Merseyside Joint Agency Protocol

SUDDEN UNEXPECTED DEATH IN CHILDHOOD (S.U.D.i.C)

For Children aged 0 to under 18 Years

June 2020

Dear Colleagues,

The original Merseyside SUDI protocol was first launched in September 2002. The revisions have taken into consideration updates of Working Together to Safeguard Children, experience, research and the reports of a working group chaired by Baroness Helena Kennedy QC, with the most recently revised publication occurring in November 2016. It is our view that this protocol represents the best standard of investigation and service available given the resources and infrastructure of this region.

The investigation of all sudden and unexpected deaths must be of the highest forensic standard. This is necessary for the care of the bereaved, the needs of our justice system and the good of our society. The investigation of sudden and unexpected infant and child deaths deserves no less.

It must be remembered that the great majority of SUDiC cases are natural tragedies. The care of bereaved loved ones is a priority in all cases. Sensitivity, compassion and support do not detract from the thorough and detailed investigation required. For the good of all it is important that the cause of death is found not a cause of death.

This process will take time, and to ensure a funeral can take place in a reasonable time frame, an inquest will be opened in almost every case. Every care will be taken at such inquests to follow the ethos of this protocol so far as sensitivity of the subject matter is concerned.

To ensure a consistently high standard of care and investigation we have adopted and recommend to you this revised protocol as being the standard by which sudden and unexpected deaths of infants and children is to be carried out in Merseyside.

Graham Jackson
HM Coroner (Interim) for Sefton, St Helens & Knowsley

André Rebello
HM Coroner for Liverpool and Wirral

Anita Bhardwaj
HM Coroner for Liverpool and Wirral

THIS PROTOCOL HAS BEEN DRAWN UP IN CONSULTATION WITH:

- Liverpool Safeguarding Children Partnership
- Sefton Safeguarding Children Board
- Knowsley Safeguarding Children Board
- St. Helens Safeguarding Children Board
- Wirral Safeguarding Children Board
- H.M. Coroner, Liverpool and Wirral
- H.M. Coroner, Sefton, Knowsley and St. Helens
- North West Ambulance Service
- Cheshire & Merseyside Health Protection Agency
- Representatives of all agencies involved in the SUDiC process

The SUDI and SUDC protocols have been revised and merged into one document, known as the SUDiC protocol.

This is the third version of the SUDiC protocol that replaced the SUDI and SUDC protocols from 2012.

This is the guidance document to be used by agencies for unexpected child deaths from 0-18 years old.

The efforts of all who have contributed to this document are acknowledged and greatly appreciated.

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1. INTRODUCTION

1.1.1 This protocol provides guidance for professionals from agencies involved in dealing with Sudden Unexpected Death in Childhood (SUDiC: 0 up to 18 years).

1.1.2 The protocol uses the generic term 'child' to refer to all age groups from newborn to young person up to the age of 18 years. It contains a definition of child, as determined by Children Act legislation, and SUDiC, and there is general advice and guidance on inter-agency management of the child's death. It also describes some of the factors that may raise concern about the circumstances surrounding the death. Each agency will have internal guidelines that will complement this protocol.

1.2 Why the need for the protocol?

1.2.1 The majority of unexplained child deaths occur as a result of natural causes and are an unavoidable tragedy for any family.

1.2.3 Child death review functions became compulsory from 1 April 2008. The Local Safeguarding Children Board/Partnership (LSCB/P) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Board Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB/P is responsible for:

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);

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

(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.

1.2.2 **Chapter 5 of Working Together to Safeguard Children (2018)** indicates that where a Joint Agency Response (JAR) is required, practitioners should follow the process set out in Sudden and Unexpected Death in Infancy and Childhood: multi-agency guidelines for care and investigation (2016).
A Joint Agency Response is required if a child's death:
• is or could be due to external causes
• is sudden and there is no immediately apparent cause (including sudden unexpected death in infancy/childhood)
• occurs in custody, or where the child was detained under the Mental Health Act
• occurs where the initial circumstances raise any suspicions that the death may not have been natural
• occurs in the case of a stillbirth where no healthcare professional was in attendance
1.2.3 If there is an unexplained death of a child at home or in the community, the child should normally be taken to an emergency department rather than a mortuary. In some cases when a child dies at home or in the community, the police may decide that it is not appropriate to move the child's body immediately, for example, because forensic examinations are needed.

1.2.4 In a criminal investigation, the police are responsible for collecting and collating all relevant information pertaining to the child's death. Practitioners should consult the lead police investigator and the Crown Prosecution Service to ensure that their enquiries do not prejudice any criminal proceedings.

1.2.5 Where a child dies outside their usual area of residence Merseyside CDOP can review the death of that child should they wish. With regard to the joint agency review there should be a discussion and agreement reached between the professionals involved as to which authority's protocol should be followed, and which authority should take the lead. If the outside area protocol is used every effort should be made to ensure that the principles and standards contained within the Merseyside SUDiC Protocol are maintained as a minimum.

2. ORGAN AND TISSUE DONATION

2.1.1 The principle of ‘never say never’ should be focused upon when considering the possibility of organ and tissue donation

2.1.2 In all investigations following a death, the fact the death is subject to coronial and/or criminal investigation is not an absolute bar to the consideration of organ and/or tissue donation.

2.1.3 In the event that a deceased child’s next of kin expresses a wish to consent to organ or tissue donation, or the deceased child is on the organ/tissue donation register, the Coroner with jurisdiction over the death should be contacted (24/7) to establish if organ and/or tissue donation would obstruct the investigation or otherwise interfere with the interests of justice.

2.1.4 Prior to making a decision the Coroner will consult with professionals, usually in this context: Consultant Paediatrician, Police Senior Investigating Officer, Paediatric and/or the Forensic Pathologist instructed to investigate the cause of death.

2.1.5 Where professionals involved in the care of a child are of the view that organ donation is a possibility, but there has been no expressed wish by the parents/next of kin, or the deceased young person, agreement of the Coroner should be sought following discussion with professionals prior to any consultation with family members.

2.1.6 Taking all matters into consideration the Coroner will make a ruling as to whether donation, according to the request, should go ahead.

3. DEFINITIONS

3.1.1 An unexpected death is defined as a death that was not anticipated as a significant possibility 24 hours before, or where there was a seemingly unexpected collapse, leading to or precipitating the events that led to death.

3.1.2 The Merseyside Joint Agency Sudden Unexpected Death in Childhood (SUDiC) protocol should be used for the death of any child aged from 0 up to 18 years.

3.1.3 The Designated Doctor for Child Deaths, when in post, is responsible for the process relating to all deaths in childhood, and should be consulted where professionals are uncertain about whether the death is unexpected. In the event that the designated doctor is not available consultation should take place with the designated paediatrician. If in doubt these procedures should be followed until the available evidence enables a different decision to be made. Once commenced, however, the agreement of HM Coroner is required before 'standing down' the process. This is achieved through liaison between Merseyside Police and HM Coroner.

3.1.4 Within the Children Act 1989 a child (subject to paragraph 16 of Schedule 1) is defined as '*a person under the age of eighteen years*.'

3.1.5 The generic term 'child' has been used throughout this protocol to refer to any person from the age of 0 up to the age of 18 years.

3.1.6 Where necessary, the terms SUDI (0-2 years) and SUDC (2-18 years) have been used in the protocol to identify sections that are age specific and in the appendices to differentiate the medical proformas.

3.1.7 This protocol can also be utilised in cases of an acute life threatening event (ALTE) if, as the result of a discussion of professionals involved in the case, it is deemed appropriate, reasonable and proportionate. For this purpose the definition of ALTE is:

Any sudden/unexpected collapse of an infant or child (0 up to 18 years) requiring some form of active intervention/resuscitation and subsequent intensive care / high dependency unit admission and it remains unexplained.

In the event of dealing with an ALTE the hospital proformas in Appendices A or B should be used dependent upon the age of the infant/child.

4. PRINCIPLES

4.1.1 When dealing with a SUDiC all agencies need to follow five common principles, especially when having contact with family members:

- Sensitivity, open mind/balanced approach
- An inter-agency response
- Sharing of information
- Appropriate response to the circumstances
- Preservation of evidence

NB: All items on this list are of equal importance.

4.1.2 In applying the above principles individuals and agencies should ensure that their actions are legal, necessary, relevant and proportionate in order to comply with The Human Rights Act 1998.

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

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

5.1.2 Remember that people are in the first stages of grief. They may be shocked, numb, withdrawn or hysterical.

5.1.3 All professionals must record history and background information given by parents/carers in as much detail as possible. The initial accounts about the circumstances, including timings, must be recorded verbatim.

5.1.4 It is normal and appropriate for a parent/carer to want physical contact with their deceased 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.

5.1.5 The child should always be handled as if they were still alive, remembering to use their name at all times as a sign of respect and dignity.

5.1.6 All professionals need to take into account any religious and cultural beliefs which may impact on procedures. Such issues must be dealt with sensitively, but the importance of the preservation of evidence should not be forgotten.

5.1.7 The parents/carers 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.

5.1.8 Where possible, written contact names and telephone numbers for relevant agencies and personnel should be given to the family.

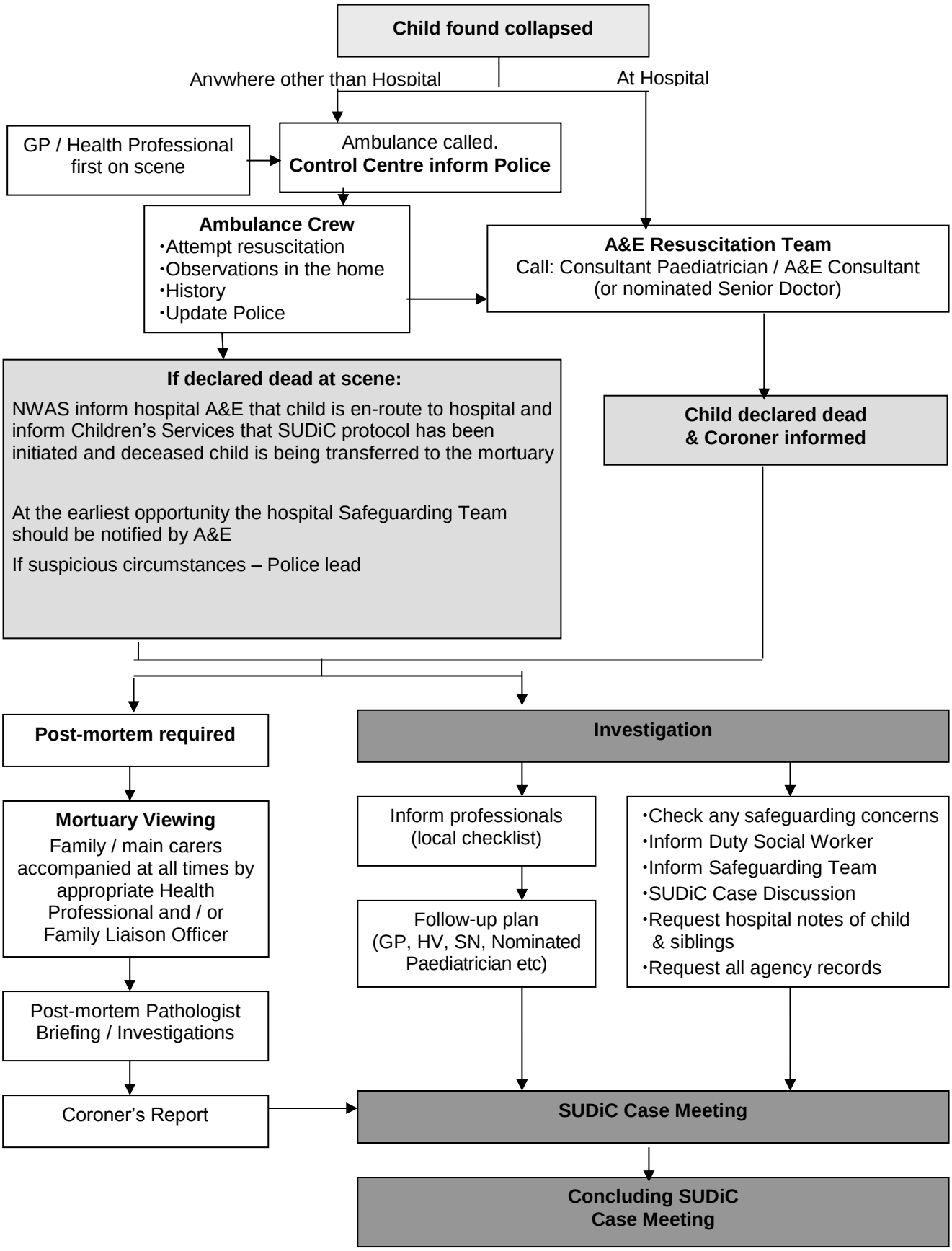
5.1.9 In unexplained child death cases an investigation will be pursued by police to inform HM Coroner on whether it is necessary to progress an inquest. This will not be necessary if, following post-mortem or other investigations, it is established that the child died of natural causes. H.M. Coroner will indicate if a post-mortem is necessary.

5.1.10 Staff from all agencies need to be aware that on rare occasions, in the event of suspicious circumstances, the early arrest of the parents/carers may be essential in order to secure and preserve evidence.

5.1.11 Agency professionals must be prepared to provide Statements of Evidence promptly in the above circumstances. (Local procedures will be followed).

5.1.12 **Post mortem examination is usually only authorised by HM Coroner when necessary.**

SUDiC - Recommended Sequence of Events



Please note: there may be local variations to this section for different hospitals – refer to local guidance.

This process can be implemented for acute life threatening events (ALTE) if appropriate. Throughout this process of investigating a SUDiC, managers must consider the need to initiate a Serious Case Review

6. INTER-AGENCY WORKING

This protocol can be used for acute life threatening events (ALTE) if deemed appropriate.

6.1 SUDiC Case Discussions (SCD) and SUDiC Case Meetings (SCM)

6.1.1 All unexpected child deaths must be reviewed on a multi-agency basis.

6.1.2 **In ALL cases of SUDiC a SUDiC Case Discussion (SCD) will be convened, by the Accident and Emergency Consultant/Consultant Paediatrician involving a Children's Services Team Manager, the Police and could involve a nominated Education lead if the deceased child is school age. This should take place within 24 hours of the child's death.**

6.1.3 Where appropriate this discussion can be facilitated by telephone. Any decisions made during a SCD will be recorded by all involved on the agreed form.

6.1.4 A SCD will normally take place in the early stages of a SUDiC coming to light (within 24 hours)

6.1.5 A multi-agency strategy meeting will then be convened, unless directed otherwise by HM Coroner, arranged through the relevant Local Authority Safeguarding / Reviewing / Quality Assurance Unit (hereafter referred to as the Safeguarding Unit). This should take place within **three working days** of the child's death.

6.1.6 At all stages through the enquiry, consideration should be given to the needs of surviving children in the family. It may be necessary to commence a Single Assessment using the local assessment framework that incorporates the child's development, parental capacity and family/environmental factors as components. This assessment may result in a Section 47 enquiry and a child protection conference if safeguarding concerns are identified.

6.2 SUDiC Case Discussions

6.2.1 The following are areas that must be covered in SCDs. However, this list is not meant to be exhaustive and each case should be considered on its own merits.

- Background information/ presentation of the SUDiC
- Background information of the child, family and significant others (Children's Services to check whether the child/family are known and in what context)
- Nature of concerns if any
- Consider the safeguarding needs of other children
- Contact with HM Coroner and outcome
- Request blood samples from parents/carers using the Blood Test Consent Form (Appendix G) – **if refused suggest urine samples**
- Scene management, as appropriate
- Immediate support of the bereaved (e.g. allocation of family liaison officer (FLO) or named point of contact).
- Consider restrictions on viewing the child's body where appropriate
- Co-ordination of professionals' contact with the family including the paediatrician's meeting with the family. It may be considered appropriate to do this jointly with police.

- Significant police action where appropriate (e.g. arrest of suspect, obtaining statements).
- Timing of post mortem and briefing of pathologist
- Status of the enquiry (section 17 [Child in Need] /Section 47 [child protection]/criminal investigation)
- Consider liaison with Consultant in Communicable Disease Control/Director of Public Health if appropriate
- Time and date of SUDiC strategy meeting
- Staff welfare

6.3 Recording of Strategy Discussion

6.3.1 The key points of the strategy discussion will be recorded by the Senior Investigating Officer (SIO) on the proforma (Appendix J) included in this protocol. The recording will clearly identify the agreed decisions, actions, and outcomes and who is responsible for progressing them. A copy of the document will be forwarded to all agencies involved in the strategy discussion at the earliest opportunity but prior to the strategy meeting. This will enable the content to be included in the strategy meeting notes, which will assist in the auditing process to consider agency compliance.

6.3.2 Each agency, on receipt of the strategy discussion document, will ensure it is inputted into their agency system/s.

6.3.3 If a decision is made not to proceed to a SUDiC strategy meeting, agreement has to be reached as to how professionals working with the family are informed of the outcome and by whom, and the reasons for this outcome should be clearly recorded**.** Consultation with HM Coroner should have occurred to arrive at this outcome.

6.4 SUDiC Strategy Meetings

6.4.1 Chairing the Meeting

- A SUDiC strategy meeting will be chaired by staff from the relevant local authority safeguarding unit.
- If the death of the child occurs outside their normal area of residence discussions should be held between staff in the safeguarding unit where the child ordinarily resided and the safeguarding unit in the area in which the child died, to determine who would chair the SUDiC strategy meeting. Safeguarding officers should satisfy themselves that the minimum agenda is being covered if the external safeguarding unit staff member is chairing the meeting.

6.4.2 The Chairperson is responsible for: (via line management if necessary)

- Ensuring the Chair of their Local Safeguarding Children Board/Partnership is made aware of the child's death;
- Ensuring the Chair of the Child Safeguarding Practice Review Group / Critical Incident Group is aware of the death of the child. The Chair will then decide if a meeting should be convened to consider the circumstances of the death and whether the circumstances meet the threshold for a Child Safeguarding Practice Review /Management Review.

6.4.3 Attendance

It is the responsibility of all agencies to manage attendance at the strategy meeting and ensure that those attending are able to provide the relevant information and make decisions on behalf of their respective agency. In the event that any agency invited cannot be present they should always ensure their information is conveyed in a written report detailing the extent of their involvement.

6.4.4 Each SUDiC will be unique but in considering appropriate attendance at the strategy meeting the following may assist:

Health:	Health visitor, health practitioner, GP, designated / named health professionals for safeguarding children, pathologist, nominated paediatrician, child and adolescent mental health (CAMHs) professionals.
Social Care:	Duty manager and assigned social worker if appropriate.
Police:	Senior investigating officer (SIO), Protecting Vulnerable Persons Unit (PVPU) representative, family liaison officer and coroner's officer as appropriate.
Education:	Designated school child protection coordinator, early years care provider.
Others:	Ambulance service (NWAS), youth offending service (YOS/YOT), drug and alcohol team, Connexions, voluntary agencies and others as appropriate.

6.4.5 The purpose of the SUDiC strategy meeting will be:

- For each agency to share information which may shed light on the circumstances leading up to the child's death. This information will need to be shared with the Pathologist, HM Coroner, and CDOP
- To plan any subsequent joint agency investigation.
- To enable consideration of any safeguarding risks to siblings/any other children living in the household and whether a referral within 'safeguarding children' procedures is necessary.
- To ensure a co-ordinated bereavement care plan is compiled for the family and any others immediately affected by the death eg pupils and teachers
- To consider staff welfare and support.
- Details of the meeting and decisions made will be recorded.

6.4.6 SUDiC Strategy Meetings - Documentation

SUDiC documentation should be used to ensure the meeting participants consider all aspects on the agenda and the information shared should be recorded on the SUDiC proforma:

- Introductions
- Apologies
- Confirmation of Chair / Recorder

- Background information to the SUDiC
- Background information relating to the child, family and significant others (including domestic violence, bullying, mental health issues, substance misuse, health issues, cultural & religious issues)
- Consideration of safeguarding children, issues of surviving children
- Contact with the Coroner
- Results of post mortem or briefing of Pathologist regarding the outcome of the strategy meeting
- Changes to restrictions on viewing the body
- Plan of investigation (section 17 / section 47 / criminal investigation)
- Coordination of professionals' contact with the family.
- Support strategy for bereaved parents, carers and siblings (FLO / social worker / bereavement support worker)
- Agree information to be fed back to the family; by whom and when
- Agree timescales for a further SUDiC case meeting or request for a child protection conference if appropriate
- Staff welfare
- Press strategy if appropriate
- **Copies of meeting minutes should be forwarded to HM Coroner, LSCB/LSCP, and CDOP within 10 working days.**

6.4.7. Confirmation of agreed decisions and actions to be signed, copied and distributed immediately to a representative of each agency present and those who have sent apologies.

6.4.8 Decisions made 'in absentia' must be actioned by the Chair to the respective agency and should be discussed promptly with the relevant individual / agency.

6.4.9 In all SUDiC meetings there should be an explicit discussion of the possibility of abuse or any other safeguarding issue contributing to the death. If no evidence is identified to suggest safeguarding issues this should be documented as part of the minutes of the meeting. All information that may be relevant to the child's death, irrespective of sensitivity, should be shared at the strategy meeting.

6.4.10 In all cases where HM Coroner is involved consent should be sought for the pathologist's findings to be shared at the final SUDiC case meeting.

6.4.11 Where an inquest has been opened and adjourned, until the final hearing the Coroner and all relevant parties must be informed promptly should any new information come to light, e.g. expert evidence in care proceedings.

6.4.12 It is considered good practice that files relating to cases of SUDiC should be retained for 25 years from the date of death.

6.5 Merseyside Child Death Overview Panel

6.5.1.Information from the joint agency review process outlined in this protocol should be fed into Merseyside Child Death Overview Panel (CDOP) for any child who was ordinarily resident in Knowsley, Liverpool, Sefton, St Helens, or Wirral. This is to enable Merseyside CDOP to consider the information during their review process.

7. FACTORS WHICH MAY AROUSE CONCERN

This protocol can be used for acute life threatening events (ALTE) if deemed appropriate.

7.1.1 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 'safeguarding children' concerns within the family** - relating to this child or any siblings, including concealed pregnancy/births.

- **Inappropriate delay in seeking help.**

- **Inconsistent explanations** - the account given by the parent/carers of the circumstances of death should be documented verbatim. Any inconsistencies in the story given on different occasions should arouse suspicions, although it is important to bear in mind that some inconsistencies may occur as a result of the shock and trauma caused by the death.

- **Evidence of drug/alcohol abuse** - particularly if the parent/carers remain under the influence.

- **Evidence of domestic abuse.**

- **Evidence of parent/carer having mental health problems** - including Fabricated or Induced Illness (F.I.I. - formerly known as Munchausen Syndrome or Munchausen Syndrome by Proxy).

- **Unexplained injury** - unexplained bruising/burns/bite marks. (However, it is very important to remember that an infant may have serious internal injuries without any external evidence of trauma).

- **Presence of blood** - the presence of blood must arouse suspicion, although it is occasionally found 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 Sudden Infant Death Syndrome (SIDS).

- **Neglect issues** - observations about the condition of the accommodation, general hygiene and cleanliness, the availability of food, adequacy of clothing, bed, cot and bedding, and temperature of the environment in which the infant was found are important. This will assist in determining whether there may be any underlying neglect issues involved.

8. AMBULANCE SERVICE (NWAS)

8.1.1 When the ambulance service is called to attend the scene of a sudden unexpected collapse or death of a child (SUDiC, aged from 0 -18 years), the attending crew must notify the Ambulance Emergency Operations Centre (EOC). **The EOC will inform the police at the Joint Contact Centre regarding the nature of the call at the earliest possible opportunity, without delaying access to treatment.**

8.2 Resuscitation

8.2.1 Resuscitation, if indicated, should be continued according to the UK Resuscitation Guidelines (2010) unless a healthcare professional, usually a NWAS paramedic or a member of the medical staff, has made a decision that it is appropriate to stop further efforts. This will be carried out in line with revised NWAS Diagnosis of Death Procedures (2013).

8.2.2 When transferring the child, the EOC should pre-alert the receiving Emergency Department with information about the child's condition and expected time of arrival.

8.2.3 At hospital the completed Patient Report Form, with details of history, observations at scene and resuscitation information, should be handed over to the relevant hospital staff along with a verbal handover of events, including any concerns or suspicions.

8.2.4 The police, if present, at this point, may wish to arrange interviews with the crew members who must immediately pass on any concerns, suspicions or observations which they have witnessed or heard.

8.3 Considerations when assessing a sudden death

8.3.1 The following should be taken into account in accordance with the NWAS Diagnosis of Death Procedure (2013) and documented by the ambulance crew when assessing a sudden death:

- Information supplied by those present.
- History given about the incident
- Medical assessment.
- Observation of the scene
- The position and condition of the child's body.
- The condition of the clothing.
- The conditions at the place where the child's body was found.
- Presence of drug paraphernalia
- Security of the property.
- Anything considered to be out of the ordinary

8.3.2 The crew will be careful to protect the scene and preserve any evidence until the police arrive. The crew will record their findings on the Patient Report Form and pass this information to the police. Ambulance crew may be required to give statements which will be taken by the police at an agreed time.

8.4 Action after death has been established

8.4.1 It is not necessary for a medical practitioner (e.g. GP) to attend to confirm the fact of death as this can be done by NWAS staff (NWAS staff will refer to the Diagnosis of Death Procedure [2013]).

8.4.2 The crew will inform the relatives (if applicable) that the police will need to attend, and notify EOC to ensure police have been alerted.

8.4.3 Where a sudden death has occurred (except when there are clearly suspicious circumstances and upon police instruction), and the death has been confirmed by completion of the Diagnosis of Death form by the appropriate NWAS professional, the Senior Investigating Officer, on arrival, may request the attendance of the Police Force Medical Examiner (FME) if there are any concerns.

8.4.4 In a situation where a child has been pronounced deceased at the scene NWAS must contact the emergency department to inform them that the SUDiC Protocol has been triggered and request they make arrangements for hospital staff to receive the deceased child. The emergency department staff member will then liaise back with NWAS to confirm the arrangements have been made and agree an estimated time of arrival for the deceased child.

8.4.5 The above arrangements remain the same for Alder Hey but the child will be taken directly to the mortuary and not the emergency department. In these circumstances A&E staff will inform mortuary and bereavement staff and NWAS will take the child directly to the Bereavement Suite. Out of hours, A&E staff will open the Bereavement Suite and meet NWAS with the child at the Bereavement Suite. A&E staff will notify on call bereavement staff, Rainbow Consultant, and mortuary technician and wait until on call staff arrive. The mortuary technician is responsible for completion of the Alder Hey Hospital death set order.

8.4.6 If it is not possible for NWAS to convey the deceased child to the hospital they should inform Merseyside Police who will make arrangements for the Coroner's Removal Service to convey them.

8.4.7 The joint agency review process requires that the body is examined by a paediatrician and the initial information gathering and support for the family is initiated. This takes place in the area defined within each hospital's internal procedure, usually the Accident and Emergency Department, but it can take place in the bereavement suite.

8.4.8 The EOC will inform the 'on duty 'advanced paramedic for the provision of ongoing support to the crew.

8.4.9 If possible, the crew will make arrangements for the immediate support of the bereaved adults/children (contacting relatives, neighbours, priest etc.)

8.4.10 The ambulance crew will complete the appropriate documentation, Patient Report Form, with internal notification by telephone to the NWAS Safeguarding Team via the NWAS Support Centre.

8.4.11 If possible the crew will record details of the police officer dealing with the case including the incident log number.

9. GENERAL PRACTITIONERS (G.Ps)

9.1.1 There are times when a G.P. is called to or present at the scene first. In such circumstances they should adhere to the same general principles as required for the Ambulance staff in implementing basic resuscitation skills (see above). Call an ambulance immediately.

9.1.2 It is important for the G.P. to contact the Police or Coroner's Office if they are the first on the scene. If required to certify the child's death G.Ps must take into account the regulations regarding death certification and inform HM Coroner and/or the Police accordingly. They should also ensure that the paediatric liaison staff, for the hospital in the area where the child resided, is made aware of the death. This is achieved through the G.P informing the practice manager who should take responsibility for contacting paediatric liaison staff so that the Child Death Overview Panel (CDOP) process can be initiated.

9.1.3 The G.P will be requested to attend the SUDiC strategy meeting and should prioritise attendance.

9.1.4 Alternatively, a discussion between the G.P and the Nominated Paediatrician may enable the G.P's information to be shared at the SUDiC case meeting. The Named GP for Safeguarding Children may assist in this process if there is any difficulty.

9.1.5 Additional guidance for G.Ps, particularly in relation to the longer term care of the family, can be obtained from the Lullaby Trust, Alder Centre or Child Bereavement UK.

10. HOSPITAL WARDS/MATERNITY UNITS

This protocol can be used for acute life threatening events (ALTE) if deemed appropriate.

10.1.1 When a child is found collapsed in the hospital a resuscitation team will be called and resuscitation attempted.

10.1.2 When death is pronounced the family will be supported by a senior member of staff and the local bereavement policy will be followed.

10.1.3 The senior person on duty/call will inform the police and implement the SUDiC protocol.

10.1.4 Within the hospital, the location where the child was found collapsed should be treated as a potential crime scene and processed accordingly, i.e. do not touch, move or disturb anything around the bed/cot.

10.1.5 A Police Crime Scene Investigator (CSI) will attend and exhibits will be recorded and taken as appropriate, e.g. bedding, clothing, feed, medical equipment.

10.1.6 The SUDiC medical pro forma should be completed by the consultant paediatrician or nominated senior doctor. Consideration should be given to asking for photographs of any skin discolouration or unusual marks or injuries as soon as possible, ideally before the child is moved.

10.1.7 All information and records will be updated and maintained. Health records will be secured by the named professionals until the situation is clarified.

10.1.8 Staff should be offered support and de-briefing wherever possible (please refer to local policies).

10.1.9 The most appropriate member of staff should attend the SUDiC strategy meeting, which must be considered a priority.

10.1.10 Ensure the GP, health visitor, and/or school health practitioner are notified.

Please note: Maternity hospitals and neonatal units may also refer to additional guidance contained within the following:

'Guidelines for the Investigation of Newborn Infants Who Suffer a Sudden and Unexpected Postnatal Collapse in the First Week of Life (March 2011)'.

11. MERSEYSIDE POLICE

This protocol can be used for acute life threatening events (ALTE) if deemed appropriate.

11.1.1. Every child who dies deserves the right to have their sudden and unexpected death fully investigated in order that homicide can be excluded and a cause of death identified.

11.1.2 Article 2 of the Human Rights Act (1998) states that everyone's right to life shall be protected by law. This requires public authorities to establish **the** cause of death. Apart from anything else, this will help to support the grieving parents and relatives of the child. It is also important to enable medical services to understand the cause of death and, if necessary, create interventions to prevent future child deaths.

11.1.3 The police have a key role in the investigation of child deaths, and their prime responsibility is to the child, as well as to siblings and any future children who may be born into the family concerned.

11.1.4 It is important for police officers to remember that for most SUDiC incidents the death has been accidental or the result of natural causes. A small proportion of deaths are, however, caused deliberately. Police officers' actions, therefore, need to be a careful balance between consideration for the bereaved family and the potential of a crime having been committed. The principles of the 'Golden Hour' will still apply.

11.1.5 The scene is referred to in this protocol as the child's home or the place where the child was, immediately prior to his/her death, where the incident occurred. On some occasions the child will still be at the 'scene' when the police and other professionals attend. On other occasions, the child will have been removed to the hospital. In each case, the principles remain the same. In such a situation there may be two scenes and resources will need to be allocated accordingly. It is important to note that, even if the child has already been moved, professionals visiting the home/place of death should still treat it as a potential 'scene'.

11.1.6 In **ALL** cases of sudden unexpected death, whether immediately suspicious or not, this protocol will be followed unless HM Coroner determines otherwise.

11.2 Deployment

11.2.1 It is the responsibility of the Force Contact Centre and Area Supervision to ensure that appropriate personnel attend at the scene.

11.2.2 If the police are the first professionals to attend the scene urgent medical assistance should be requested as the first priority.

11.2.3 Police attendance should be kept to the minimum required. Several police officers arriving at a house can be distressing, especially if they are uniformed officers in marked police cars.

11.2.4 A Detective Inspector must attend the scene to ensure a consistently high standard of police input.

11.2.5 Levels of police attendance should be subject to constant review by the Detective Inspector present. At an appropriate time the Detective Inspector should explain to the bereaved family the reason for police attendance.

11.2.6 Officers should, at all times, be sensitive in the use of personal radios and mobile phones. If at all possible, the officers liaising with the family, whilst remaining contactable, should have such equipment turned off.

11.3 Initial Action & Investigation

11.3.1 The provision of medical assistance to the child is a priority. If an ambulance is not already in attendance then one must be requested immediately unless it is absolutely clear that the child has been dead for some time. If North West Ambulance Service (NWAS) staff have not confirmed the death of the child and completed the Diagnosis of Death Form, a Forensic Medical Examiner (FME) will need to be called to certify death. If the child has already been removed to hospital, death will be certified by a hospital doctor.

11.3.2 The first officer at the scene must liaise with paramedics and make a visual check of the child and his or her surroundings, noting any obvious signs of injury, any obvious hazards and note the persons present. It must be established whether the child's body has been moved and the current position should be recorded. All other relevant matters should also be recorded. The Detective Inspector is responsible for ensuring that this is done.

11.3.3 Officers attending the scene should be aware of cultural issues and the needs of the family.

11.3.4 A record of events from the parents/carers describing the circumstances leading up to the child being found dead is essential, including details of the child's recent health. All comments should be recorded. Any conflicting accounts should raise suspicion, but it must not be forgotten that any bereaved person is likely to be in a state of shock and possibly confused. Attending officers should ask appropriate questions to establish the circumstances surrounding the death, but avoid progressing the questioning to interview, as this is the responsibility of the local Protecting Vulnerable Persons Unit (PVPU), formerly known as the Family Crime Investigation Unit (FCIU)

11.3.5 The Duty Senior Investigating Officer (SIO) should be notified at the earliest opportunity and will liaise with the local PVPU as soon as practicable. The SIO will decide on the appropriate investigation strategy.

11.3.6 Form 97 (F97), used by Police to notify HM Coroner of a sudden death, must be completed at an early stage by the reporting officer and forwarded to HM Coroner's Office. The Detective Inspector has a duty to ensure the form is completed to a high standard and is submitted in a timely manner.

11.3.7 Questions regarding the child's recent health can be recorded on the Form 97 under the appropriate heading. These questions should include the basic medical history of the child and family. Other relevant details, which are thought to be pertinent to the child's death, should also be included, an example of this, for an infant, would be when they were last fed.

11.3.8 The PVPU Detective Inspector and the PVPU should become involved at the earliest opportunity. The Detective Inspector will decide on the appropriate investigation team.

11.3.9 Police officers need to be aware of other professionals' responsibilities, i.e resuscitation attempts, taking details from the parents/carers, examination of the child's body and looking after the welfare needs of the family.

11.3.10 It may be necessary for the police officer to wait until some of the procedures have been completed. Information from the involved professionals should be obtained prior to being introduced to the parents/carers

11.3.11 There may be evidential reasons why the police need to take urgent action. This is where liaison and joint working is essential. It is strongly advised that the PVPU is utilised for such liaison wherever possible.

11.3.12 The Detective Inspector attending the scene will be responsible for:

- Requesting the attendance of a Crime Scene Investigator (CSI)
- Any questioning of family members/witnesses. This should be sensitively undertaken. Consideration should be given to parents/carers being spoken to separately to avoid the possibility of confusing the other person's version of events. This must be assessed against the support needs of the parents/carers.
- The seizure of any salient evidence, which may assist in identifying the cause of death, and explaining the reasons for doing so to the family.
- Evidencing factors of neglect which may have contributed to the death such as temperature at the scene, the condition of the accommodation, general hygiene and the availability of food or drink, any items administered to the child and the containers eg. medication and bottles/packaging should be seized.
- Obtaining written statements from non-familial witnesses at appropriate venues. **This will not be done in A&E or the mortuary.**
- Checking of Force systems: PNC; PND; Niche; Corvus and Storm, for prior police involvement.
- Family members or persons supervising the child prior to the incident should be requested to provide voluntary blood samples for alcohol/drug testing using the blood test consent form (appendix G). The blood sample should be taken at the hospital and NOT at their home address. If unable to provide a blood sample a sample of urine should be requested.
- It must be explained to the family members or persons supervising the child that they have the right to obtain legal advice prior to volunteering blood or urine samples.
- A Force Medical Examiner (FME) will need to be contacted at the earliest opportunity for this purpose.
- Officers must provide the FME with a RTA blood sampling kit (available at all custody suites) in order to assist the FME in obtaining the voluntary samples. The samples should **NOT** be taken in a custody suite, unless the person is in police custody.
- The blood sample should be appropriately labelled and sent to the forensic laboratory by the police along with the relevant documentation.

11.3.13 The PVPU Detective Inspector will be responsible for:

- The allocation of a Family Liaison Officer (FLO)

- The co-ordination and attendance at any subsequent multi-agency strategy discussion/meeting
- **At the meeting, the Detective Inspector will present photographs of the scene (but not of the deceased child) for consideration of the risk factors by the attending partner agencies.**
- All policy decisions will be clearly and appropriately recorded including whether it is necessary to conduct a joint police/health professional visit to the family. If there are no suspicious circumstances or previous police involvement the meeting will be co-ordinated by the respective safeguarding unit.
- Obtaining written statements or 'achieving best evidence (ABE) accounts from family members at appropriate venues. **This will not be done in A&E departments or the mortuary.**

11.4 Contact with HM Coroner

11.4.1 HM Coroner must be notified as soon as possible. The Coroner will direct the Detective Inspector as appropriate. It will be the decision of the Coroner as to whether a joint paediatric and Home Office post mortem will be required.

11.4.2 Children's Social Care (Social Services) and the on call Paediatrician, and in Alder Hey Hospital the on call Rainbow consultant need to be informed of the death as soon as practicable.

11.4.3 In most cases the child will be taken directly to a hospital A&E Department. Arrangements must be made for a Consultant in A&E/Paediatrician to be informed of the child's death, in order that an appropriate examination of the child's body can be made prior to the post mortem.

11.4.4 It is important that arrangements are made for the child's body to be taken to the emergency department in all Merseyside hospitals with the exception of Alder Hey Hospital where the child will go directly to the mortuary. In a situation where a child has been pronounced deceased at the scene NWAS must contact the emergency department to inform them that the SUDiC Protocol has been triggered and request they make arrangements for hospital staff to receive the deceased child. The emergency department staff member will then liaise back with NWAS to confirm the arrangements have been made and agree an estimated time of arrival for the deceased child. If it is not possible for NWAS to convey the deceased child to the hospital they should inform Merseyside Police who will make arrangements for the Coroner's Removal Service to convey them. Each Coroner engages a removal service and has a procedure. **Police vehicles must not be used at any time to transport a deceased child.**

11.4.5 In cases where the death is thought to be suspicious the standard approach contained within these procedures should cease and a murder investigation should commence. In these circumstances the child should remain in situ until the SIO directs otherwise. HM Coroner's Removal Service will be used to transport the child to the relevant mortuary. For continuity purposes, a police patrol will accompany the child to the mortuary.

11.4.6 Ambulance staff will complete a proforma statement documenting their involvement and hand it to the police

11.4.7 The issues of the continuity of identification must be considered. This will preferably be performed by the police officer at the scene, but could be done by HM Coroner's Officer, appropriately and sensitively. The child should be handled as if he or she were still alive.

11.4.8 If arrangements have been made for transporting the child directly to the mortuary at Alder Hey the mortuary technician must be informed if the child's family will be attending and if there are any visiting restrictions imposed.

11.4.9 Handling of the child should be kept to a minimum and always supervised by an officer. This also applies to parents/relatives wanting to touch or hold the child at the hospital or bereavement suite.

11.4.10 If the parents/carers wish to accompany their child to the mortuary, this should normally be facilitated, ensuring that they are accompanied by an investigating officer, coroner's officer, or family liaison officer (FLO) as appropriate.

11.4.11 It is entirely natural for a parent/carer to want to hold or touch their child. Providing this is done with a professional present, ie a police officer or nurse, it should be allowed in most cases as it is highly unlikely that forensic evidence will be lost. If, however, the death is being considered suspicious the SIO **MUST** be consulted before a parent/carer is allowed to hold the child.

11.4.12 In most cases delay in the release of the body by the Coroner is routine. This is to allow toxicology and other testing to take place. This should be explained sensitively to the family.

11.4.13 The Public Protection Unit must be informed that a SUDiC has occurred.

11.5 Post Mortem

11.5.1 It is the role of the Inspector/SIO to attend the post-mortem examination and to fully brief the pathologists with the following:-

- A copy of the completed hospital medical pro-forma record (Appendix A (0-2) and B (2-18) dependent on the age of the child
- Continuity/sequence of all the events leading to the death, preferably with photographs/video with the following information:-
    - The position that the child's body was found in, by the person finding them, or in relation to the person(s) if there was 'bed sharing'
    - Details of the scene/s
    - Any history of smoking/alcohol consumption/drug use with details of substance, amounts and timing by either parents/carers or the child (if relevant)
    - Copy of the case notes of obstetric and paediatric period where relevant
    - Copy of GP records
    - Copy of ambulance attendance sheet
    - Details of any resuscitation, including by whom and when
    - List of investigations initiated or samples taken by the A&E doctors and any results when available

11.5.2 H.M. Coroner is to be informed of the above details together with any useful information or developments. This can be facilitated through the relevant Coroners Officer.

11.6. Pathology Investigation Findings

11.6.1 Notwithstanding that pathology investigations are ongoing and interim results may be inconclusive, in any case where the pathologist is satisfied that an injury may have contributed to the child's death and there is a possibility that the said injury may have been caused by the parent(s) of the child, or other family member, the pathologist will prepare a statement setting out interim findings and detailing any further investigations to be undertaken. Such statement shall be provided to HM Coroner and Children's Social Care.

11.6.2 Upon receipt of such statement Children's Social Care shall immediately seek legal advice with a view to court proceedings being issued in respect of any surviving sibling(s).

11.6.3 In cases where court proceedings are issued in respect of siblings, the Coroner's Office will liaise with Children's Social Care prior to any decision being taken to release the body for burial.

11.7 Recovery & Removal of Property

11.7.1 If it is considered necessary to remove items from the scene(s), do so with consideration for the parents/carers. Explain that it may help to find out why their child has died. With regard to infants this may include the hand held maternity records and the personal child health record (the 'red' book)

11.7.2 Any articles, including clothing and feeding bottles, recovered from the scene should be correctly secured and documented. Collection of clothing/bedding should be considered if there are signs of forensic value such as blood, vomit or other residues.

11.7.3 If articles have been kept during the investigation the parents/carers must be asked if they want them back.

11.7.4 If the family have indicated that they want the articles returned, ensure they are presentable and that any official labels or wrappings are removed before returning them. Establish if they want the items returned in a 'clean' condition.

11.7.5 Return any items as soon as possible after the Coroner's verdict or at the conclusion of the investigation. The term investigation will include any possible trial or appeal process.

11.7.6 A checklist for investigators accompanies this protocol (appendix H). Investigating officers should also comply with the relevant ACPO 2014 'A Guide to Investigating Child Deaths' and guidance on 'infant deaths' contained in the ACPO 2006 Murder Investigation Manual (MIM)

11.7.7 Once the SUDiC protocol commences, it can only be stood down at the direction of HM Coroner, no other agency can take on this responsibility.

11.7.8 Police take ultimate responsibility for the investigation. They will liaise with HM Coroner to establish if the protocol is being stood down and confirm the outcome to agencies.

11.8 Transport of Deceased Child

11.8.1 On occasion, parents/families may wish to transport their child in their own or a private vehicle. If there are no proceedings likely to be impacted upon by this it should be considered an acceptable request. Every effort should be made to accommodate this request as there is no legislation that prevents parents/families from doing so. Families would need to be provided with the appropriate documentation, given by the hospital the child is being discharged from, to enable them to do so.

12. ACCIDENT AND EMERGENCY STAFF (Emergency Department)

This protocol can be used for acute life threatening events (ALTE) if deemed appropriate.

12.1.1 In a situation where a child has been pronounced deceased at the scene NWAS must contact the emergency department to inform them that the SUDiC Protocol has been triggered and request they make arrangements for hospital staff to receive the deceased child. The emergency department staff member will then liaise back with NWAS to confirm the arrangements have been made and agree an estimated time of arrival for the deceased child.

12.1.2 The above arrangements remain the same for Alder Hey but the child will be taken directly to the mortuary (bereavement suite) and not the emergency department. In these circumstances A&E staff will inform mortuary and bereavement staff and NWAS will take the child directly to the bereavement suite. Out of hours, A&E staff will open the bereavement suite and meet NWAS with the child at the bereavement suite. A&E staff will notify on call bereavement staff, Rainbow Consultant, and mortuary technician and wait until on call staff arrive. The mortuary technician is responsible for completion of the Alder Hey Hospital death set order.

12.1.3 If it is not possible for NWAS to convey the deceased child to the hospital they should inform Merseyside Police who will make arrangements for the Coroner's Removal Service to convey them.

Initial assessment of the child presenting unexpectedly dead or moribund

12.2 Resuscitation

12.2.1 The great majority of children found collapsed or dead will be brought immediately to an A&E department where resuscitation will be initiated or continued. Nothing in this protocol should interfere with the absolute priority of effective resuscitation if this is possible. Resuscitation, once commenced, should be continued according to the Advanced Paediatric Life Support protocol until an experienced doctor (usually the consultant paediatrician on call or A&E consultant) has made a decision that it is appropriate to stop further efforts.

12.2.2 On occasions, it may be apparent to the attending doctor or ambulance staff that a child found collapsed out of hospital has been dead for some time and attempted resuscitation is inappropriate. These children will be taken directly to the mortuary at Alder Hey (see Mortuary Section), or to the bereavement suite if the child's family or a bereavement care worker is present. Local arrangements may require the child to be taken to another hospital. In any other hospital, the child should always be taken to the A&E department. The care of the family and investigation of the cause of death should follow a similar course whether or not resuscitation has been attempted.

12.2.3 All access sites (i.e. venepuncture or intraosseous needle) need to be left in situ or, if removed, sites need to be carefully recorded. Endotracheal tubes need to either be left in situ or removed only after correct placement in the trachea has been independently confirmed by direct laryngoscopy (by someone other than the person inserting the tube and preferably also independent from the resuscitation attempts)

12.3 History and Examination

12.3.1 Following confirmation of death the SUDiC (0-2 years) medical pro-forma (appendix A) or the SUDiC (2-18 years) medical pro-forma (appendix B), relevant to the child's age, should be completed by the consultant paediatrician, or the consultant in A&E, or the nominated senior doctor. Consideration should be given to requesting photographs of any skin discolouration or unusual marks or injuries as soon as possible as it may help in estimating the time of death as well as determining the position in which the child was lying.

12.4 Investigations

12.4.1 During the process of resuscitation, if any blood is obtained for investigations, some should be preserved for cultures and sensitivity. Should there be difficulty in obtaining this blood sample and the post mortem is likely to be delayed for more than 48 hours there is an expectation that blood for culture and sensitivity be obtained by cardiac stab wherever possible. If this is not possible HM Coroner and the pathologist should be informed. The investigations undertaken should be clearly demarcated in order to inform the pathologist. (see list at end of appendix A or B)

12.4.1 Post mortem blood samples should be taken as soon after death as possible, to improve the possibility of diagnosis. Where the cause of death is explained, e.g. major trauma or meningococcal disease, this may not be necessary.

12.4.2 If the post mortem is to be conducted within 24 hours of death blood samples may be more appropriately taken by the pathologist at the beginning of the post mortem.

12.4.3 Any stool or urine passed by the child together with any gastric or nasopharyngeal aspirate obtained should be carefully labelled and frozen after samples have been sent for bacteria, culture and for virology testing. If the nappy/underwear is wet or soiled it should be removed, labelled and frozen.

12.5 Referral to Coroner and Transfer

12.5.1 Not all SUDiCs will require a post mortem. If HM Coroner deems a post mortem necessary, arrangements need to be made for transfer of the body to the appropriate facility, for a child under the age of 16 years this will usually be Alder Hey Hospital. If a post mortem is not required the child should go to the mortuary in the hospital in which they presented.

12.5.2 If a post mortem is required the police will arrange the transfer to the relevant hospital using the Coroner's Removal Service.

12.5.3 On occasion parents/families may wish to transport their child in their own or a private vehicle. If there are no proceedings likely to be impacted upon by this it should be considered an acceptable request. Every effort should be made to accommodate this request as there is no legislation that prevents parents/families from doing so. Families would need to be provided with the appropriate documentation, by the hospital the child is being discharged from, to enable them to do so.

12.6 **Care of the Parents/ Carers**

12.6.1 Immediately upon their arrival at the hospital the parents/carers should be allocated a member of staff to care for them, explain what is happening and to keep them fully informed during the course of the resuscitation.

12.6.2 Once the child has been pronounced dead the consultant paediatrician, A&E consultant or the nominated doctor should break the news to the parents/carers, having first reviewed all the available information. This interview should be in the privacy of an appropriate room. The member of staff allocated to care for the family should also be present at this time.

12.6.3 The family must also be informed at this time that HM Coroner will need to be informed because the child has died suddenly and unexpectedly and that, as a matter of routine practice, the police may have to investigate the death. The paediatrician must explain that possible medical causes of the child's death will also be very carefully and thoroughly sought.

12.6.4 Prior to the parents/carers leaving the Accident and Emergency Department written contact details of the family liaison officer or bereavement care worker should be given. The family should be aware of how to arrange to see the child's body and of the next steps in the investigation process.

12.6.5 In certain circumstances, eg where there has been co-sleeping the police will ask parents/carers for blood samples to test for alcohol or drugs, and they will be provided with a consent form advising them of their rights. If parents/carers are unable to provide a blood sample they should be requested to provide a urine sample as an alternative.

12.7 **Initial multi-agency communication**

12.7.1 It is the duty of A&E staff to inform:

- Bereavement Care Services (where available)
- Children's Services (Social Care)
- Police
- Nominated Paediatrician
- Coroner's Office
- Named Nurse and Designated Nurse
- Midwifery Services if the child is under 28 days old

12.7.2 A&E staff should ensure that the original of the completed SUDI/SUDC pro-forma medical record accompanies the child to the mortuary for the pathologist carrying out the post mortem. A copy of the completed pro-forma should also be given to the nominated paediatrician.

12.7.3 It is the responsibility of the A&E consultant or consultant paediatrician to take part in the SUDiC case discussion with police and social care.

13. PAEDIATRICIAN (Nominated)

This protocol can be used for acute life threatening events (ALTE) if deemed appropriate.

13.1.1 All areas should nominate a paediatrician to co-ordinate the ongoing information gathering and investigation. In most areas this will be a community paediatrician, but in some circumstances it may be a hospital paediatrician.

13.1.2 The nominated paediatrician should be informed as soon as possible after the child's death.

13.1.3 The nominated paediatrician may be involved in the SUDiC case discussion.

13.1.4 Prior to the SUDiC strategy meeting the nominated paediatrician will request and review all hospital records of the child. The records may be secured at this time if the death is being treated as suspicious. At the same time the GP records should be requested.

13.1.5 The nominated paediatrician may arrange to meet with the family for further information gathering if agreed at a SUDiC strategy meeting.

13.1.6 If the paediatrician meets with the family prior to the post mortem, any additional information should be communicated to the pathologist.

13.1.7 The paediatrician should consider further investigation of the family (e.g. ECG, genetics referral) if this is a second death or there is a family history.

13.1.8 If the child has complex needs the nominated paediatrician should discuss the case with the child's usual paediatrician.

13.1.9 The nominated paediatrician should attend the SUDiC strategy meeting, having collated all medical records, and with initial post mortem results if available.

13.1.10 Follow up should be offered to the family with either the nominated paediatrician or the paediatrician involved in the resuscitation. This needs to be an item on the SUDiC review meeting agenda. The timing of this meeting may vary but there should always be a meeting once the final post mortem results are known.

14. BEREAVEMENT CARE SERVICE (According to Local Arrangements)

14.1.1.In a situation where a child has been pronounced deceased at the scene, NWAS must contact the emergency department to inform them that the SUDiC protocol has been triggered and request they make arrangements for the mortuary and bereavement staff to receive the deceased child. The emergency department staff member will then liaise back with NWAS to confirm the arrangements have been made and agree an estimated time of arrival for NWAS. In the event that NWAS cannot convey the deceased child the Coroner's Removal Service should be utilised through contact by Merseyside Police.

14.1.2 If a bereavement care worker is not available, it is the Trust's responsibility to allocate a member of staff to care for the family and ensure that appropriate bereavement support is provided, as outlined in this section.

14.1.3 A bereavement care worker* will:

- attend the hospital and assist in offering immediate care to the family and colleagues.
- work closely with hospital staff to identify people arriving and their relationship to the child.
- advise and inform hospital staff with regard to the SUDiC protocol.
- assist hospital staff with documentation and contact with other departments and agencies.
- liaise with hospital staff and assist with the transfer of the child to the mortuary / bereavement suite.
- assist family with practical issues i.e. informing family / friends, travel arrangements.

14.1.4 The Bereavement Care Service* will:

- liaise with HM Coroner and police regarding the arrangements for families to view the child in the bereavement suite.
- be the named contact for the hospital in the continuing support for families.
- assist with the coordination and continuity of support between family, hospital staff and outside agencies (Coroner, police, social care etc).

**or allocated member of staff or service, where a specific bereavement support worker or service is not available.*

15. MORTUARY STAFF

In a situation where a child has been pronounced deceased at the scene, NWAS must contact the emergency department to inform them that the SUDiC protocol has been triggered and request they make arrangements for the mortuary and bereavement staff to receive the deceased child. The emergency department staff member will then liaise back with NWAS to confirm the arrangements have been made and agree an estimated time of arrival for NWAS. In the event that NWAS cannot convey the deceased child the Coroner's Removal Service should be utilised through contact by Merseyside Police.

15.1.1 On occasions it may be apparent to the attending doctor or ambulance staff that a child found collapsed out of hospital has been dead for some time and attempted resuscitation is inappropriate. These children will be taken directly to the mortuary at Alder Hey (admission in other hospitals will be via the A&E department).

15.1.2 Should a child be taken directly to the mortuary in any other hospital they should be transferred to the local A&E department for examination by a consultant paediatrician (see Section 12 - A&E Section).

15.1.3 The care of the family and investigation of the cause of death should follow a similar course whether or not resuscitation has been attempted.

15.1.4 Mortuary staff at Alder Hey should contact bereavement care services, bleep holder if out of hours, and the on-call / nominated paediatrician as soon as they are aware that a child is expected. A&E should also be notified, in case visitors arrive in the department enquiring about the child or family.

16. PATHOLOGIST AND THE POST MORTEM EXAMINATION

16.1.1 After the death is certified, the Coroner has control of the body and mementos and medical samples should not be taken without prior consultation.

16.1.2 Where a post-mortem examination is required, a paediatric pathologist will usually carry out the post mortem examination. If the young person is over 16 years old and not considered vulnerable, the post mortem will normally be conducted by an adult pathologist.

16.1.3 In certain circumstances, at the discretion of the Coroner, a Home Office pathologist will also be instructed. In these circumstances the Home Office pathologist will be the lead pathologist.

16.1.4 Both HM Coroner and the pathologist must be provided with a full history at the earliest possible stage. A copy of the completed SUDiC medical proforma (SUDI or SUDC dependent on the age of the child) should be made available to the pathologist prior to the post mortem. This will include:

- a full medical history from the paediatrician,
- any relevant background information concerning the child and the family **and**
- any concerns raised by any agency.

The senior investigating officer (SIO), or coroner's officer is responsible for ensuring that this is done.

16.1.5 The coroner's officer must ensure that all relevant professionals are informed of the time and place of the post mortem examination and it will be conducted as soon as possible after the pathologist has been informed.

16.1.6 The senior investigating officer (SIO) should attend the post mortem examination. If this is not possible, then he/she must send a representative who is aware of all the facts of the case. A crime scene investigator (CSI) must attend all post mortem examinations conducted by a Home Office pathologist. The consultant paediatrician should also be invited to attend.

16.1.7 A number of investigations will be arranged by the pathologist at post mortem examination. These may include a post mortem skeletal survey, taking samples for virological, microbiological, toxicological and genetic (where appropriate) investigations and tissue samples for metabolic investigations.

16.1.8 In cases in which there is circumstantial evidence or strong suspicion of non-accidental injury or any other form of child abuse, the paediatric pathologist will require the consultant paediatric radiologist's report regarding the skeletal survey before the commencement of the post mortem.

16.1.9 A paediatric post-mortem examination will always involve the taking of tissue samples to produce blocks and slides for routine microscopic examination. This will be explained to the family by the nominated paediatrician/A&E consultant.

16.1.10 If the pathologist carrying out the post-mortem examination wishes to retain a whole organ (solely for the purpose of establishing the cause of death) he will ask the permission of HM Coroner first. HM Coroner, through his officer, will discuss with the family their wishes in relation to the future storage or disposal of blocks and slides as

well as any organs or tissues retained. The family's decision should be communicated to the pathologist(s) in a written format by the coroner's officer.

16.1.11 If the paediatrician has initiated any investigations before the child's death the results should be shared with HM Coroner and must also be sent to the pathologist(s).

16.1.12 All professionals must endeavour to conclude their investigations expeditiously in order to facilitate the finalisation of the post mortem examination report. The funeral of the deceased child must not be delayed unnecessarily.

16.1.13 The interim findings of the post mortem will be discussed with the SIO immediately after the completion of the post mortem and they will be updated with significant results as they become available. These findings should be shared in subsequent multi-agency discussions.

16.1.14 Following the post mortem there will be a discussion between the pathologist and the nominated paediatrician regarding the necessity for the pathologist to attend the SUDiC strategy meeting.

16.1.15 As the pathologist may not be able to attend all the multi-agency meetings the minutes **must** be sent to the pathologist.

16.1.16 The final report should be sent to HM Coroner when all investigations are completed and the results of all tests made available to the pathologist. If, for any reason, there will be any undue delay then the pathologist will discuss this with HM Coroner.

16.1.17 The SIO should ensure that a copy of the post mortem examination report is forwarded to the PVPU for inclusion on file for future reference. The post mortem report must not be shared with other agencies without the permission of HM Coroner. Permission should always be sought by an agency if the content of the report could potentially affect the agency's future actions.

16.1.18 The nominated paediatrician (responsible for the follow up) may request a copy of the post mortem examination report from the Coroner's Office. This cannot be released without the permission of HM Coroner.

16.1.19 It is important that the pathologist is provided with the following information, when available, to assist in the compilation of the post mortem report or any addendum required:

a) Copy of the ambulance sheet
b) Copy of the A&E notes
c) Copy of the GP record
d) Completed SUDI or SUDC medical pro-forma
e) Police report (if joint PM) containing summary of relevant events day(s) prior to death and including report from death scene.
f) Strategy meeting notes

16.2 Pathology Investigation Findings

16.2.1 Notwithstanding that pathology investigations are ongoing and interim results may be inconclusive, in any case where the pathologist is satisfied that an injury may

have contributed to the child's death and there is a possibility that the said injury may have been caused by the parent(s) of the child, or other family member, the pathologist will prepare a statement setting out interim findings and detailing any further investigations to be undertaken. Such statement shall be provided to HM Coroner and Children's Social Care.

16.2.2 Upon receipt of such statement Children's Social Care shall immediately seek legal advice with a view to court proceedings being issued in respect of any surviving sibling(s).

16.2.3 In cases where court proceedings are issued in respect of siblings, the Coroner's Office will liaise with Children's Social Care prior to any decision being taken to release the body for burial.

16.2.4 Post mortem examination is usually only authorised by HM Coroner when necessary.

17. CORONER & CORONER'S OFFICER

17.1 Role of the Coroner

17.1.1 HM Coroner enquires into those deaths reported to them. It is the Coroner's duty to find out the medical cause of the death, where it is not known, and to enquire about the cause, whether it was due to violence or was otherwise unnatural. The Coroner needs to ascertain the cause of death and this will often be done by ordering a post mortem examination.

17.1.2 If the cause of death is unnatural or is not ascertained after a post mortem then an inquest will be held. This will give time for further tests and analysis to be carried out on retained material from the examination without unnecessarily delaying the funeral.

17.1.3 The inquest is an inquiry to find out who has died, when and where he or she died, by what means, and in what circumstances the medical cause of death arose; together with information needed by the Registrar of Deaths, so that the death can be registered.

17.1.4 An inquest is not a trial. It is a limited inquiry into the facts surrounding a death. It is not the job of HM Coroner to blame anyone for the death, as a trial would do.

17.2 Role of the Coroner's Officer

17.2.1 The Coroner's Officer works under the direction of HM Coroner. The Officer liaises with all persons having an interest in the death (i.e. bereaved families, witnesses, police, doctors, pathologists, funeral directors, solicitors, social workers, registrars etc.) with a view to investigating all those matters to be determined at the inquest (see above). In the case of sudden deaths, where the death is considered suspicious the police will take the lead on investigation. The officer reviews and collates all the required reports and statements relating to the death so as to formulate an inquest file for the attention of HM Coroner.

17.2.2 If the pathologist carrying out the post-mortem examination wishes to retain a whole organ (solely for the purpose of establishing the cause of death) he will ask the permission of HM Coroner first. HM Coroner, through the officer, will discuss with the family their wishes in relation to the future storage or disposal of blocks and slides as well as any organs or tissues retained. The family's decision should be communicated to the pathologist(s) in a written format by the coroner's officer.

17.3 Pathology Investigation Findings

17.3.1 Notwithstanding that pathology investigations are ongoing and interim results may be inconclusive, in any case where the pathologist is satisfied that an injury may have contributed to the child's death and there is a possibility that the said injury may have been caused by the parent(s) of the child, or other family member, the pathologist will prepare a statement setting out interim findings and detailing any further investigations to be undertaken. Such statement shall be provided to HM Coroner and Children's Social Care.

17.3.2 Upon receipt of such statement Children's Social Care shall immediately seek legal advice with a view to court proceedings being issued in respect of any surviving sibling(s).

17.3.3 In cases where court proceedings are issued in respect of siblings, the Coroner's Office will liaise with Children's Social Care prior to any decision being taken to release the body for burial.

18. MIDWIFERY SERVICE

This protocol can be used for acute life threatening events (ALTE) if deemed appropriate.

18.1 These guidelines will inform midwives of the procedures they will be expected to follow in the event of the unexpected death of an infant. This can be a difficult time for everybody and additional support can be obtained from the designated/named professionals and from the care of the next infant (CONI) co-ordinators where applicable.

18.1.1 Records will be secured by the named midwife as soon as possible after the death has been notified. A copy will be made available for the midwives. This is a precautionary measure until the situation is clarified. Midwives should also refer to their own organisation's procedures/protocols where available.

18.1.2 All midwives should have a level of competence to deal with the issues of bereavement, but they should make reference to the approved leaflet and the Merseyside SUDiC protocol for additional information.

18.1.3 There is an expectation that ongoing care and support will be provided by the midwife until the end of the postnatal episode of care unless:

- the family specifically request another member of the team; **or**
- the midwife is a witness in the case and the employing organisation advises against a particular person visiting. In this event, check with your line manager/legal department and make careful notes of the events.

18.2 If the midwife is first on the scene

18.2.1 When an unexpected fresh stillbirth or SUDI has occurred without the presence of a health professional, or if the birth has been concealed, the midwife must assess the infant and the mother's medical condition and immediately send for the paramedic services who will inform the police.

18.2.2 CPR should be attempted if deemed appropriate by the attending midwife. If the indications are that the infant is dead and no active resuscitation has been attempted, the body should remain in situ pending the arrival of the police.

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

18.2.4 When the paramedics arrive, spend time listening to the parents/carers and offering support.

18.2.5 If the parents/carers go to the hospital with the infant, ensure that appropriate arrangements are made for the care of any siblings, if necessary.

18.2.6 If the mother is alone, ensure that she has the appropriate family support.

18.2.7 Give the parent/carers/family a work telephone number where you can be contacted.

18.2.8 If the mother's condition requires obstetric intervention, she should be transferred to the **nearest** maternity unit, whether she is booked in there or not. A midwife must accompany the mother in the ambulance.

18.2.9 If the infant is not resuscitated, in most cases the infant's body will be taken to a hospital A&E department. However, those infants being transported to Alder Hey Hospital will be taken directly to the mortuary. NWAS will convey the child but if unable to do so the police will arrange transfer utilising the Coroner's Removal Service.

18.2.10 Parent/carers and family members may have access to the infant's body in circumstances as agreed at a SUDiC Case Discussion. **An appropriate professional MUST ALWAYS be present.**

18.2.11 If the midwife has any relevant information about the pregnancy or the family, this should be reported directly to the police and receiving doctors at the hospital as soon as possible.

18.2.12 As soon as possible after the incident, but within 24 hours, make a precise and thorough report of the event in the infant's record, making particular reference to:

- Any inappropriate delay in seeking help
- The position of the infant and the condition in which they were found
- Inconsistent explanations - accounts should be recorded verbatim in quotes where appropriate
- Evidence of drugs/alcohol abuse
- Parent/carers' reaction/demeanour
- Unexplained injury e.g bruises, burns, bites, presence of blood
- Neglect issues
- Position of the infant and their surroundings
- General condition of the accommodation
- Evidence of high risk behaviour eg domestic abuse

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

18.2.13 As soon as possible the senior midwifery manager must be informed and the SUDiC/ALTE notification/incident form (Appendix D) of the SUDiC protocol should be completed and forwarded to the designated nurse for the area, for onward transmission to the strategic health authority.

18.2.14 Midwifery staff involved in the case should be offered support and the opportunity to speak to their supervisor of midwives.

18.2.15 The family GP and health visitor must also be informed as soon as possible.

18.3 Acute Life Threatening Event (A.L.T.E.) if the Midwife is first on scene

18.3.1 If the infant has been resuscitated and is transported to hospital, inform the designated nurse /named midwife as soon as possible.

18.3.2 Check if the infant or siblings are subject to child protection plans.

18.3.3 Complete appendix C SUDiC/ALTE Notification/Incident Form of the SUDiC Protocol and forward to the designated nurse for the area, for onward transmission to the strategic health authority.

18.3.4 Ensure the record keeping steps outlined in 18.2.12 are actioned.

18.3.5 Ensure the GP, midwifery service (if baby is under 28 days) and health visitor are informed as soon as possible.

18.4 If you learn later that a sudden infant death has occurred, best practice requires that the midwife should:

18.4.1 Check that the following agencies/professionals have been informed of the infant's death:

- Medical records department/maternity/children's hospitals to avoid follow up appointments being sent;
- Child Health Records to avoid immunisation appointments/reminders being sent;
- The family GP in case s/he has not already been contacted by the Police/Hospital;
- Health visitor;
- Infant feeding team if mum is breastfeeding;
- Midwifery service if baby is under 28 days
- Named midwife/child protection specialist nurse and the relevant line manager;
- School nurse if there are older siblings in the family;
- Any other department to which the infant has been referred/seen if follow up appointments are possible, e.g. Sure Start, Social Care;
- Known research projects in the area, which might result in a questionnaire being sent to parents/carers;
- Ensure that appendix C SUDiC/ALTE Notification/ Incident Form of the SUDiC protocol is completed and forwarded to the designated nurse for the area for onward transmission to the strategic health authority.

18.4.2 The existing midwife should contact the family to acknowledge the death, offer condolences and answer any questions that the parents/carers may have.

18.4.3 Discuss the nature of the support that the parents/carers/extended family require. If there is inadequate support available, consider the need for more intensive midwifery support or consider alternatives: Alder Centre/bereavement support resources.

18.4.4 If the mother was breastfeeding, discuss and advise on the suppression of lactation and give appropriate support. Refer to the GP if necessary.

18.4.5 Ensure that the midwifery records are available to the nominated paediatrician as required and be available to attend the SUDiC strategy meeting. If still visiting the mother, photocopy the hand held records and ensure the originals are available to the professional attending the SUDiC strategy meeting.

18.4.6 Be prepared to provide a statement of evidence if requested and seek advice from the designated nurse/named midwife.

18.5 The next pregnancy:

18.5.1 Ensure that the care of the next infant (CONI) co-ordinator for the relevant trust has been notified as soon as possible, following the trust procedures.

18.5.2 In the antenatal period ensure that the family health visitor and GP are aware of the pregnancy and forthcoming delivery.

18.5.3 Scrutinise previous records to ascertain whether it is necessary to inform any other professional/agency of the pregnancy. e.g social worker.

18.5.4 Ensure that the history of the sudden infant death is highlighted in the maternity records.

18.5.5 Ensure that the family receives appropriate support during the pregnancy, delivery, and postnatal period.

18.5.6 Ensure evidence based practice is shared with carers in respect of the following more specific risk factors such as:

- co-sleeping following the ingestion of prescribed medication and substances;
- sleep positions;
- smoking;
- temperature control; **and**
- Use your local CONI coordinator for advice, support, guidance and for up to date research.

19. HEALTH VISITING SERVICE

This protocol can be used for acute life threatening events (ALTE) if deemed appropriate.

19.1.1 These guidelines will inform health visitors of the procedures that they will be expected to follow in the event of an unexpected death of a child. This can be a difficult time for everybody and additional support can be obtained via the named professionals and from the care of the next infant (CONI) coordinators, if available.

19.1.2 Paper and electronic records will be secured, according to local processes, by the named nurse as soon as possible after the death has been notified. A copy will be made available for the health visitor. This is a precautionary measure until the situation is clarified.

19.1.3 Health visitors should assess each individual situation on a case by case basis, taking into account their own previous involvement with the family and any other members of the team. Health visitors should refer to their own organisation's procedures and protocols where available.

19.1.4 All health visitors should have a level of competence to deal with the issues of bereavement. However, they should make reference to the approved literature and the Merseyside SUDiC protocol for additional information.

19.1.5 There is an expectation that this work is undertaken by the family health visitor unless:
- The family specifically request another member of the team. However, it is the health visitor's responsibility to ensure that this member of staff has the competence and confidence to carry out this role.
- The family health visitor is a witness in the case and the employing organisation advised against a particular person visiting.

19.1.6 In the unlikely event that the health visitor is first on the scene, follow the guidance contained in the information sheet, appendix Q in this protocol. This can be printed and laminated as an A5 diary insert.

19.2 If the Health Visitor is first on the scene:

19.2.1 **These guidelines equally apply to any health professional visiting the family home who becomes aware that a sudden and unexpected death of an infant or child has occurred. They should follow the same advice.**

19.2.2 Dial 999 and ask for an ambulance to attend the scene immediately. Attempt resuscitation if trained or as instructed by the Ambulance Service. If the indications are that the child is deceased and no active resuscitation has been attempted, the body of the child should remain in situ pending the arrival of the police.

19.2.3 The position of the child's body and the conditions in which it was found must be noted together with any comments or explanations made by the parent/carer or any other person who was at the scene. Try not to disturb the scene i.e. do not touch or move anything.

19.2.4 When the paramedics arrive, spend time listening to the parent/carer, offering support. If the parent/carer goes to the hospital with the child ensure, if it is necessary, that appropriate arrangements are made for the care of any siblings.

19.2.5 If the parent/carer is alone, ensure that they have appropriate family support. Provide the parent/carer with a work telephone number where you can be contacted.

19.2.6 As soon as possible after the incident, but within 24 hours, make a precise and thorough report of the event in the child's records making particular reference to:

- Any delay in seeking help, including appropriate delay
- The position of the child and the condition in which they were found
- Any explanations, including any inconsistencies, should be recorded verbatim (in quotes where appropriate)
- Evidence of drugs/alcohol abuse
- Parents/carers reactions and demeanour
- Any injuries eg bruises, burns, bites and presence of blood
- Neglect issues
- General condition of the accommodation
- Evidence of high risk behaviour eg domestic abuse

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

If you learn later that a sudden unexpected death of a child has occurred, the health visitor should:

19.2.7 Inform the named nurse/safeguarding children specialist nurse immediately. This is to ensure that the records can be secured quickly, other relevant professionals/departments are informed and the nominated child death overview panel lead for the area is notified of the death.

19.2.8 The records must be reviewed for evidence of any known involvement with any other professionals/departments. They must be contacted and informed of the death of the child as per your own organisational processes. You may wish to consider the following:

- The Child Health Department/Information Service to avoid immunisation appointment reminders being sent.
- Local children's hospitals in your area to ensure that follow up appointments are not sent
- The family GP in case he/she has not already been contacted by the police/hospital
- The school nurse for any other siblings in the family
- Any other department to which the child has been referred or seen, if follow up appointments are possible, e.g. Audiology, Dietetics, Therapy Services.
- Community Dental Health
- Community Paediatrician
- Known research projects in the area, which might result in a questionnaire being sent to parents/carers.

19.2.9 Contact the family to acknowledge the infant or child's death, offer condolences and answer any questions the parent/carer may have.

19.2.10 The health visitor or relevant health professional may be asked to accompany the nominated paediatrician and/or a police officer on an initial home visit to collate medical information as agreed at the SUDiC strategy meeting. Your role at this visit will be in a supportive capacity to both the professionals and parent/carer. In this case ensure that you take any relevant information or approved literature with you to discuss and give to the parent/carer.

19.2.11 Ensure that the parent/carer has received a copy of the current approved infant death booklet and have the helpline number for the Lullaby Trust. The helpline number is 0808 802 6869 for information and advice and 0808 802 6868 for bereavement support (free phones)

19.2.12 Discuss the nature of the support that the parents/carers/extended family require. If there is inadequate support available consider the need for more intensive health visiting support or consider alternatives i.e. Alder Centre 0151 252 5391 or the National Child Death Helpline 0800 282 986

19.2.13 Ensure that the parent/carer has your work contact number in case they wish to talk to you.

19.2.14 Ensure that a copy of the health visiting records is made available to the nominated paediatrician as required and be available to attend the SUDiC strategy meeting.

19.2.15 Be prepared to provide a statement of evidence if requested and seek advice from the named nurse/safeguarding children specialist nurse.

19.3 In the months following the death:

19.3.1 Ensure that the records manager for the organisation is advised that the child's records should be retained for 25 years from the date of the death.

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

19.3.3 Suggest that the parent/carer sees a paediatrician to discuss the results of the post mortem examination, if one has taken place, and to answer any questions they may have. Assist in arranging this as necessary.

19.3.4 You may wish to remember the first anniversary of the child's death and consider a visit at this time. Health visitors may wish to set up a system to remind themselves of anniversaries for these families to ensure that a visit is offered if necessary.

19.3.5 Offer support for any future pregnancies via the CONI scheme if available in your area and refer to your local CONI procedures if available.

19.3.6 Access any support you may require for yourself ie staff counselling service/named nurse/SCSN/CONI coordinator

20. LULLABY TRUST (previously Foundation for the Study of Infant Deaths)

20.1 Aims

20.1.1 The Lullaby Trust provides specialist support for bereaved families, promotes expert advice on safer baby sleep and raises awareness on sudden infant death.

20.1.2 Working with the NHS the Lullaby Trust runs a national health-visitor led service for bereaved parents, care of next infant (CONI) programme, which supports families before and after the birth of their new baby.

20.1.3 We are committed to supporting research to understand why babies die suddenly and unexpectedly in the UK and to find out more about how to prevent these tragic deaths.

20.1.4 The Lullaby Trust operates nationwide across England, Wales and Northern Ireland. We run an information line for parents and professionals (0808 802 6869) and a dedicated line for bereaved families (0808 802 6868). Both are free to call from landlines and mobiles.

20.1.5 We campaign tirelessly, lobbying government to keep sudden infant death on the public health agenda. Since we formed as The Foundation for the Study of Sudden Infant Deaths in 1971 we have been pivotal in reducing sudden infant death syndrome by 70%.

20.2 Work of Lullaby Trust

20.2.1 Every year in the UK, a significant number of babies, the majority of whom appear to be perfectly healthy, will die suddenly and unexpectedly. Although some of these can be explained after investigation, many cannot. All are individual tragedies.

20.2.2 The Lullaby Trust is working hard on four critical fronts to tackle this issue:

- We aim to ensure that all parents, healthcare professionals, and others in close contact with families are aware of the most up-to-date, evidence-based advice on safer sleep for babies, and how to reduce the risk factors that can lead to an unexpected death.
- The Lullaby Trust helps families who experience the sudden and shocking loss of a baby, providing immediate, practical support in the form of advice and guidance. We connect them with others who have experienced a similar bereavement. In these ways we work to ensure that families are fully supported during what is a devastating and isolating experience.
- Working with the NHS we run a national health-visitor led service for bereaved parents, Care of Next Infant (CONI) programme, which supports families before and after the birth of their new baby. We also fund the specialist monitoring equipment for CONI babies which provides much-needed reassurance for their anxious parents.
- The Lullaby Trust has funded cutting-edge research for over 40 years, making a major contribution to reducing sudden infant death by 70%. We have invested £11 million in SIDS research and continue to support new research.

20.2.3 The Lullaby Trust also campaigns tirelessly, lobbying government to keep sudden infant death on the public health agenda and working in a coordinated way to build public awareness and knowledge.

Contact details

Information & advice: **0808 802 6869**

Bereavement support: **0808 802 6868**

11 Belgrave Road
London SW1V 1RB
Office: 020 7802 3200

Registered Charity Number: 262191

21. SCHOOL HEALTH PRACTITIONER

21.1.1 The role of the school nurse dictates that the majority of their work with children is undertaken within the school setting. In most cases, the school nurse will have only minimal direct contact with the extended family, although if there is no other health visitor/school nurse involved with the family, she/he will be the main point of contact and retain the child health records.

21.1.2 These guidelines inform school nurses of the procedures they will be expected to follow in the event of the unexpected death of a child. This can be a difficult time for everybody and additional support can be obtained from their line manager and named professionals.

21.1.3 Records will be secured by the named nurse as soon as possible after the death has been notified. A copy will be made available for the school nurse. This is a precautionary measure until the situation is clarified.

21.1.4 The school nurse should assess each individual situation on a case by case basis, taking into account their previous involvement with the family and any other members of the team. School nurses should also refer to their own organisation's procedures/protocols where available.

21.1.5 All school nurses should have a level of competence to deal with the issues of bereavement, but they should make reference to the approved literature and the Merseyside SUDiC protocol for additional information.

21.1.6 There is an expectation that this work is undertaken by the school nurse involved with the deceased child unless:

- There is a health visitor currently involved with the family and the health visitor may be better placed to undertake this role (this should be discussed and negotiated between the health professionals as to who may be most appropriate).
- There is more than one school nurse involved with the family in which case the role should be undertaken by the nurse who has had the most contact with the family/is most agreeable to the family
- The family specifically request another member of the health team. However, it is the school nurse's responsibility to ensure that this member of staff has the competence and confidence to carry out this role.
- The school nurse is a witness in the case and the employing organisation advises against a particular person visiting.

21.1.7 In the unlikely event that the school nurse is first on the scene, follow the guidance contained in the information sheet, appendix Q in this protocol. This can be printed and laminated as an A5 diary insert.

21.1.8 Be prepared to provide a statement of evidence if requested and seek advice from the named nurse/safeguarding children specialist nurse.

21.2 If the School Nurse is first on the scene:

21.2.1 These guidelines apply equally to any other health professional visiting the family home who becomes aware of the sudden unexpected death of a child. They should follow the same advice.

21.2.2 Dial 999 and ask for an ambulance to attend the scene immediately. Attempt resuscitation if trained or as instructed by the ambulance service. If the indications are that the child is dead and no active resuscitation has been attempted, the body of the child should remain in situ pending the arrival of the police.

21.2.3 The position of the child and the condition in which they were found must be noted together with any comments/explanations made by the parents/carers or any other person who was at the scene. Try not to disturb the scene, ie do not touch or move anything.

21.2.4 When the paramedics arrive, spend time listening to the parents/carers offering support. If the parents/carers go to the hospital with the child ensure, if necessary, that appropriate arrangements are made for the care of any siblings.

21.2.5 If the parent/carer is alone, ensure that they have appropriate family support. Provide the parents/carers with a work telephone number where you can be contacted.

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

- Any delay in seeking help, including appropriate
- The position of the child and the condition in which they were found
- Any explanations including any inconsistencies should be recorded verbatim, in quotes where appropriate
- Evidence of drugs/alcohol abuse
- Parents/carers reactions and demeanour
- Any injury eg bruises, burns, bites, presence of blood
- Neglect issues
- General condition of the accommodation
- Evidence of high risk behaviour eg domestic abuse

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

If you learn later that a sudden unexpected death of a child has occurred the school nurse must:

21.2.7 Inform the named nurse/safeguarding children specialist nurse immediately and the relevant line manager. This is to ensure that the records can be secured quickly, other relevant professionals/departments are informed and the nominated child death overview panel lead for the area is notified of the death.

21.2.8 The records must be reviewed for evidence of any known involvement with any other professionals/departments. They must be contacted and informed of the death of the child as per your own organisation processes. You may wish to consider the following:

- The Child Health Department/Information Service to avoid immunisation appointment reminders being sent
- Local children's hospitals in your area to ensure that follow up appointments are not sent
- The family GP in case he/she has not already been contacted by the police/hospital
- The school nurse for any other siblings in the family
- The health visitor if there are pre-school age siblings
- Any other department to which the child has been referred/seen if follow up appointments are possible, e.g. Audiology, Dietetics, Therapy Services.
- Community dental health
- Community paediatrician
- Known research projects in the area, which might result in a questionnaire being sent to parents/carers.

21.2.9 Contact the family to acknowledge the death, offer condolences and answer any questions that the parents/carers may have.

21.2.10 Ensure that parents/carers have your work contact number in case they wish to talk to you.

21.2.11 Ensure that the child's health records are available to the nominated paediatrician as required (unless they have already been secured) and be available to attend the SUDiC strategy meeting.

21.3 In the months following the death:

21.3.1 It is considered good practice for the school nurse to liaise closely with colleagues in Education and Children's Social Care regarding how best to support the family. Where there are other health professionals involved, close liaison is essential to ensure that the family receive appropriate and timely health interventions when necessary.

21.3.2 Assess whether additional help is required to assist the parents/carers to cope with their grief and arrange the appropriate support as necessary: Alder Centre 0151 252 5391 or the National Child Death Helpline 0800 282 986.

21.3.3 Ensure that the records manager for the organisation is advised that the child's records should be retained for 25 years from the date of the death.

21.3.4 Access any support you may require for yourself ie staff counselling service/named nurse/SCSN/CONI coordinator

22. CHILDREN'S SOCIAL CARE

22.1.1 Social care must be contacted whenever a child dies and the death is unexpected.

22.1.2 Social care staff will check whether the child and any members of the family are known. This check will include a search to the social care information systems operating at the time e.g. Integrated Children's System, Liquid Logic, and whether the child is subject to a child protection plan or looked after, including looked after at home.

22.1.3 Social care staff will, in all cases, report the death to their team manager who will be responsible for informing the Safeguarding/Quality Assurance Unit manager. The Safeguarding/Quality Assurance Unit manager will be responsible for informing the Head of Service, Director of Children's Services, and ensuring the Chair of the Local Safeguarding Children Board/Partnership (LSCB/P) and the colleague/s responsible for the child death overview panel process are informed.

22.1.4 The Chair of the LSCB/P will determine whether or not the case meets the criteria (set out in Working Together to Safeguard Children 2018) to be referred to the Critical Incident Group (CIG) for consideration of a Practice Learning Review. The Chair of the CIG, in conjunction with partner agencies, should consider whether the circumstances relating to a child death warrant discussion at a rapid review meeting, to determine if the threshold for a Practice Learning Review have been met.

22.1.5 The social care team manager will be responsible for agreeing with the police senior investigating officer (SIO) an appropriate course of action. This will be deemed a SUDiC case discussion and will involve discussion with a number of other professionals. This discussion should be conducted as a multi-agency strategy discussion involving police, health and social care as a minimum and any other relevant services under s17 (Child in Need). It should take place as soon as possible but within 24 hours at the latest, and recorded by the senior police officer on the appropriate forms for the respective LSCB/P area. A SUDiC strategy meeting should be convened to take place within 3 working days of the child's death.

22.1.6 SUDiC strategy meetings must always include detailed discussion on surviving children relating to their needs, including safeguarding if there are concerns about abuse or neglect. In all cases a Single Assessment must be undertaken regarding surviving children once enquiries have been completed. If there are concerns relating to the death of the child and there are siblings a s47 child protection investigation should commence. The outcome of this should be relayed to the SUDiC strategy meeting. There must be an accurate record of agreements made and a copy sent to the SIO who will be responsible for any correspondence with the Coroner.

22.1.7 If the post mortem results are not known at this stage contact must be maintained between key professionals to convey the relevant information when it is available.

22.1.8 The attendance of all involved professionals is essential to ensure the relevant and appropriate information is shared so that an informed plan of action can be agreed. Any agency unable to attend the strategy meeting is required to provide a written report to the chair of the meeting in advance of it being held. **It is not appropriate to invite family members or carers to any strategy meeting.**

22.1.9 At the conclusion of the initial strategy meeting the Chair must complete a monitoring form and forward to Merseyside Child Death Overview Panel. **A further meeting should be convened within agreed timescales to consider the results of any medical tests in addition to the welfare of the family.** The strategy meetings for all SUDiC cases should be chaired by a member of the Safeguarding/Quality Assurance Unit, who is also responsible for ensuring the meeting is recorded. It is the responsibility of the Chair to ensure that an appropriate action plan is compiled based on all information and that tasks are shared between the relevant agencies.

22.1.10 Agreement should be sought at the earliest stage regarding who informs the parents/carers of the process and maintains liaison with the family. This should be agreed at the initial strategy discussion/meeting.

22.1.11 The Safeguarding/Quality Assurance Unit manager is responsible for monitoring all SUDiC cases, which will include keeping the Chairs of the LSCB/P, Child Death Overview Panel (CDOP) and the SUDiC Implementation Group (Merseyside monitoring group) informed as appropriate.

22.1.12 A referral to CIG for consideration may also be made following the SUDiC strategy meetings if those present feel the information shared at the meeting warrants consideration at the CIG because the grounds for a practice learning review may be met. Similarly, referrals to CIG can be made by Merseyside CDOP when panel members consider the grounds for a practice learning review are met.

22.2 Pathology Investigation Findings

22.2.1. Should concerns come to light, during the course of the post mortem, that indicate the possibility of a non-accidental injury Children's Social Care will be informed.

22.2.2 Notwithstanding that pathology investigations are ongoing and interim results may be inconclusive, in any case where the pathologist is satisfied that an injury may have contributed to the child's death and there is a possibility that the said injury may have been caused by the parent/s or carer/s of the child, or other family member, the pathologist will prepare a statement setting out interim findings and detailing any further investigations to be undertaken. Such a statement shall be provided to HM Coroner and Children's Social Care.

22.2.3 Upon receipt of such statement Children's Social Care shall immediately seek legal advice with a view to court proceedings being issued in respect of any surviving sibling(s).

22.2.4 In cases where court proceedings are issued in respect of siblings, the Coroner's Office will liaise with Children's Social Care prior to any decision being taken to release the body for burial.

23. EDUCATION

23.1.1 Education Services must be contacted whenever a child of school age dies and the death is unexpected. A nominated education lead should be invited to participate in the strategy discussion if available to do so.

23.1.2 Education staff will check whether any members of the family are known. This check will include a search of the safeguarding system.

23.1.3 Each educational setting must have a designated person, which is usually the person with designated responsibility for safeguarding. Each local authority has a designated person within the education service with safeguarding responsibility.

23.1.4 It is the responsibility of both designates to share information regarding the sudden unexpected death of a child

23.1.5 All the child's educational/personal records/files must be secured at the time of notification. It is expected that the designated person would contribute to and attend strategy discussions/meetings as appropriate. Once actions are identified, it is the responsibility of the designated person to ensure that actions are carried out and maintain liaison with the chair of the SUDiC strategy meeting.

23.1.6 A decision will be made at the SUDiC strategy meeting regarding who should inform the parents/carers and maintain liaison with the family.

24. EARLY YEARS

24.1.1 Early years providers will be contacted whenever a child has died.

24.1.2 Early years staff should check whether any members of the family are known. This check will include a search of the safeguarding system.

24.1.3 Early years providers should ensure their systems, including safeguarding, are checked to establish what information is known to the service, including any safeguarding issues.

24.1.4 Early years managers/designated safeguarding coordinators will be invited to attend a strategy meeting which should take place within 3 working days of the child's death. Invitations are extended from the safeguarding units in each LSCB/P area.

24.1.5 Attendance at the strategy meeting should be prioritised if early years have information relating to the child or family members. It is the responsibility of both designates to share information regarding the sudden unexpected death of a child

24.1.6 All the information known to the early years provider must be secured at the time of notification. It is expected that the manager/designated person would contribute and attend strategy discussions/meetings as appropriate. Once actions are identified, it is the responsibility of the designated person to ensure that actions are carried out and maintain liaison with the chair of the SUDiC strategy meeting.

24.1.7 A decision will be made at the SUDiC strategy meeting regarding who should inform the parents/carers and maintain liaison with the family.

24.1.8 The setting/provider will be requested to complete an agency report form for the child death overview panel (CDOP) process following contact from Merseyside CDOP team.

APPENDIX A - Hospital SUDiC Proforma Medical Record (0-2 years)

SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI) - PROFORMA MEDICAL RECORD (Also for use with unexplained Acute Life Threatening Events requiring resuscitation & Intensive Care intervention*)	
Time: ____ : _____	Date: ____ / ____ / _____
Infant Name:	Name of Doctor:
Date of Birth: ___ / ___ / ____	Grade:
Hospital Number:	Signature:

A&E CHECKLIST		
Arrival in A&E Department:	Time: ____ : ____	Date: ____ / ____ / _____
Condition of baby on arrival: What Cardio-Pulmonary Resuscitation was applied?		
Death certified at:	Time: ____ : ____	Date: ____ / ____ / _____

HISTORY	
History taken from:	☐ Mother ☐ Father ☐ Carer ☐ Other (specify) _____ Name _____
When infant was found:	Time: ____ : ____ Date: ____ / ____ / _____
Position of infant when found:	☐ prone ☐ supine ☐ other
Room found in:	☐ own bedroom ☐ parent's bedroom ☐ living room Other (specify):
Location:	☐ cot ☐ bed ☐ basket ☐ sofa Other (specify):
Circumstances:	Co-sleeping: Clothes: Bed covers: Smoking in room: Heating: Windows / doors:

Body fluids on face / bed:	☐ vomitus ☐ blood ☐ mucous

Infant Name: Date of Birth: ____ / ____ / _____

HISTORY (continued)		
Last feeding:	Time: ____ : ____	By whom:
	☐ breast	
	☐ bottle	
	☐ solids	
	Did child feed normally:	
What prompted carer to check child:	☐ feeding time	
	☐ nappy change	
	☐ crying	
	☐ quiet	
	Other:	
Persons who looked after the infant in the last 12 hours:		
Last seen alive:	Time: ____ : ____	By whom:

Account preceding the event (record verbatim)

What was the reported condition of the infant when found:

Action was taken?
When / who called ambulance?
Who was with infant?
What resuscitation?
Any response?
How long until ambulance arrived?

Symptoms in the last 72 hours:

Feeding:

Recent illness:

Behaviour and sleep:

	Breast / bottle / solids	Volume	Frequency	Additives
Normal feeding pattern:				

SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI)

Time: ____ : _____ Date: ____ / ____ / _____

Infant Name: Name of Doctor:

Date of Birth: ___ / ___ / ____ Grade:

Hospital Number: Signature:

PAST HISTORY

Pregnancy / Delivery:

Gestation:

Birth weight:

APGAR Score/Resuscitation at birth:

Admission to SCBU:

Developmental Progress:

Growth:

Immunisation:

Allergies:

Other:

Last visit to:	Health Visitor:	Date: ___ / ___ / _____	Reason:
	GP visit:	Date: ___ / ___ / _____	Reason:
	A&E Dept:	Date: ___ / ___ / _____	Reason:

Any recent minor injuries not seen by health professionals:

Infant Name: Date of Birth: ____ / ____ / _____

SIBLINGS

Name:	Sex:	Date of Birth:	Residential address (if different to mother)
1. ……..	…..…	___ / ___ / ____	……..…….……..
2. ……..	…..…	___ / ___ / ____	……..…….……..
3. ……..	…..…	___ / ___ / ____	……..…….……..
4. ……..	…..…	___ / ___ / ____	……..…….……..
5. ……..	…..…	___ / ___ / ____	……..…….……..
6. ……..	…..…		……..…….……....

Family tree:

Previous Miscarriages / Stillbirths:

Previous SIDS / ALTE*:

Any significant past medical history:

SOCIAL HISTORY
Complete for mother, current partner, and other adults in house
(e.g. father of other children, grandparents, daytime carer or other household resident)

	Mother	Partner	Other adult
DOB			
Occupation			
Significant medical problems			

**Sudden Infant Death Syndrome / Acute Life Threatening Event*

SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI)	Page 5 of 10
Time: ____ : _____	Date: ____ / ____ / _____
Infant Name:	Name of Doctor:
Date of Birth: ___ / ___ / ____	Grade:
Hospital Number:	Signature:

SOCIAL HISTORY (continued)			
	Mother	Partner	Other adult
Mental health problems			
Domestic violence			
Smoking			
Alcohol *(amount, type and time last taken)*			
Prescription drugs / other drugs *(name & time last taken)*			

OTHER HOUSEHOLD MEMBERS
Details of those living in the household (other than mother, siblings) state relationship (e.g. parent, carer, lodger etc)

Infant Name: Date of Birth: ____ / ____ / _____

DOCUMENTATION OF PHYSICAL EXAMINATION

General appearance:

Rectal Temperature: _____ ^{o}C

State of nutrition and cleanliness:

Visible signs of bleeding or discharge:

Was anything abnormal noted in the mouth at intubation?

Examination:

Spine:

Skull:

Ophthalmic:

ENT:

Chest:

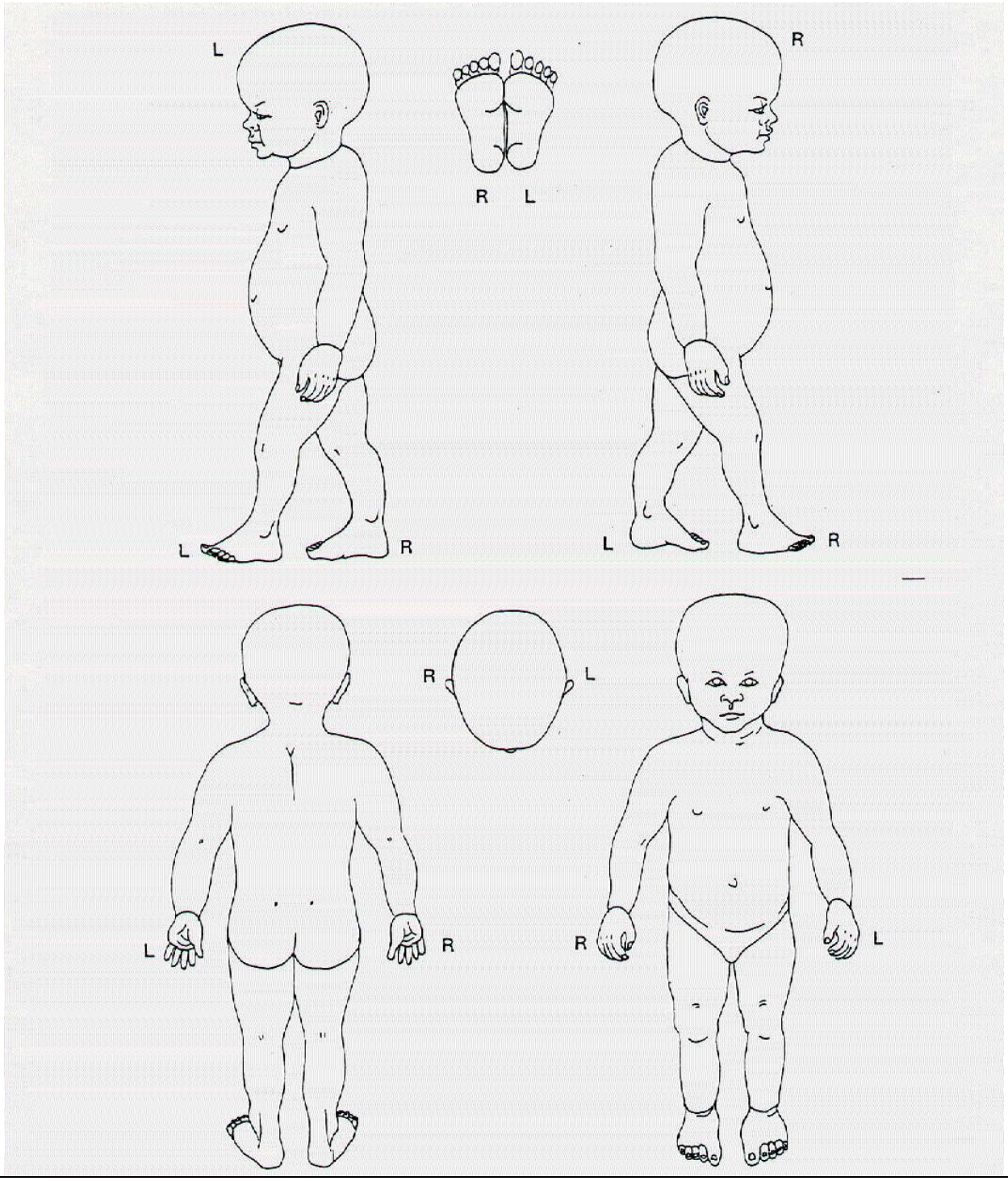
Upper limbs:

Lower limbs:

SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI)	Page 7 of 10
Time: ____ : _____	Date: ____ / ____ / _____
Infant Name:	Name of Doctor:
Date of Birth: ___ / ___ / ____	Grade:
Hospital Number:	Signature:

PHYSICAL EXAMINATION (continued)

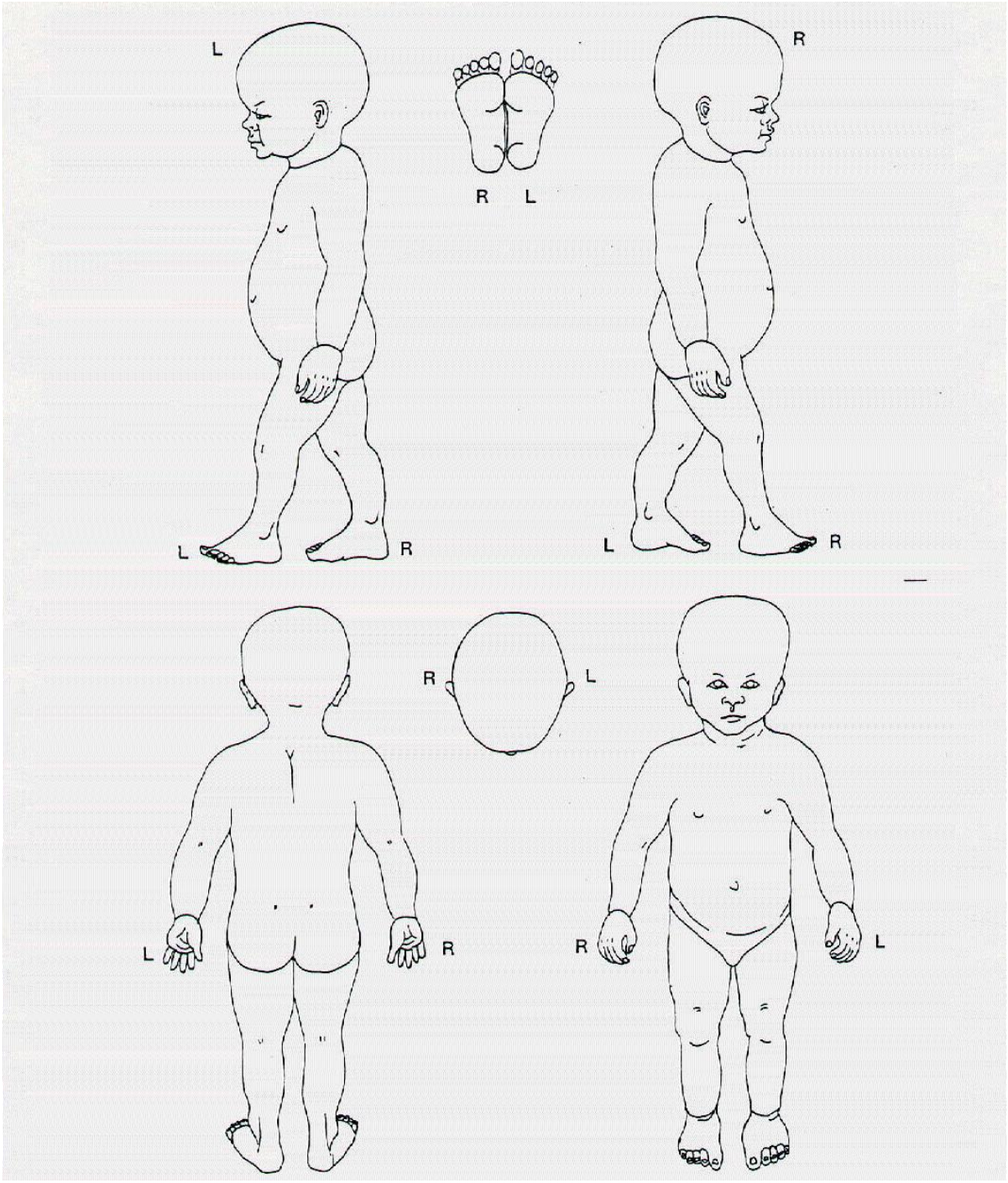
Observe & measure any visible bruises, lacerations or signs of injury



SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI) Page 8 of 10

Infant Name: Date of Birth: ____ / ____ / _____

SITES OF MEDICAL INTERVENTION
Sites of medical intervention (list & mark on body chart)



SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI) Page 9 of 10

Time: ____ : _____	Date: ____ / ____ / _____
Infant Name:	Name of Doctor:
Date of Birth: ___ / ___ / ____	Grade:
Hospital Number:	Signature:

SAMPLES TAKEN (if any)			
Blood culture		Yes ☐	No ☐
Blood Chemistry	U&E	Yes ☐	No ☐
	Glucose	Yes ☐	No ☐
	Liver function tests	Yes ☐	No ☐
	Amino Acids	Yes ☐	No ☐
	MCAD - medium chain Acyl-CoA-dehydrogenase *(Guthrie card)*	Yes ☐	No ☐
EDTA sample	Metabolic screen (Organic & Fatty acids)	Yes ☐	No ☐
	Hb CO (Carboxy Haemoglobin)	Yes ☐	No ☐
	MetHb (Methaemoglobin)	Yes ☐	No ☐
	DNA studies	Yes ☐	No ☐
Drug assay - Opiates, Benzodiazepines, Alcohol, Salicylates, Paracetamol *(5ml clotted blood)*		Yes ☐	No ☐
Swab visible blood *(before cleaning)*		Yes ☐	No ☐
Urine sample *(suprapubic for drugs)*		Yes ☐	No ☐
Photographs of injuries		Yes ☐	No ☐
Lateral x-ray neck for ETT localisation		Yes ☐	No ☐
Direct visualisation of ETT through cords by independent observer		Yes ☐	No ☐
Name: _____ Grade: _____			
Signature: _____			

ADDITIONAL INFORMATION

SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI)	Page 10 of 10
Infant Name:	Date of Birth: ____ / ____ / _____

CONTACT LIST FOR CASE DISCUSSION	
Social Services	Involved in discussion

Name: …… Contact No: …….. Yes ☐ No ☐

Police Senior Investigating Officer

Name: ……..…… Contact No: …….. Yes ☐ No ☐

Community Paediatrician on call

Name: ……..…… Contact No: …… Yes ☐ No ☐

Child's own Paediatrician (Alder Hey or other Trust, if applicable)

Name: ……..……..… Contact No: …….. Yes ☐ No ☐

Bereavement Care Services

Name: ……..…… Contact No: …….. Yes ☐ No ☐

Pathologist

Name: ……..…… Contact No: …….. Yes ☐ No ☐

General Practitioner

Name: ……..…… Contact No: ……. Yes ☐ No ☐

Other (specify) ……..……..……..….

DOCUMENTATION OF SUDI CASE DISCUSSION

Name: Signature:

APPENDIX B – Hospital SUDiC Proforma Medical Record

SUDDEN UNEXPECTED DEATH IN CHILDREN AGED 2 TO UNDER 18 YEARS (SUDC) PROFORMA MEDICAL RECORD	
Time: ____ : _____	Date: ____ / ____ / _____
Name:	Name of Doctor:
Date of Birth: ___ / ___ / ____	Grade:
Hospital Number:	Signature:

A&E CHECKLIST		
Arrival in A&E Department:	Time: ____ : ____	Date: ____ / ____ / _____
Mode of arrival: Accompanied by: Condition of child on arrival: What Cardio-Pulmonary Resuscitation was applied?		
Death certified at:	Time: ____ : ____	Date: ____ / ____ / _____

HISTORY	
History given by:	☐ Mother ☐ Father ☐ Carer ☐ Other (specify) _____ Name: _____ Others present: _____
When child was found:	Time: ____ : ____ Date: ____ / ____ / _____
History of event (including account preceding event and any relevant circumstances / illness / injury):	

Name: Date of Birth: ____ / ____ / _____

HISTORY (continued)

Persons who looked after the child in the last 12 hours:

Last seen alive: Time: ____ : ____ By whom:

SUDDEN UNEXPECTED DEATH IN CHILDREN AGED 2 TO UNDER 18 YEARS (SUDC) *Page 3 of 12*	
Time: ____ : _____	Date: ____ / ____ / _____
Name:	Name of Doctor:
Date of Birth: ___ / ___ / ____	Grade:
Hospital Number:	Signature:

PAST HISTORY

Birth history:

Development:

Significant medical problems:

A&E attendances:

Hospital attendances:

Medication:

Immunisations:

Allergies:

Other:

Professionals involved in child's care:

GP: Name: _____ Date last seen: ___ / ___ / _____
Reason: _____

Health Visitor: Name: _____ Date last seen: ___ / ___ / _____
Reason : _____

School Nurse: Name: _____ Date last seen: ___ / ___ / _____
Reason : _____

Consultants etc: Name: _____ Date last seen: ___ / ___ / _____
Reason: _____
Name: _____ Date last seen: ___ / ___ / _____
Reason: _____

SUDDEN UNEXPECTED DEATH IN CHILDREN AGED 2 TO UNDER 18 YEARS (SUDC) *Page 4 of 12*

Name: Date of Birth: ____ / ____ / _____

RELEVANT FAMILY HISTORY

Previous Miscarriages / Stillbirths:

Previous SIDS / ALTE* / other deaths:

Any significant past medical history:

SOCIAL HISTORY

Mother: Married ☼ Co-habiting ☼ Separated ☼ Other ☼ Length of relationship: _____

Complete the following section for mother, current partner, and other adults in house (eg father of other children, grandparents, daytime carer or other household resident)

	Mother	Partner	Other adult
Name			
DOB			
Occupation			
Significant medical problems *(including mental health problems)*			
Domestic violence			
Smoking			
Alcohol *(amount, type & time last taken)*			
Prescription drugs / other drugs *(name & time last taken)*			

SIBLINGS

Names:	Sex:	Date of Birth:	Residential address *(if different to mother)*
1. _____	____	___ / ___ / ____	_____
2. _____	____	___ / ___ / ____	_____
3. _____	____	___ / ___ / ____	_____
4. _____	____	___ / ___ / ____	_____
5. _____	____	___ / ___ / ____	_____
6. _____	____	___ / ___ / ____	_____

*Sudden Infant Death Syndrome / Acute Life Threatening Event

SUDDEN UNEXPECTED DEATH IN CHILDREN AGED 2 TO UNDER 18 YEARS (SUDC) *Page 5 of 12*	
Time: ____ : _____	Date: ____ / ____ / _____
Name:	Name of Doctor:
Date of Birth: ___ / ___ / ____	Grade:
Hospital Number:	Signature:

DOCUMENTATION OF PHYSICAL EXAMINATION

General appearance:

Rectal Temperature_____ ^{o}C

State of nutrition:

Weight_____ kg

Cleanliness:

Visible signs of injury / bleeding:

Examination:

Ophthalmic:

ENT:

Mouth:

Skull / scalp:

Spine:

Chest:

Abdomen:

Genitalia:

Upper limbs:

Lower limbs:

Name: Date of Birth: ____ / ____ / _____

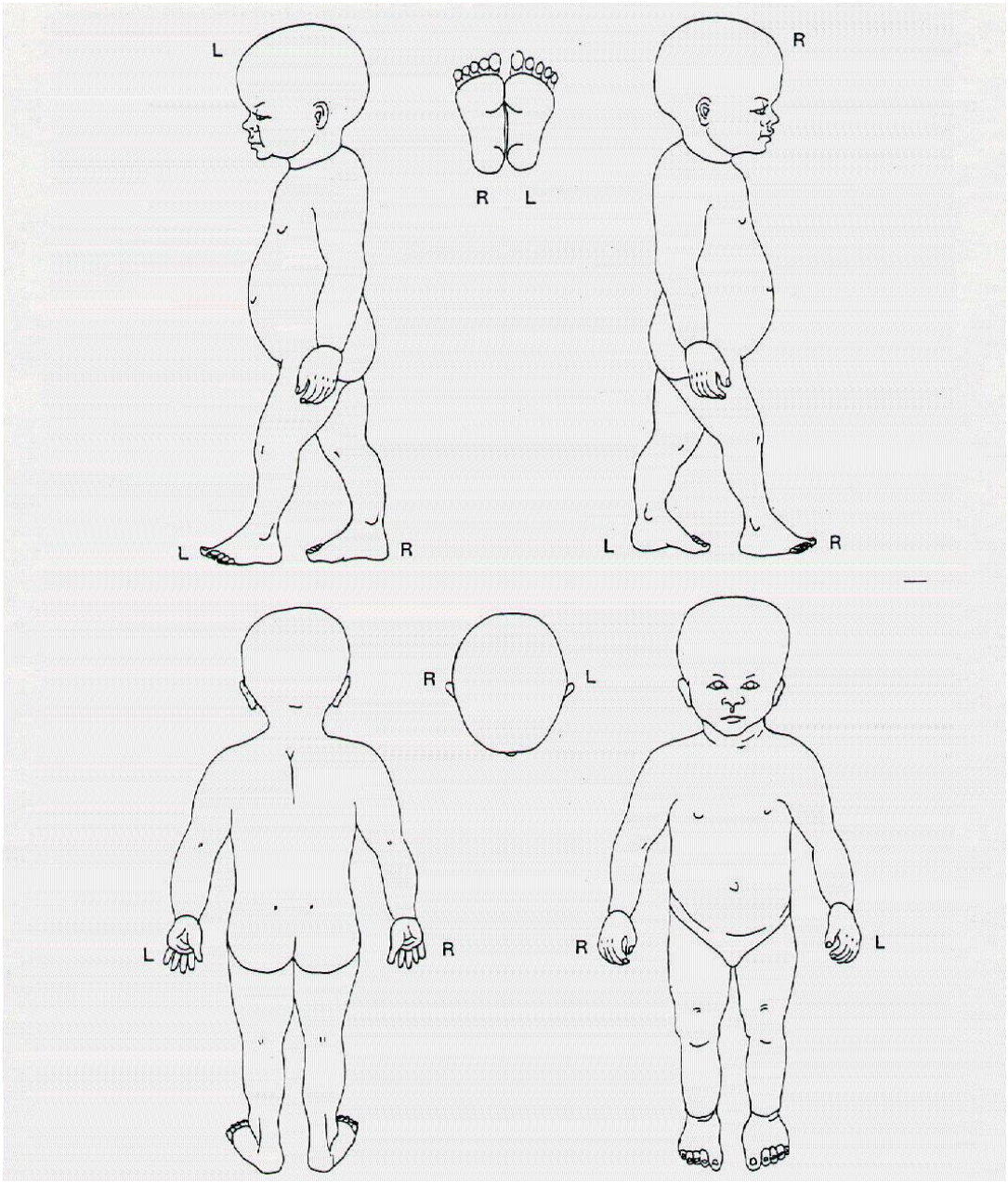
CONTINUATION SHEET

SUDDEN UNEXPECTED DEATH IN CHILDREN AGED 2 TO UNDER 18 YEARS (SUDC) *Page 7 of 12*	
Time: ____ : _____	Date: ____ / ____ / _____
Name:	Name of Doctor:
Date of Birth: ___ / ___ / ____	Grade:
Hospital Number:	Signature:

PHYSICAL EXAMINATION (continued)

Observe & measure any visible bruises, lacerations or signs of injury

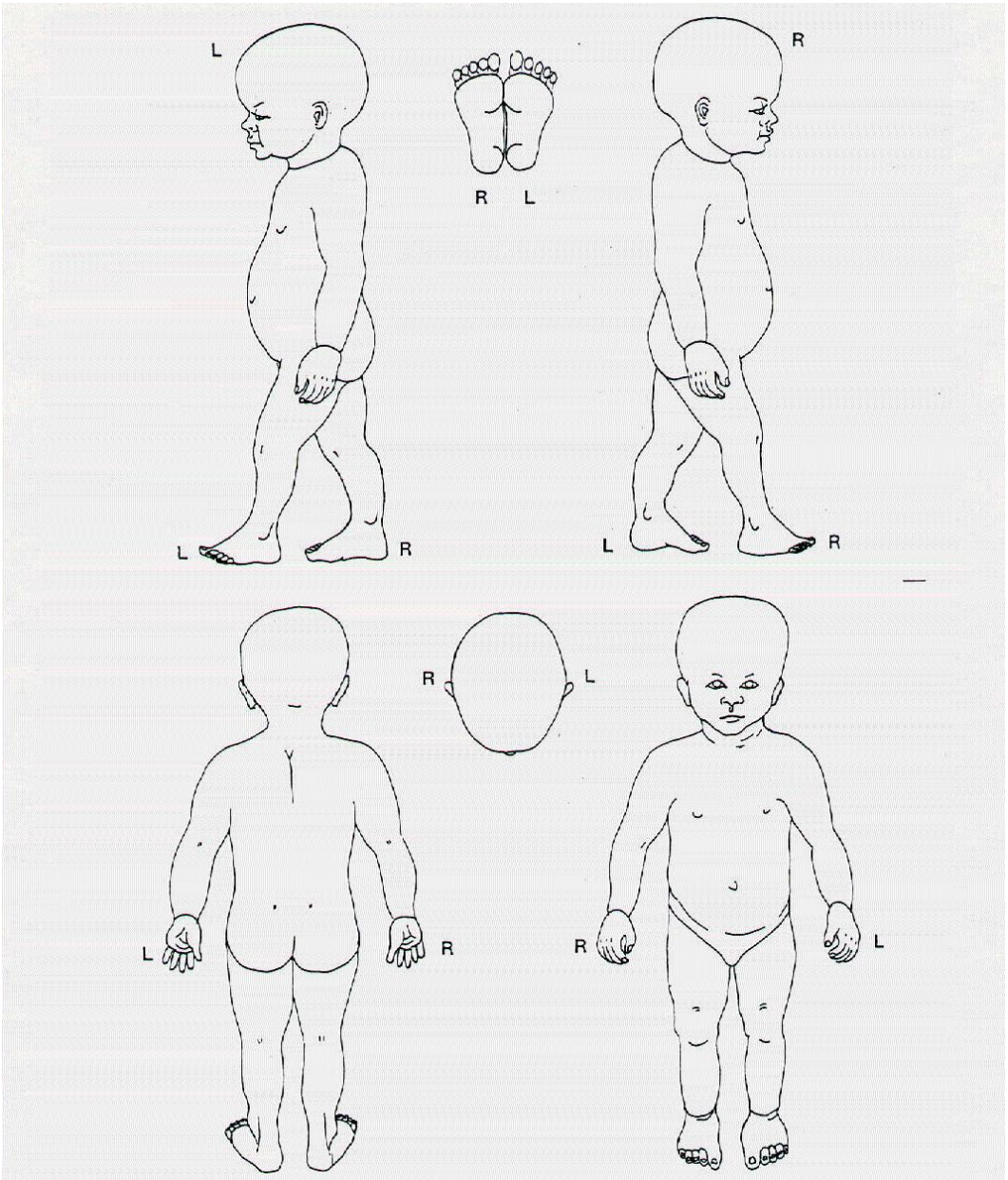
Photographs taken Yes ☐ No ☐



Name: Date of Birth: ____ / ____ / _____

SITES OF MEDICAL INTERVENTION

Sites of medical intervention (list & mark on body chart)

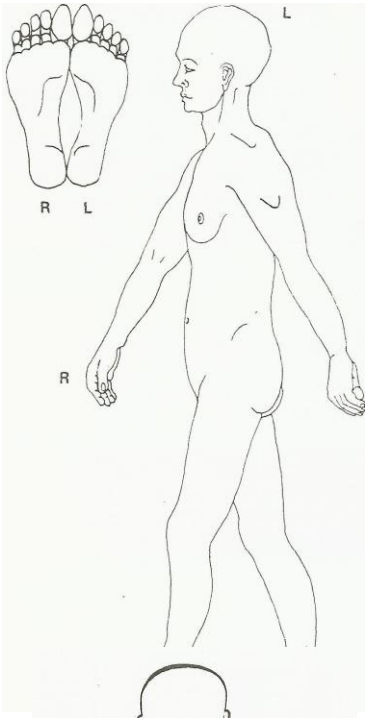


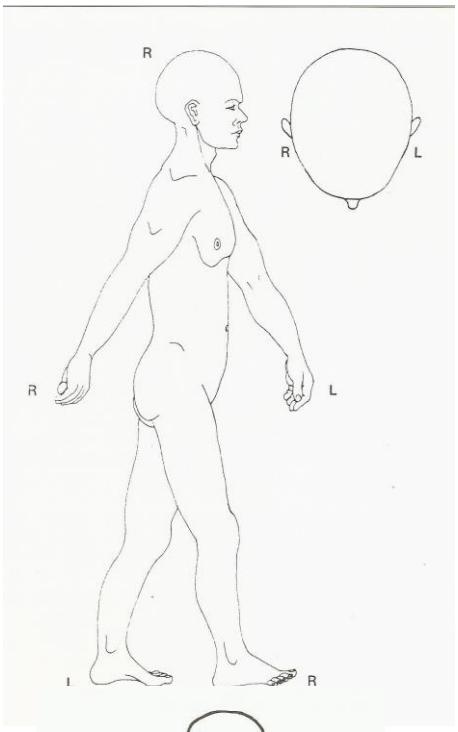
SUDDEN UNEXPECTED DEATH IN CHILDREN AGED 2 TO UNDER 18 YEARS (SUDC) *Page 9 of 12*	
Time: ____ : _____	Date: ____ / ____ / _____
Name:	Name of Doctor:
Date of Birth: ___ / ___ / ____	Grade:
Hospital Number:	Signature:

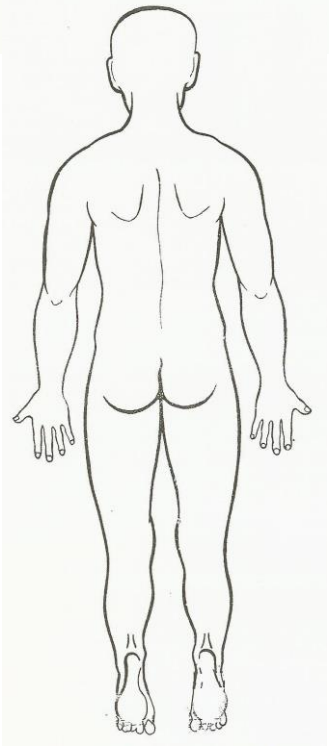
PHYSICAL EXAMINATION (continued)

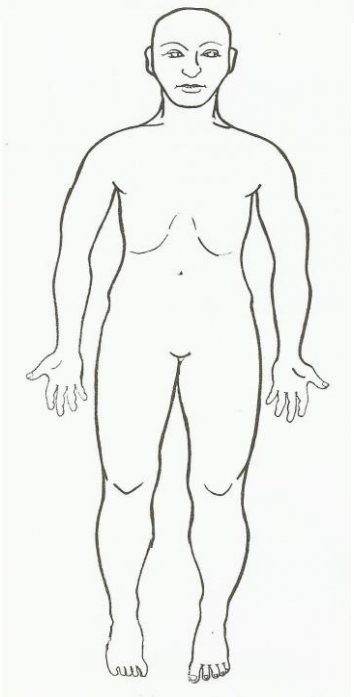
Observe & measure any visible bruises, lacerations or signs of injury

Photographs taken Yes ☐ No ☐





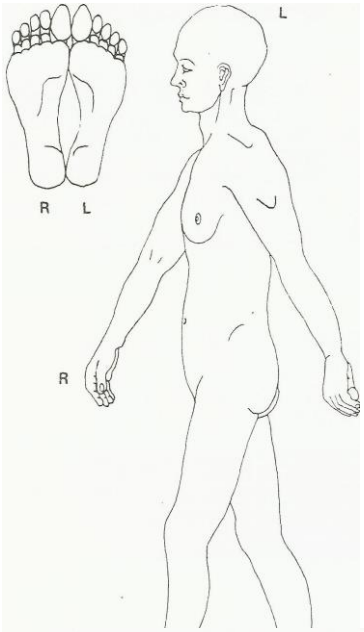


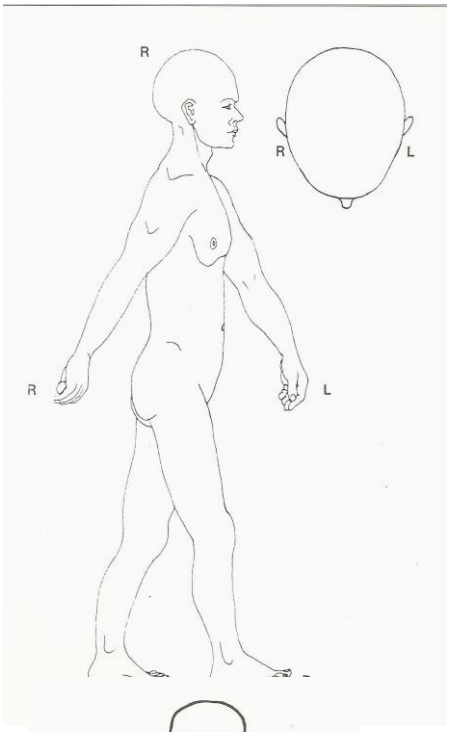


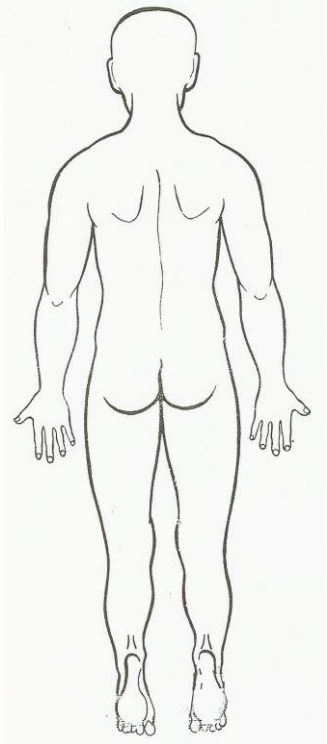
Name: Date of Birth: ____ / ____ / _____

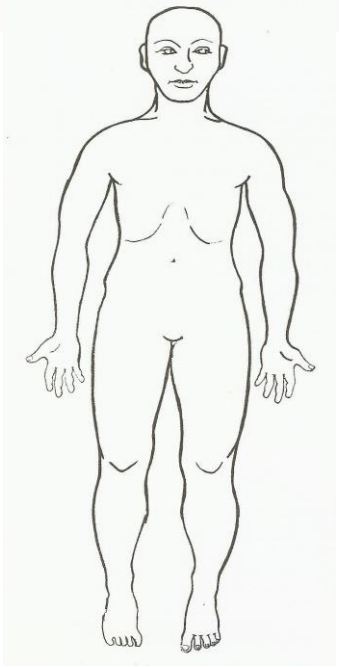
SITES OF MEDICAL INTERVENTION

Sites of medical intervention (list & mark on body chart)









SUDDEN UNEXPECTED DEATH IN CHILDREN AGED 2 TO UNDER 18 YEARS (SUDC) *Page 11 of 12*	
Time: ____ : _____	Date: ____ / ____ / _____
Name:	Name of Doctor:
Date of Birth: ___ / ___ / ____	Grade:
Hospital Number:	Signature:

SAMPLES TAKEN (if any)			
Blood culture		Yes ☐	No ☐
Urine culture		Yes ☐	No ☐
Blood Chemistry	U&E	Yes ☐	No ☐
	Glucose	Yes ☐	No ☐
	Liver function tests	Yes ☐	No ☐
Haematology	FBC	Yes ☐	No ☐
	Blood Group	Yes ☐	No ☐
	Clotting screen	Yes ☐	No ☐
	Other (specify) :		
Drug assay	Blood (5ml clotted blood)	Yes ☐	No ☐
	Urine	Yes ☐	No ☐
	(for Alcohol, Opiates, Benzodiazepines, Salicylates, Paracetamol		
Swab visible blood (before cleaning)		Yes ☐	No ☐
Radiological examination (as appropriate)		Yes ☐	No ☐
_____			
_____			
_____			
_____			
Lateral x-ray neck for ETT localisation		Yes ☐	No ☐
Direct visualisation of ETT through cords by independent observer		Yes ☐	No ☐
Name: _____ Grade: _____			
Signature: _____			
Other investigations:			

Photographs of injuries	Yes ☐	No ☐

ADDITIONAL INFORMATION

SUDDEN UNEXPECTED DEATH IN CHILDREN AGED 2 TO UNDER 18 YEARS (SUDC) *Page 12 of 12*

Name: Date of Birth: ____ / ____ / _____

CONTACT LIST FOR CASE DISCUSSION

Involved in discussion

Social Services
Name: _____ Contact No: _____ Yes ☐ No ☐

Police Senior Investigating Officer
Name: _____ Contact No: _____

Community Paediatrician on call Yes ☐ No ☐
Name: _____ Contact No: _____

Child's own Paediatrician (Alder Hey or other Trust, if applicable) Yes ☐ No ☐
Name: _____ Contact No: _____

Bereavement Care Services Yes ☐ No ☐
Name: _____ Contact No: _____

Pathologist Yes ☐ No ☐
Name: _____ Contact No: _____

General Practitioner Yes ☐ No ☐
Name: _____ Contact No: _____

CAMHS (if applicable) Yes ☐ No ☐
Name: _____ Contact No: _____

Other (specify) _____ Yes ☐ No ☐

DOCUMENTATION OF CASE DISCUSSION

Name: Signature:

APPENDIX C – NOMINATED COMMUNITY PAEDIATRICIAN PROFORMA RECORD

SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI)
NOMINATED COMMUNITY PAEDIATRICIAN PROFORMA RECORD

(Also for use with unexplained Acute Life Threatening Events requiring resuscitation & Intensive Care intervention*)

Infant Name:	Name of Doctor:
Date of Birth: ___ / ___ / ____	Grade:
Hospital Number:	Signature:

CHECKLIST TO BE COMPLETED BY THE NOMINATED COMMUNITY PAEDIATRICIAN

Please refer to the "SUDI proforma medical notes" completed in A&E. Any gaps should be noted and the information completed subsequently after review of the notes & discussion with the Police.

1. **Have hospital records of the child and any siblings been requested?** **YES / NO**
2. **Have Primary Care records of the child and any siblings been requested?** **YES / NO**
3. **Has an interview with the family been arranged for the collection of further information?** **YES / NO**

   Conducted by: ☐Health Visitor ☐Nominated Paediatrician
   Venue: ☐Home ☐Bereavement Suite
   Details: _____

4. **Has a Case Discussion been convened by the Senior Investigating Officer?** **YES / NO**
   (involving the Nominated Paediatrician and Social Services)
5. **Have the decisions made during the strategy discussion been recorded in the proforma medical notes?** **YES / NO**
6. **Has a discussion taken place with the Pathologist who is going to carry out the post mortem to communicate any significant information arising from the strategy discussion?** **YES / NO**
7. **Has the Strategy Meeting been arranged?** **YES / NO**

   Date: ___ / ___ / ____ Time: ____ : ____ Venue: _____
8. **Has information from all medical records been collated for the Strategy Meeting?** **YES / NO**
9. **Have ongoing bereavement support arrangements for the family been discussed with the Bereavement Care Team?** **YES / NO**
   (& any relevant information passed on following the strategy meeting)

CASE DISCUSSION NOTES

Date / Time		Sign
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI)

Infant Name: Date of Birth: ____ / ____ / _____

STRATEGY MEETING / FOLLOW-UP NOTES

Date / Time Sign

Infant Name:	Name of Doctor:
Date of Birth: ___ / ___ / ____	Grade:
Hospital Number:	Signature:

STRATEGY MEETING / FOLLOW-UP NOTES

Date / Time Sign

SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI)

Infant Name: Date of Birth: ____ / ____ / _____

STRATEGY MEETING / FOLLOW-UP NOTES

Date / Time		Sign

APPENDIX D - Health Notification Form

SUDDEN UNEXPLAINED DEATH IN INFANCY (S.U.D.i.C & A.L.T.E.) Notification / Incident Form

This form is to be completed by a health professional when:

a) a child under the age of 18 years dies at home and is taken to an A/E dept.

b) a child under the age of 18 years dies in an A&E dept, maternity unit or paediatric ward

c) a child for whom they have professional responsibility is notified to them as a S.U.D.i.C / A.L.T.E

Name of Child	Date of Birth	Date of Death	Time of Death

Home Address	**Address Child Found**
Tel.	Tel.

Name of Mother	**Name of Father**	**Name of Main Carer** (If different from parents)
D.o.b	D.o.b	Relationship:

Professionals Involved With The Family:

Name	Discipline	Contact Details
GP -	N/A	
HV/ School Nurse	N/A N/A	
Other		

Details of circumstances surrounding child death: _____

_____

_____

_____

_____

Details of professionals involved in the SUDiC, if known:

	Name	Contact details
Police S.I.O		
Com. Paediatrician		
SW Team Manager		

Are the circumstances thought to be suspicious (please delete) YES / NO

Was the child transferred to Alder Hey Hospital (please delete) YES / NO

Date of S.U.D.i.C Strategy Meeting: _____ Time: _____

Venue of Meeting: _____

Name & Signature: _____ Date: _____

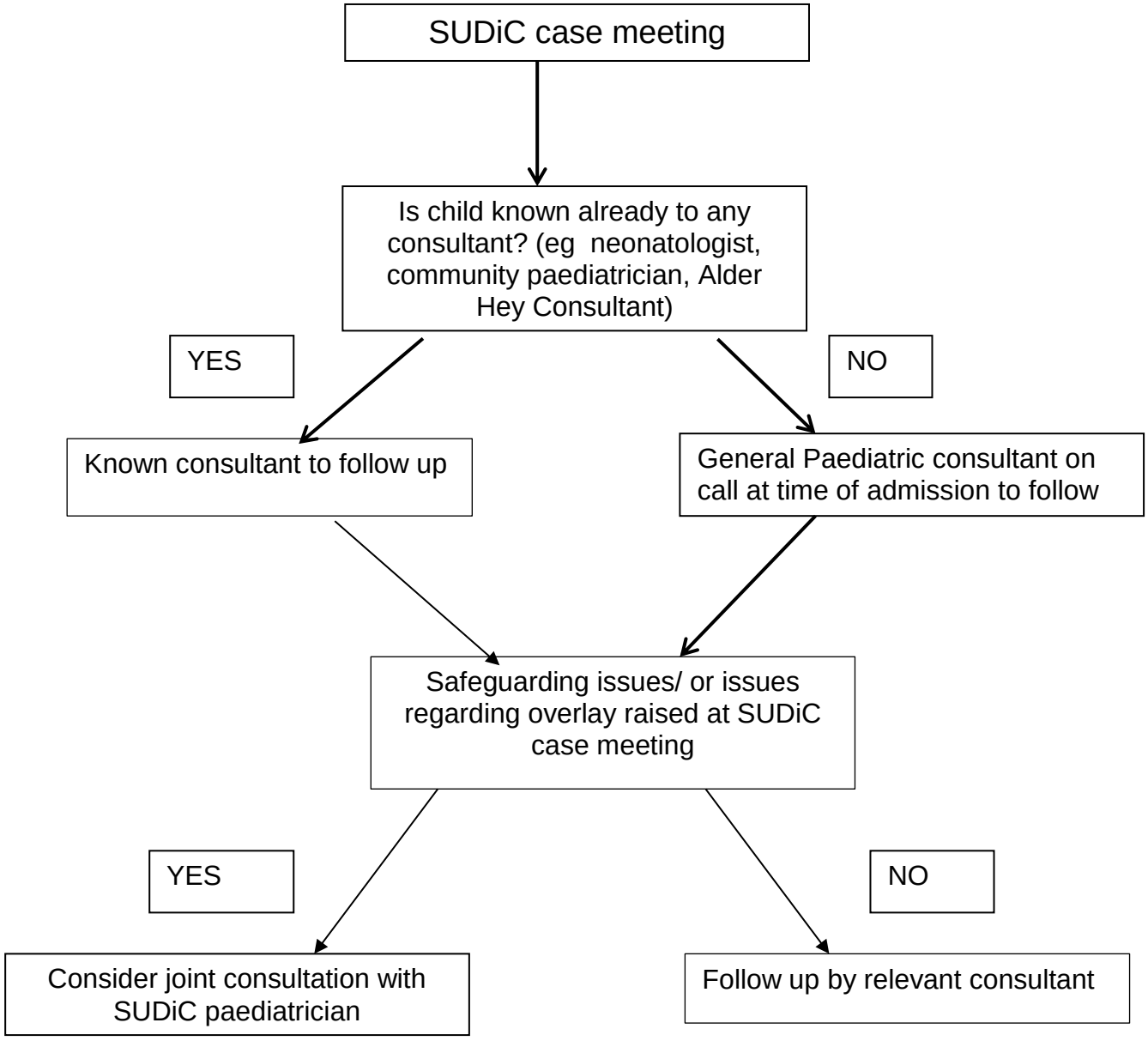
Designation: _____ Base: _____ Tel: _____

This form to be faxed to (please see separate fax list for details.):

- The Designated Nurse and Doctor **for the area** who will notify: the relevant DPH and Senior Manager for notification to the SHA, and the Police Public Protection Unit fax 0151 777 4782

APPENDIX E - SUDiC Follow Up Flowchart – Wirral

Follow Up of SUDiC Families

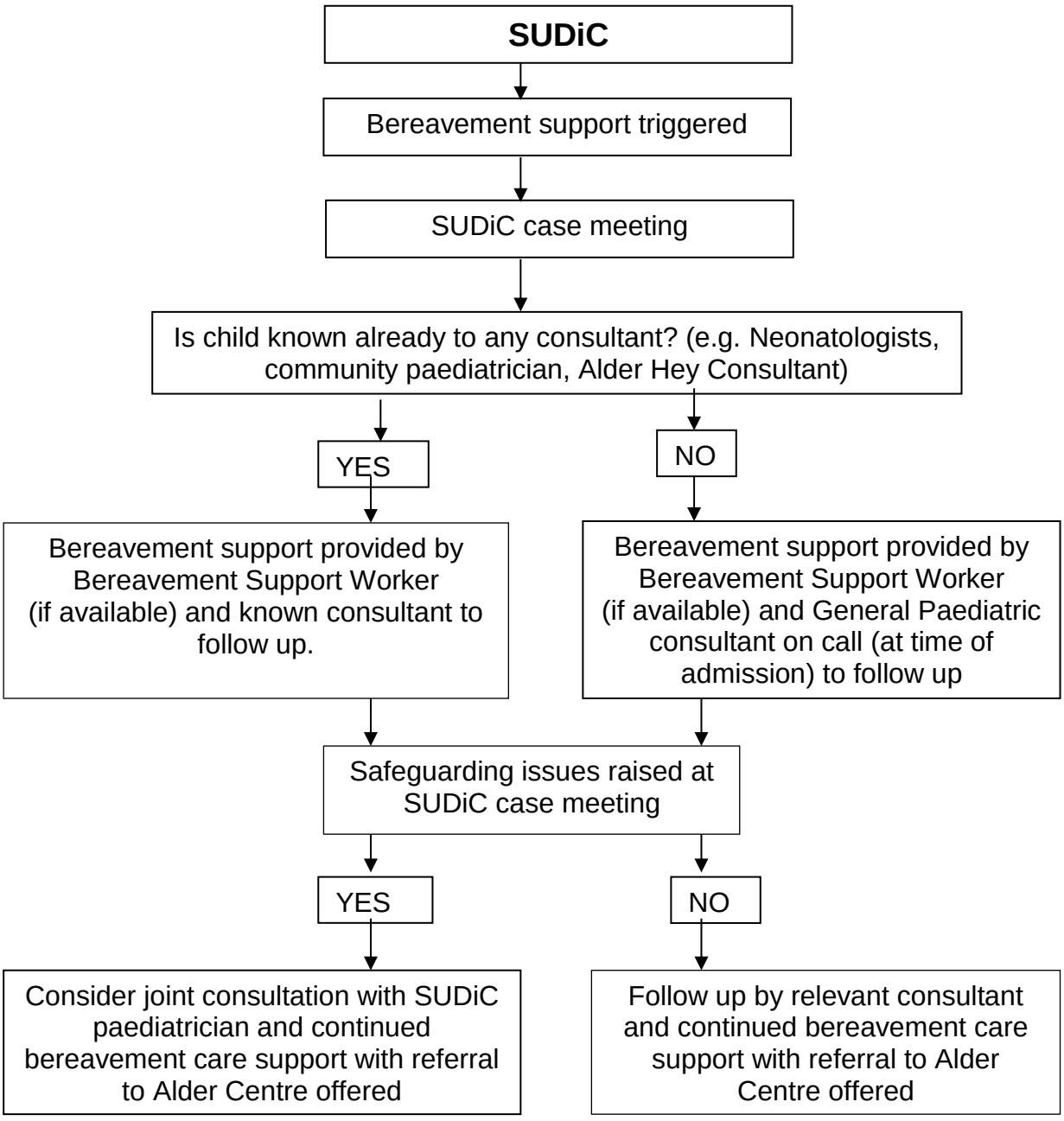


Notes

- CDOP paediatrician or named nurse for safeguarding will attend SUDiC case meeting and will then contact relevant paediatrician to arrange follow-up.
- Minutes of SUDiC case meeting to be forwarded to relevant consultant.
- Relevant social information to be passed on eg is it appropriate to see parents together or separately?
- Follow up usually to be offered at around 6 weeks following death however SUDiC panel to advise if FU required sooner

APPENDIX F – SUDiC Follow Up Flowchart – Merseyside except Wirral

Bereavement Support for SUDiC Families



Notes

- CDOP paediatrician and/or named nurse for safeguarding will attend SUDiC case meeting and will then contact relevant paediatrician to arrange follow-up.
- Minutes of SUDiC case meeting to be forwarded to relevant consultant.
- Relevant social information to be passed on to relevant Consultant and BCS (eg is it appropriate to see parents together or separately?)
- Follow up usually to be offered at around 6 weeks following death however SUDiC panel to advise if follow up required sooner

APPENDIX G

CONSENT FORM FOR BLOOD/URINE TESTING

You have been asked to provide a voluntary sample of blood for analysis. This is a routine part of the investigation process.

The sample will be screened for alcohol and drugs. If the test results show considerable amounts of substances within your blood this may be used against you in criminal proceedings and/or family court proceedings.

In exceptional circumstances or, in the event that blood cannot be taken, a urine sample may be given.

I have read the above and have had it explained to me and I agree to provide a sample.

Signature ……

Date/Time……..

APPENDIX H

MERSEYSIDE POLICE CHECK LIST

Post Mortem

It is the role of the senior detective to attend the post-mortem examination and to fully brief the pathologists with the following:-

a. A copy of the completed medical pro-forma.

b. Continuity / sequence of all events leading to the death, preferably with photographs / video with the following information:-

- The position in which the baby was found and, if co-sleeping, the position in relation to the co-sleeper(s);
- The child's clothes;
- Details of the bedding;
- Room temperature and type of heating;
- Any history of smoking / alcohol consumption / drug use in the house with details of amounts and timing;
- Time of last feed including details of food given by whom and when.

c. Copy case notes of obstetric and paediatric period.

d. Copy of GP record.

e. Copy of ambulance attendance sheet.

f. Details of any resuscitation including by whom and when.

g. List of investigations initiated or samples taken by the A&E Doctors and any results when available.

When dealing with SUDiC all agencies need to follow 5 common principles, especially when having contact with the family:

- Adopt a sensitive, open-minded, balanced approach;
- An inter-agency response;
- Appropriate sharing of information;
- Appropriate response to the circumstances;
- Preservation of evidence.

Further reading - available on the intranet

ACPO Guidelines on SUDI
Merseyside Joint Agency SUDiC Protocol 2015
Police Visual Handbook

Investigators Check List

- ✓ If first on scene liaise with Paramedics, make a visual check of child and scene, note visible injuries and establish original position and current position of child.
- ✓ Follow “Golden Hour” principles.
- ✓ Identify scene(s) and parameters.
- ✓ Note the location of any objects proximal to the body of the child, which may have some relevance and preserve them in situ.

- ✓ Establish family tree.

- ✓ Prepare a ‘timeline’ of movement of the infant, parent(s) / carer(s) over previous 24 hours (including all present and siblings).

- ✓ Record temperature of the scene.

- ✓ List all people present at scene and, if possible, note the clothing worn by people at the scene other than professionals.

- ✓ Note general hygiene and availability of food and drink (neglect issue).

- ✓ CSI to video / photograph the scene.

- ✓ Record parent(s) / carer(s) current demeanour, include details of alcohol, tobacco, drugs, medication taken and when.

- ✓ Obtain and record early account from parent(s) / carer(s) and include:-
    - Medical history of the child and family including previous infant death;
    - Medication prescribed / administered to the infant (seize);
    - Where infant was, sleeping position and clothing worn;
    - When last fed, by whom and food content. Seize if possible;
    - When nappy last changed and by whom. Seize if possible;
    - Health and demeanour of child 48-72hrs prior to death;
    - Last seen alive and by whom;
    - What caused adult to look / check on infant.

- ✓ Complete Form 97 and forward to Coroners Officer ASAP.

- ✓ Request blood samples from the parent(s) / carer(s) using the consent to blood / urine testing form. APPENDIX G SUDiC Protocol 2015.

- ✓ Detective inspector to co-ordinate Strategy Discussion / Meeting.

APPENDIX J

SUDiC Strategy Discussion Proforma

DISCUSSION DETAILS	
Date of discussion:	

CHILD / YOUNG PERSON'S DETAILS			
Family Name: Forename:			
Date of Birth: Date of Death:		Gender:	
Address:		Telephone No:	

SIBLING(S) DETAILS	
Family Name: Forename: DOB:	
Family Name: Forename: DOB:	
Family Name: Forename: DOB:	
Family Name: Forename: DOB:	

PARENT 1 DETAILS			
Family Name:		Forename:	
DOB:		Gender:	
Address:		Telephone No:	

PARENT 2 DETAILS			
Family Name:		Forename:	
DOB:		Gender:	
Address:		Telephone No:	

Agencies involved in strategy discussion			
Name	**Agency**	**Role**	**Telephone Number**

Record of discussion:

Actions:	Responsible:	Timescale:

APPENDIX K: SUDiC Monitoring Form

MERSEYSIDE SUDiC MONITORING FORM (revised 23.10.2014)

This form should be completed by the Chair of the initial SUDiC strategy meeting and returned via secure **email** to irene.wright@liverpool.gcsx.gov.uk

Local Authority	
Child's Unique CDOP number	
Home Postcode/Ward	
Place Where Child Died	
Name of Person Completing Form	
Date Completed	
Contact number	

CHILD'S DETAILS:

Brief circumstances of child's death	

1) DoB:						
2) DoD:						
3) Gender						
4) Ethnicity:						
5) Multiple birth	(select)	How many siblings in family?		What number is child?		
6) Birth Weight:		lb & oz		g		
7) Gestation:		Weeks				

8) Feeding Method	a) Breast	☐
	b) Bottle	☐
	c) Mixed Feeding	☐
	d) Other (please specify)	

9) Sleeping Position	a) Front	☐
	b) Back	☐
	c) Other (please specify)	

10) Sleeping place:	a) Cot	☐
	b) Moses Basket	☐

	c) Sharing Bed	☐
	d) Sharing couch/chair	☐
	e) Other (please specify)	

11) Existing medical condition/s:	
12) Medication:	

MOTHER						
Age:						
Ethnicity:						
Smoker:	Y	☐	N	☐	N/K	☐
Alcohol Use:	Y	☐	N	☐	N/K	☐
Drugs/illicit substance use:	Y	☐	N	☐	N/K	☐
Domestic Violence:	Y	☐	N	☐	N/K	☐
Prescribed/over the counter medication use:	Y	☐	N	☐	N/K	☐
Mental health issues:						

FATHER						
Age:						
Ethnicity:						
Smoker:	Y	☐	N	☐	N/K	☐
Alcohol Use:	Y	☐	N	☐	N/K	☐
Drugs/illicit substance use:	Y	☐	N	☐	N/K	☐
Domestic Violence:	Y	☐	N	☐	N/K	☐
Prescribed/over the counter	Y	☐	N	☐	N/K	☐

medication use:						
Mental health issues:						

OTHER ADULT						
Age:						
Ethnicity:						
Smoker:	Y	☐	N	☐	N/K	☐
Alcohol Use:	Y	☐	N	☐	N/K	☐
Drugs/illicit substance use:	Y	☐	N	☐	N/K	☐
Domestic Violence:	Y	☐	N	☐	N/K	☐
Prescribed/over the counter medication use:	Y	☐	N	☐	N/K	☐
Mental health issues:						

OTHER ADULT						
Age:						
Ethnicity:						
Smoker:	Y	☐	N	☐	N/K	☐
Alcohol Use:	Y	☐	N	☐	N/K	☐
Drugs/illicit substance use:	Y	☐	N	☐	N/K	☐
Domestic Violence:	Y	☐	N	☐	N/K	☐
Prescribed/over the counter medication use:	Y	☐	N	☐	N/K	☐
Mental health issues:						

APPENDIX L – Initial Strategy Meeting Agenda

Sudden Unexpected Death in Childhood (0-18 years)

Agenda for Initial Strategy Meeting

Professionals invited should make every effort to attend or provide details via a written report or discussion with the Chair beforehand. The protocol can be used for circumstances where there are concerns relating to an ALTE (Acute Life Threatening Event).

Every strategy meeting held should confirm the following at the start of the meeting:

- Family details with names and dates of birth identifying clearly the deceased infant or child and their date of death;
- Address of mother, father, siblings
- Details of any significant others
- Ethnicity; gender; any disabilities of family members

Agenda Items

1. Introductions and Apologies

2. Information relating to the SUDiC

3. Details of strategy discussion: date, time; agreed action plan and agency participants;
   initial investigation outcome; photographic evidence of scene (not child) available

4. Were blood tests from parents/supervising adults requested and if so what was the outcome?

5. Background information for the child, family and significant others: *this should include health prior to any incident; history of any safeguarding issues relating to the infant/child or any other family members*

6. Current or previous involvement with agencies/services: specify which agency/services, in what capacity and with whom: *obtain a summary of the extent of involvement*

7. Consideration of safeguarding issues for surviving children

8. Results of post mortem (interim as appropriate); testing progressed; briefing of Pathologist regarding strategy discussion

9. Contact with Coroner

10. Summary of information

11. Plan of investigation: s17/s47/criminal investigation/scene management/statements/

interviews/consideration for Serious Case Review Process.

12. Restrictions on viewing the infant/child's body: any amendments required

13. Co-ordination of professionals' contact with the family: specify who, what and when: consider follow up meeting with Consultant/ Community Paediatrician

14. Support strategy for bereaved family: specify who, what and when. Consider FLO/bereavement support worker/social worker/health practitioner/school-education

15. Agreed information to be fed back to family: what, by whom and when

16. Staff welfare

17. Press strategy

18. Review date: set for 8-16 weeks from initial meeting, convene as an interim if necessary, when a further final date should be set

COMPILE AGREED ACTION PLAN AND TIMESCALES

SUDiC Strategy Meeting Chair needs to ensure that copies of strategy meeting notes are sent to the Coroner; LSCB; and CDOP within 10 working days and that the SUDiC monitoring form is completed and returned to Irene Wright at lscbteam@liverpool.gcsx.gov.uk

APPENDIX M - Review Strategy Meeting Agenda

Sudden Unexpected Death in Childhood (0-18 years)

Agenda for Review Strategy Meeting

Professionals invited should make every effort to attend or provide details via a written report or discussion with the Chair beforehand.

Agenda Items

1. Introductions and apologies
2. Information relating to the progress of the SUDiC action plan including progress of investigation and results of any tests pursued
3. Feedback on progress of any other investigations undertaken eg s47, criminal
4. Feedback regarding contact with Consultant/Community Paediatrician
5. Information relating to bereavement support and the wellbeing of family members
6. Contact with Coroner and status of Inquest
7. Summary of progress and any outstanding issues
8. Confirm ongoing support strategy for bereaved family and others if required:
9. Agreed information to be fed back to family: what, by whom and when
10. Staff welfare
11. Press strategy
12. Review date: if the current meeting is deemed an interim and a further review strategy is felt necessary

COMPILE AGREED ACTION PLAN AND TIMESCALES

SUDiC Strategy Meeting Chair needs to ensure a copy of the review strategy meeting notes are sent to the Coroner; LSCB; and CDOP (lscbteam@liverpool.gcsx.gov.uk) within 10 working days.

APPENDIX N - Agency Invitation List

AGENCIES TO BE INVITED TO SUDiC STRATEGY MEETINGS FOR 0-2 YEARS

- Consultant Paediatrician or colleague presenting information relating to child death
- Hospital Named Nurse and/or Safeguarding Children Specialist Nurse
- Merseyside Police: SIO or representative
- Bereavement Services
- Maternity Hospital – Midwifery Services
- Health Visitor and Safeguarding Children Specialist Nurse
- Any agencies involved with the family:
  Potential agencies:
  - Children's Centre/Nursery
  - School
  - Merseycare
  - Drug/Alcohol Services
  - Voluntary Agency
  - Housing representative if appropriate
  - Merseyside Probation
  - Any agency known to be involved with the family

FOR 2-18 YEARS:

- Remove MATERNITY HOSPITAL unless appropriate to include based on circumstances
- Include EDUCATION
- Include SCHOOL HEALTH and SAFEGUARDING CHILDREN SPECIALIST NURSE
- Consider YOUTH OFFENDING SERVICE

APPENDIX P: PROFORMA FOR RECORDING INITIAL STRATEGY MEETINGS (available as a word document)

CONFIDENTIAL

SUDDEN UNEXPECTED DEATH IN INFANCY/CHILDHOOD INITIAL STRATEGY MEETING

Minutes of Meeting held on (date/time)
In (venue)

Present:

Apologies:

Minutes:

Family Composition:

Name of child:
Gender:
Date of birth:
Date and time of death:
Address:
Ethnicity/Disabilities:

Mother's name:
Mother's date of birth:
Mother's address (if different from above):
Ethnicity/Disabilities:

Father's name:
Father's date of birth:
Father's address (if different from above):
Ethnicity/Disabilities:

Sibling's name:
Sibling's date of birth:
Sibling's address (if different from above):
Ethnicity/Disabilities:

Significant family member's name:
Significant family member's date of birth:
Significant family member's address (if different from above):
Ethnicity/Disabilities:

	Agenda Item	Action
1.	**Introductions and Apologies**	
2.	**Information relating to the SUDI/SUDC including photographic evidence of the scene**	
3.	**Details of strategy discussion, date; time; agreed action plan and agency participants; initial investigations outcome**	
4.	**Were blood tests from parents/supervising adults requested and if so what was the outcome?** **If blood tests were refused were urine tests requested**	
5.	**Background information for the child, family and significant others** (this should include health prior to any incident, history of any safeguarding issues relating to the infant/child or any other family members)	
6.	**Current or previous involvement with agencies/services: specify which agency/services, in what capacity and with whom** (obtain a summary of the extent of involvement)	
7.	**Consideration of safeguarding issues for surviving children**	
8.	**Results of post mortem (interim as appropriate); testing progressed; briefing of Pathologist regarding strategy discussions**	

9.	**Contact with Coroner**	
10.	**Summary of information**	
11.	**Plans of investigations: s17/s47/criminal investigations/scene management/statements/interviews/consideration for Serious Case Review Process**	
12.	**Restrictions on viewing the infant/child's body: any amendments required**	
13.	**Co-ordination of professionals contact with the family: specify who, what and when: consider follow up meeting with Consultant/Community Paediatrician**	
14.	**Support strategy for bereaved family: specify who, what and when. Consider FLO/bereavement support worker/social worker/health practitioner/school-education**	
15.	**Agreed information to be fed back to family: what, by whom and when**	
16.	**Staff welfare**	

17.	**Press strategy**	
18.	**Review date** (set for 8-16 weeks from initial meeting, convene as an interim if necessary, when a further final date should be set)	
19.	**Referral for Serious Case Review Consideration** Does the information relating to this child death require consideration by the Critical Incident Group/Serious Incident Review Group? If so, the relevant LSCB procedures for notification to CIG/SIRG should be followed.	

Name
Designation

ACTION PLAN

	Action	By Whom	Timescale	Outcome
1.				
2.				
3.				
4.				
5.				
6.				
7.				

APPENDIX Q

Notification of Child Death

Notification to be reported to CDOP administrator at:

Secure email:

Tel:

Please remember it is a statutory requirement to notify CDOP of all child deaths from birth up to their 18th birthday. If there are a number of agencies involved, liaison should take place to agree which agency will submit the Notification. However, unless you know someone else has done so, please notify CDOP with as much information as possible.

Sentinel Number	
Merseyside Number	
NCMD Number	

Referral details:

Date of referral	
Name of referrer	
Agency	
Address	
Tel Number	
Email	
Has this death been reported as a serious incident	Yes/No/Not known
Has this death been referred to HSIB	Yes/No/Not known

Child's details:

Full name of child				
Any aliases				
Gender	☐ Male	☐ Female	☐ Other	☐ Unknown
DOB / Age				
Gestational age at birth:	Number of completed weeks: Number of completed days:			

NHS No.	
Address	
Postcode	
Ward	
Name of school/nursery	

What was the child's ethnic group?	White: ☐ British ☐ Irish ☐ Any other White background
	Mixed: ☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Any other mixed background
	Asian or Asian British: ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Any other Asian background
	Black or Black British: ☐ African ☐ Caribbean ☐ Any other Black background
	Other ethnic group: ☐ Chinese ☐ Any other ethnic group
	☐ Not known/ not stated

Mother's details:

Name	
Surname	
DOB / Age	
NHS No.	
Address	

Occupation (please specify if high risk occupation e.g. health care professional, First responder, care worker)	

Other significant household and family members (parents, siblings, other relevant adults):

Name	**DOB**	**Relationship**	**Address**	**Occupation** (please specify if high risk occupation e.g. health care professional, First responder, care worker)

Death details:

Date of death	
Time of death	
Where was the child when they died? [1](please include name of hospital if relevant)	
Suspected cause of death	
What was the mode of death?	☐ Planned palliative care ☐ Withholding, withdrawal, or limitation of life-sustaining treatment) ☐ Brainstem death ☐ Unsuccessful cardio-pulmonary resuscitation ☐ Found dead ☐ Not known
Was this child known or suspected to have been exposed to COVID-19 in the two	☐ Yes ☐ No ☐ Not known

[1] The place where the child is believed to have died regardless of where death was confirmed. Where a child is brought in dead from the community and no signs of life were recorded during the resuscitation, the place of death should be recorded as the community location; where a child is brought in to hospital following an event in the community and is successfully resuscitated, but resuscitation or other treatment is subsequently withdrawn, the place of death should be recorded as the location within the hospital where this occurs

weeks before death? (Please also answer this question for babies who may have been exposed in utero)	
If **yes**, please give details of known or suspected exposure	
Did this child show symptoms of COVID-19 in the two weeks before death? e.g. fever, dry cough, wet cough, fatigue, shortness of breath, sore throat, headache, myalgia, arthralgia, rigors, nausea, vomiting, nasal congestion, diarrhoea, haemoptysis, conjunctival congestion	☐ Yes ☐ No ☐ Not known
If yes, please describe the child's symptoms in as much detail as possible and include duration of symptoms and time between symptoms and presentation	
Had this child been tested for COVID-19 at any point?	☐ Yes – tested during life ☐ Yes – tested after death ☐ Yes – tested at post-mortem ☐ No ☐ Not known
If yes, what was the result of the test?	☐ Positive ☐ Negative ☐ Not known
In the case of neonatal / infant death, was the mother tested for Covid-19?	☐ Yes – tested Positive ☐ Yes – tested Negative ☐ Not tested ☐ Not known
Did this child require respiratory support and	☐ Yes ☐ No

/ or intubation at any point?	☐ Not known
If yes, what was the highest level of respiratory support required?	☐ Oxygen ☐ High flow O2 ☐ CPAP ☐ BIPAP ☐ Invasive conventional ventilation ☐ HFOV ☐ ECMO ☐ Other ☐ Not known
Did this child have a chronic respiratory problem? *(please tick all that apply)*	☐ Asthma ☐ Cystic Fibrosis ☐ Chronic Lung Disease of Prematurity ☐ Other, please specify: ☐ No, this child did not have a chronic respiratory problem ☐ Not known
Did this child have any other co-morbidities? *(please tick all that apply)*	☐ Diabetes ☐ Cardiac disease ☐ Neurological/neuromuscular condition (including cerebral palsy) ☐ Genetic syndrome ☐ Malignancy ☐ Immunocompromised ☐ Other, please specify: ☐ No, this child did not have any other co-morbidities ☐ Not known
Was this child known to be a smoker?	☐ Yes, tobacco cigarettes ☐ Yes, vaping ☐ Other - specify ☐ No ☐ Not known☒ Not applicable
Were any significant family members in the house known to be smokers?	☐ Mother ☐ Father ☐ Other significant adult ☐ Sibling

	☐ Not known
Was the infant breastfed before the illness?	☐ Yes ☐ No ☐ Not known ☐ Not applicable

Case management:

Is there to be a Joint Agency Response?	☐ Yes ☐ No ☐ Not known
Death discussed with the medical examiner?	☐ Yes ☐ No ☐ Not known
Death to be investigated by Coroner?	☐ Yes ☐ No ☐ Not known
Post mortem examination?	☐ Yes ☐ No ☐ Not known

Notification details:
Please outline the circumstances leading to notification. Also include if any other review is being undertaken (e.g. internal agency review); and whether any immediate action is being taken as a result of this death. **Please include as much detail as possible of any characteristics of infection that the child displayed in the weeks leading up to death.**

As above

Case alert:

Was there any cause for concern about any element in the child's environment or circumstances of death where action is required for urgent learning?

☐ Yes (if yes, please give details including the name and brand of any product if known)

☐ No

Below are some examples of what to include in response to this question. This list is not exhaustive and is included for guidance only. Please use this to alert the NCMD team of any issue of concern to you.

- *Presence of known or suspected Covid-19 in this child or someone they may have had contact with*
- *Concerns about the functioning of medical equipment e.g. pumps, syringe drivers, wheelchairs, sleep systems, orthotics*
- *Concerns about any product e.g. nappy sacks, blind cords, apnoea monitors, car seats, sleep positioning devices, swaddling devices, play equipment*
- *Concerns about specific medications*
- *Concerns regarding clusters of similar deaths known to you*

Details of relevant agency contacts (please give as much information as you have easily available to you):

Agency	**Name and contact details**	√ **Lead Professional** (only one tick is required)
Community Paediatrician		☐
Local Paediatrician/ Neonatologist		☐
Tertiary Paediatrician/ Neonatologist		☐
Other local or tertiary specialists		☐
GP		☐
Midwife		☐
Health Visitor		☐
School Nurse		☐
Obstetrician		☐
Police – Collision Investigation Unit or Child Protection		☐
Children's Social Care		☒
Nursery/School/College/or Local Education Authority		☐
Others (list all agencies known to be involved)		☐

The clinical members of the NCMD team may need further information or follow up on some of the information provided. Please confirm your permission for the team to contact you by email or phone if required by completing the section below.

☐ Yes, I give permissions to the NCMD clinical team to contact me by email and my email address is: …….

☐ Yes, I give permissions to the NCMD clinical team to contact me by phone and my telephone number is: …….

☐ No, I do not wish to be contacted by the NCMD clinical team

Details of a person who can be contacted for further information:

Name of contact	
Agency	
Address	
Tel Number	
Email	

Please send completed forms to:
CDOP Team,
1st Floor, Gerard Majella Courthouse
Boundary Street
Liverpool L5 2QD

Irene.wright@liverpool.gov.uk

Telephone number: 0151 233 1151/5412 / 07739 703929

APPENDIX R

Merseyside SUDiC Protocol

Immediate action to be taken if the HV/SN is first on the scene

1. Dial 999 and ask for an Ambulance to attend the scene immediately.

2. Attempt resuscitation if trained or as instructed by the Ambulance Service.
If the indications are that the infant /child is dead and no active resuscitation has been attempted, the body should remain in situ pending the arrival of the Police.

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

4. When the Paramedics arrive, spend time listening to the parent/care offering support.

5. If the parent/ carer goes to the hospital with the infant / child, ensure that appropriate arrangements are made for the care of the siblings if necessary.

6. If the mother is alone, ensure that she has the appropriate family support
and give the parents a work telephone number where you can be contacted.

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

a. Any inappropriate delay in seeking help,
b. The position of the infant /child and the condition in which it was found
c. Any explanations including any inconsistencies should be recorded verbatim in quotes where appropriate
d. Evidence of drug / alcohol abuse
e. Parent/ carer reaction and demeanor
f. Any injuries eg bruises, burns, bites, or presence of blood
g. Neglect issues
h. General condition of the accommodation
i. Evidence of high risk behaviour eg domestic violence

Action to be taken on return to the clinical base

1. Inform the Named Nurse immediately.

2. Check for Child Protection Plan status and involvement of Children's Social Care for the name of the infant /child and any siblings.

3. Ensure that all information is recorded in the infant/child's health records or on a continuation sheet which can be added to the health records if the records have already been secured.

4. If the infant is less that 28 days old inform the relevant Community Midwifery Service.

NB On return to the clinical base the HV / SN must follow the SUDiC protocol which is available via your own organisation intranet page and/or your local LSCB website

Staff support services are available for any staff who might need additional support following the sudden unexpected death of a child. Please access this via your Line Manager.

APPENDIX S

HOSPITAL CONTACT NUMBERS

HOSPITAL	CONTACT NUMBER
Aintree	0151 525 5980
Alder Hey	0151 228 4811
Arrowe Park	0151 678 5111
Liverpool Women's	0151 708 9988
Ormskirk	01695 656358
Royal Liverpool	0151 706 2000
Southport	01704 547471
Walton Centre	0151 525 3611
Whiston	0151 426 1600