The Pathologist must be provided with full details of the circumstances. This briefing is best done by the Responsible or Lead Paediatrician, in conjunction with the Police Investigating Officer, and should include all information obtained by their initial investigation, a full medical report based on the history given by the parents in hospital, examination of the child immediately after death, information obtained during the home visit and examination of all relevant medical and social records. In very young babies this might include obstetric records. Any photography of the scene or of the child at presentation in the Accident and Emergency Department should be provided to the Pathologist prior to starting the post mortem. Inadequate briefing may result in failure to carry out the tests that might lead to the identification of a cause of death.

10.9 The Responsible Paediatrician should also provide the Pathologist with all medical records relating to the child and details of any x-rays and tests carried out. The original x-ray films, test results and any unexamined samples should be provided to the Pathologist. These should be transferred in such a way that their evidential integrity is maintained.

10.10 All documents to be forwarded should be copied and the copies retained in place of the originals. Additional copies should be made for the Lead Paediatrician to facilitate management of the investigation and review process and for the Police Investigating Officer.

10.11 The Police Investigating Officer should attend the post mortem. A Police Photographer will also be present. If this is not possible, then

they must send a representative who is aware of all the facts of the case. A Forensic Investigator must attend all post mortem examinations conducted by a Home Office pathologist. The Responsible Paediatrician may also attend. Where this does not occur there must be adequate discussion between the Paediatrician and the Pathologist both before and after the post mortem examination.

10.12 The interim findings of the post mortem examination should be provided in writing by the pathologist to HM Coroner, who in turn will inform the Police Investigating Officer. The Lead Paediatrician will be informed in due course after the post mortem examination is completed.

10.13 The final report on the post mortem examination should be similarly provided to Coroner, who in turn will inform the Police Investigating Officer. The Lead Paediatrician will be informed in due course.

10.14 If the Lead Paediatrician needs more information regarding the post mortem then they can speak to the Pathologist via the Coroner's Office.

10.15 The Lead Paediatrician, through the Coroner's Officer, will ensure that HM Coroner is made aware of any information arising from the multi-agency Information Sharing and Planning Meeting or Case Review Meeting which may impact on HM Coroner's view determination of cause of death and whether an inquest should be held.

10.16 Notwithstanding the above, if the death is from natural causes, HM Coroner will notify the Registrar as to the medical cause of death to enable the death to be registered and a death certificate issued. If the death is not 'natural', this notification to the Registrar may be delayed pending the outcome of criminal proceedings or an inquest.

10.17 HM Coroner, the Pathologist and the Coroner's Officer will always be invited to the multi-agency Information Sharing and Planning Meeting and Case Review Meeting.

11. INTER-AGENCY WORKING

Information Sharing and Planning Meeting

11.1 A Inter-agency Information Sharing and Planning Meeting will be convened by the Lead Paediatrician within 3 days of the child's death.

11.2 Whenever possible, the meeting should be held at the family GP's surgery.

11.3 The Lead Paediatrician will arrange for the meeting to be minuted and for these to be distributed within 24 hours of the meeting. Any disagreement with the content of the minutes should be raised with the Lead Paediatrician immediately.

11.4 This meeting will be chaired by the Lead Paediatrician and will include:

- The Responsible Paediatrician or other Consultant who dealt with the family immediately after the death
- The health professional who visited the home address
- The child's GP
- The child's Health Visitor/ School Health Nurse/ Community Nurse
- The Pathologist wherever possible
- A Children's Social Care Manager
- The Police Investigating Officer
- The Police Child Abuse Investigation Unit Supervisor who dealt with the family immediately after the death
- A Coroner's Officer
- A representative from any School or Nursery attended by the child during the school term.
- Any other relevant professional providing services to the child or family
- Where the child was normally resident in and / or the event leading to the death took place in another CDOP area, appropriate professionals from the other area(s)

11.5 The purpose of this meeting is to:

- Share information held by all agencies in current or previous case notes or other records
- Coordinate agency contribution to and involvement in the investigation of the child's death
- Ensure a co-ordinated bereavement care plan is in place for the family

- Explicitly consider whether there are any child protection risks to siblings or other children in the household
- Explicitly decide whether the circumstances should be referred to the LSCB for consideration of holding a Serious Case Review
- Ensure that all relevant agencies and professionals have been notified of the child's death
- Agree what information from the meeting will be shared with the family and who will provide this to them. Generally there should be complete openness with the family unless this could undermine a criminal or child protection investigation
- Where the child was normally resident in and / or the event leading to the death took place in another CDOP area, coordinate the respective CDOP child death response arrangements and the involvement of agencies in each of the areas. Whichever CDOP is to take primacy in the investigation these arrangements should include provision of the Child Death Review Data Collection Form and final report on the death to the LSCB's.
- The provision of appropriate medical report should be made available for S47 enquiries if required or potentially for court if removal of other children is necessary.

11.6 If any child protection risks are identified at any stage of the process or prior to any meetings within this process then meetings will adopt the dual function of a formal child protection strategy meeting.

11.7 At or after the meeting the Lead Paediatrician will complete of the Child Death Review Data Collection Form, available to download from the LSCB websites, details on page 10. If this form is able to be completed it will be forwarded to the CDOP Administrator. If further information is required, this form should be retained until the multi-agency Case Review Meeting has been held.

11.8 If the initial results of the post mortem examination are not available at the time of the meeting a contingency should be agreed for when they are available. In most cases this will involve telephone contact between relevant professionals but in some circumstances, (e.g. if the post mortem examination identifies abuse of the child) it will be more appropriate for the Lead Paediatrician to re-convene the meeting.

11.9 Following the meeting the identified professional will provide the family with the information agreed.

Case Review Meeting

11.10 A multi-agency Case Review Meeting will be convened by the Lead Paediatrician as soon as possible after the final post mortem result is available (the timing will vary according to circumstances, but should be no more than 8 – 12 weeks after the death).

11.11 Whenever possible, the meeting should be held at the family GP's surgery.

11.12 The Lead Paediatrician will arrange for the meeting to be minuted. Any disagreement with the content of the minutes should be raised with the Lead Paediatrician.

11.13 This meeting will be chaired by the Lead Paediatrician and will include:

- The Responsible Paediatrician or other Consultant who dealt with the family immediately after the death
- The health professional who visited the home address
- The child's GP
- The child's Health Visitor/ School Health Nurse/ Community Nurse
- The Pathologist wherever possible
- A Children's Social Care Manager
- The lead Police Investigator
- The Child Abuse Investigation Unit Supervisor who dealt with the family immediately after the death
- A Coroner's Officer
- A representative from any School or Nursery attended by the child
- Any other relevant professional providing services to the child or family
- Where the child was normally resident in and / or the event leading to the death took place in another CDOP area, appropriate professionals from the other area(s)

11.14 The purpose of this meeting is to:

- Review all relevant information concerning the death, the child's history, family history and subsequent investigation
- Ensure that no information has been overlooked. Any further tests or opinions which may shed light on the cause of death may be recommended to the appropriate agency
- If necessary complete the Core Data Set form.
- Complete an assessment of factors that contributed to the death and agree a classification of it according to avoidability. The CDOP Assessment of Contributory Factors form should be used

to record this assessment available to download on the LSCB websites, details on page 10.

- Explicitly comment on the presence or not of concerns about abuse and neglect causing or contributing to the death. If there is no evidence of maltreatment this should be documented
- Explicitly consider whether there are any unaddressed child protection risks to siblings or other children in the household and if so what action should be taken and by whom
- Review the effectiveness of the response provided by agencies and professionals to the death and identify any elements of good practice or potential lessons to be learnt
- Comment on the quality of any services provided by agencies to the child and / or family prior to the death and identify any elements of good practice or potential lessons to be learnt
- Explicitly decide whether the circumstances should be referred to the LSCBs for consideration of holding a Serious Case Review
- Agree how accurate and appropriate information regarding the findings of the investigation will be shared with the family and by whom. Generally there should be complete openness with the family unless this could undermine a criminal or child protection investigation
- To review whether the support and guidance for the family is adequate and to plan for counselling and any further services required.
- Consider the need, and if so prepare a plan for any future pregnancies
- Where the child was normally resident in and / or the event leading to the death took place in another CDOP area, consider the information needs of the CDOP and how these will be addressed. This will normally be through providing copies of the documents prepared for the CDOP.

11.15 When appropriate, this meeting will mark the closure of the investigation into the child's death. The precise timing will depend on the progress of the **Police/Coroner investigations**.

11.16 Families should be provided with information from the meeting at the earliest opportunity, usually by the Lead Paediatrician or the Paediatrician responsible for the child's care and a member of the primary health care team. The parents should also be provided with written information on the outcome of the investigation.

11.17 Where the Police and / or Social Care are conducting a criminal and / or child protection investigation, the Lead Paediatrician should discuss with the lead professional for the relevant agency (ies) what information should be shared, how and when. Where a Police Family

Liaison Officer has been appointed the involvement of that professional in this process should be considered.

11.18 Following the multi-agency Case Review Meeting the Lead Paediatrician will provide an agreed record of the meeting and all reports to HM Coroner.

11.19 The agreed record of the meeting, the completed Child Death Review Data Collection and the Assessment of Contributory Factors form will also be forwarded to the CDOP Administrator for consideration by the Panel and the CDOP for any other area as agreed at the meeting.

Form A - Notification of Child Death

Appendix 1

Notification to be reported to CDOP Manager at:

Email: **Bedfordshire-cdopmanager@nhs.net**

Tel: **01234 292955**

Fax: **01234 292956**

The security of any system for transferring the information on these forms must be clarified and agreed with the Caldicott guardian.

If there are a number of agencies involved, liaison should take place to agree which agency will submit the Notification.

Child's Details

Full Name of Child		
Any aliases		
DOB	/ /	NHS No.
Address		
Postcode		
School/nursery etc		
Date & time of death	/ /	Time
Address of death		

Referral details

Date of referral	/ /
Name of referrer	
Agency	
Address	
Tel Number	
Email	

Details of Agency Contacts

Agency	Name, Address & Tel No.	Agency Report	
		Requested (date)	Received (date)
GP		/ /	/ /
Midwife/ Health Visitor/ School nurse		/ /	/ /
Paediatrician		/ /	/ /
Police		/ /	/ /
Children's Social Care		/ /	/ /
School/ nursery etc		/ /	/ /
Others (list all agencies known to be involved)		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

Other Significant Family & Household Members

Full Name	DOB	Relationship	Full Address
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		

N.B. Pages 1, 2 and 3 can be removed for the purposes of anonymising the case. Pages 3-5 should be made available with Form B to the child death overview panel

Child's Details

Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Age (yy/mm/dd)	/ /	Indicate if estimated	<input type="checkbox"/> Estimated <input type="checkbox"/> Confirmed
Ethnic group	<input type="checkbox"/> White	<input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any Other White background <input type="checkbox"/> Traveller of Irish Heritage <input type="checkbox"/> Gypsy/Roma	
	<input type="checkbox"/> Mixed	<input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Asian <input type="checkbox"/> Any other mixed	
	<input type="checkbox"/> Asian or Asian British	<input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any other Asian	
	<input type="checkbox"/> Black or Black British	<input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other black background	
	<input type="checkbox"/> Chinese or other ethnic group	<input type="checkbox"/> Chinese <input type="checkbox"/> Any other, specify	
	<input type="checkbox"/> Not known/ not stated		
Immigration Status	<input type="checkbox"/> Asylum seeker <input type="checkbox"/> Refugee status <input type="checkbox"/> Exceptional leave to remain		

Details of the death:

Location of death or fatal event *

Death certificate issued?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<p>For neonatal deaths</p> <p>Any known cause of death as specified on the death certificate?</p>	<p>a. Main diseases or conditions in infant</p> <p>b. Other diseases or conditions in infant</p> <p>c. Main maternal diseases or conditions affecting infant</p> <p>d. Other maternal diseases or conditions affecting infant</p> <p>e. Other relevant conditions</p>			
<p>For deaths of children aged over 28 days</p> <p>Any known cause of death as specified on the death certificate?</p>	<p>Ia</p> <p>Ib</p> <p>Ic</p> <p>II</p>			
Death expected?	<input type="checkbox"/>	Expected	<input type="checkbox"/>	Unexpected
Reported to Coroner	<input type="checkbox"/>	Yes	Date: / /	
	<input type="checkbox"/>	No	Name:	
Reported to Registrar	<input type="checkbox"/>	Yes	Date: / /	
	<input type="checkbox"/>	No	Name:	
Post mortem examination:	<input type="checkbox"/>	Yes	Date: / /	
	<input type="checkbox"/>	No	Venue:	

* place where the child is believed to have died, or where the event directly leading to death occurred. For example, if a child is involved in a road traffic accident, and is resuscitated but subsequently dies, the location of death should be recorded as the site of the collision, rather than the hospital where the child's death was confirmed

Notification Details:

Please outline circumstances leading to notification. Also include if any other review is being undertaken e.g. internal agency review; any action being taken as a result of this death.

--

Level of review	<input type="checkbox"/>	Notification only
	<input type="checkbox"/>	General review
	<input type="checkbox"/>	In depth review
	<input type="checkbox"/>	Serious Case Review
	<input type="checkbox"/>	Perinatal Review
	<input type="checkbox"/>	Other
Date of local case discussion	/ /	
Date discussed at panel	/ /	

USEFUL CONTACTS AND INFORMATION

The Foundation for the Study of Infant Deaths

The Foundation for the Study of Infant Deaths has a 24 hour helpline offering support and information to anyone who has suffered the sudden death of an infant.

Helpline: 0870 787 0554
Enquiries: 0870 787 0885 (9am-5pm weekdays)
E-mail: fsid@sids.org.uk
Website: www.sids.org.uk/fsid

The Foundation produces a wide range of leaflets and information for bereaved families and professionals.

The Childhood Bereavement Trust

Telephone: 01494446648
Website: www.childbereavement.org.uk

Winston's Wish

Telephone: 0870 787 0554 or 0207 233 2090 (9am-11pm weekdays; 6pm-11pm weekends).

USEFUL LEAFLETS

When a baby dies suddenly and unexpectedly

Foundation for the Study of Infant Deaths
Artillery House
11–19 Artillery Row
London SW1P 1RT
Phone: 020 7222 8001

A guide to the post-mortem examination procedure involving a baby or child

Department of Health Publications
PO Box 777
London SE1 6XH

Memory folder

Child Bereavement Trust
Aston House
West Wycombe
High Wycombe
Buckinghamshire HP14 3AG

CHILD DEATH HISTORY CHECKLIST

(Applicable to both Health and Police information gathering)

The child

- First name and family name (plus any other names by which the child may be known)
- If possible, obtain the NHS number as this may facilitate access to other records
- GP details
- Date of birth and place of birth

Mother

- Full name (plus any other names by which the mother may be known)
- Full address, including post code
- NHS number if possible
- GP details
- Date of birth
- First Language
- Religion
- Ethnicity
- Any special needs
- Phone number (home number and mobile number) and phone number of any available close relative or friend (to facilitate making contact again)
- Address to which mother will be returning when she leaves the hospital, plus phone number there and the name of the person with whom mother will be staying

Mother's partner and/or father of child

- Full name (including any other names by which he may be known)
- Full address, including post code
- Date of birth
- GP details
- Phone number (home number and mobile number) and phone number of any available close relative or friend (to facilitate making contact again)
- Address to which father/partner will be returning when he leaves the hospital, plus phone number here and the name of the person with whom he will be staying

Other members of the household (present and in the recent past)

- Names
- Dates of birth
- Relationship to child who has died.

Family medical history

- A detailed account of past medical and social history of all members of the immediate family and household
- Name and date and place of birth of any previous children of the parents
- Detailed information on any deaths in infancy or childhood of any offspring, siblings or other close relatives of any member of the current household (to include as much information as possible concerning date of birth, age at death, place of death, cause of death)

Social and family history

- Detailed account of the social structure of the family and of the household, including detailed information on alcohol, tobacco and other drug use, together with information on any prescription or non-prescription medications that may have been present or in use in the household
- Information on recent changes in composition of the household (e.g. who has come and who has gone, and for what reasons)

Detailed medical history of mother

- Details of past medical and social history of the mother, including any significant past illnesses or injuries
- Detailed past obstetric history, including detailed information on the pregnancy leading to the birth of the child who has died

Detailed medical and developmental history of the child who has died

- To include:
 - Gestation
 - Birth weight
 - Perinatal or neonatal problems
 - Type of feeding (and date and reason for changing type of feeding)
 - Growth, development and past assessments (e.g. health visitor or GP routine, well-baby checks)
 - Immunisations
 - Any known contact with infection
 - Medication (either prescribed or over the counter)
 - Obtain the parent-held child health record (this should be retained by the Police) and plot the weight record onto a centile chart.
- A detailed narrative account of the child's feeding, sleeping, activity and health over the two-week period prior to the death. This should include information on:
 - Changes in feeding or sleeping patterns
 - Changes in place of sleep
 - Changes in individuals responsible for providing care to the child
 - Any social, family or health related changes in routine practices over the past two weeks
 - Any illness, accident or other major event affecting other family members in the past two weeks.
 - The use of any intercom equipment

- A detailed (hour-by-hour) narrative account of events within the 48 hours prior to the infant being found dead. should include a detailed description of:
 - Precisely where the child was placed for sleep
 - Duration of sleeping period
 - Position at the end of the sleeping periods
 - Any changes in routine care or routine activity levels
 - Parents' perception of whether the child was feeding as well as, or less well than, usual in the past 24-28 hours
 - Any vomiting
 - Any respiratory difficulty, noisy breathing, in-drawing of the ribs, wheezing or stridor
 - Excessive sweating
 - Unusual activity
 - Unusual behaviour
 - Level of alertness
 - Difficulty sleeping
 - Difficulty waking the child
 - Passage of stool and urine (how often and how much)
 - Any disruptions to normal patterns
 - Information on the activity and location of all significant members of the household
 - Information on alcohol intake and recreational drug use by members of the household during this period

The final sleep

- A detailed description of when and where the child was placed to sleep, to include:
 - The nature of the surface
 - Clothing
 - Bedding
 - Arrangement of bedding
 - Precise sleeping position
 - Who was sharing the surface on which child was sleeping (e.g. bed or sofa)
 - How often the child was checked
 - When he or she was seen or heard
 - The time at which the child awoke for feeds
 - Whether feeds were given
 - Whether they were taken well
 - Who else was in the room at each stage
 - What were the activities of others in the room
 - Were they awake
 - Where, when and by whom was the child found
 - What was the position of the child when found
 - Where was the bedding
 - Were there any covers over the child
 - Had the covers and the position of the covers moved
 - Were there other objects in the cot or bed adjacent or close to the child (e.g. teddies, dolls, pillows)
 - Was the heating on

- What type of heating was there
- Were the windows and/or doors open?
- Room temperature if available - or whether a room thermometer was regularly used

Action after child was found

- A detailed narrative account of events that followed the discovery of the child collapsed or apparently dead, to include details of:
 - When, how and by whom the emergency services were called
 - Who was with the child at each stage
 - Was resuscitation attempted and if so by whom
 - Were any responses obtained from the child
 - How long it took for the emergency services to arrive

Further specific questions

- Were any healthcare professionals consulted within the past two weeks, the past 48 hours or the past 24 hours; If so, who was contacted, what was the problem described to the healthcare professionals and what advice was given
- Was the child seen and assessed by any healthcare professional during the past two weeks?

Sample	Send to	Handling	Test
Blood (serum) 1-2ml	Clinical Chemistry	Spin, store serum at -20°C	Toxicology
Blood cultures – aerobic and anaerobic 1ml	Microbiology	If insufficient blood, aerobic only	Culture and sensitivity
Blood from Guthrie card	Clinical Chemistry	Normal (fill in card; do not put into plastic bag)	Inherited metabolic diseases
Blood (Lithium heparin) 1-2ml	Cytogenetics	Normal – keep unseparated	Chromosomes (if dismorphic)
Cerebrospinal Fluid (CSF) A few drops	Microbiology	Normal	Microscopy, culture and sensitivity
Nasopharyngeal aspirate	Virology	Normal	Viral cultures, immunofluorescence and DNA amplification techniques
Nasopharyngeal aspirate	Microbiology	Normal	Culture and sensitivity
Swabs from any identifiable lesions	Microbiology	Normal	Culture and sensitivity
Urine (if available)	Clinical Chemistry	Spin, store supernatant at -20°C	Toxicology, inherited metabolic diseases
Skin biopsy for fibroblast culture	After discussion with Consultant Paediatrician		
Muscle biopsy if history suggestive of mitochondrial disorder	After discussion with Consultant Paediatrician		

GUIDANCE ON TAKING SAMPLES IMMEDIATELY AFTER THE SUDDEN UNEXPECTED DEATH OF AN OLDER CHILD

The following guidance on medical investigations following the death of an older child has been given by the Department of Histopathology, Great Ormond Street Children's Hospital and of the Department of Paediatric Metabolic Medicine, Guy's Hospital.

- Where there is any possibility of infection, the taking of samples shortly after death may improve the chances of growing the organism responsible. In these circumstances, blood cultures, throat and nose swabs should be taken routinely in the Accident and Emergency Department. CSF should be collected if the clinical information

suggests that meningitis is a possibility.

- Unless the death is clearly unnatural, full metabolic investigations are indicated.
- Always consider sending blood for toxicology

This is a basic checklist – please use clinical acumen to decide if other tests might be helpful (e.g. anti-convulsant level in a child with epilepsy, blood and urine ketones, HbA1c and accurate lab sugar in a child with diabetes)

