



National Public Health
Service for Wales

Gwasanaeth Iechyd Cyhoeddus
Cenedlaethol Cymru

SUDDEN UNEXPECTED DEATHS IN INFANTS AND CHILDREN (SUDI)

**Best practice multi-agency protocol for care and
investigation in Wales**

2006

This 2006 version replaces the previous 2004 edition

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PREFACE

The Best Practice Multi-Agency Protocol for the Investigation of Sudden and Unexpected Deaths in Infants and Children was developed by the National Public Health Service of Wales and launched in July 2004. Shortly afterwards the report of a working group convened by the Royal College of Pathologists and the Royal College of Paediatrics and Child Health led by Baroness Helena Kennedy was published in September 2004. These two documents have influenced practice in the management of sudden unexpected deaths in Wales over the past two years leading to the widespread implementation of the multi-agency protocol. Many areas have developed a specific care pathway for SUDI.

The protocol was reviewed in April 2006 and followed a similar process used in its original development. Consultation with and the expert assistance of the police forces in Wales, Her Majesty's coroners, and of forensic and paediatric pathologists in Wales is acknowledged. In addition colleagues from partner agencies, especially named health professionals, have provided constructive comments and expertise.

The new title explicitly recognises the importance of a protocol that not only thoroughly investigates the sudden unexpected death but pays equal importance to the sensitive care provided to the family in their tragic bereavement.

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1.0 INTRODUCTION

1.1 WHY THE NEED FOR BEST PRACTICE PROTOCOLS?

It is recognised that the sudden and unexpected death of a child is one of the most traumatic and sad events that can happen to a parent. The parents feel a profound sense of loss often followed by feelings of guilt, anger and depression. Each professional needs to know their role and the role of others in the investigation of the death and the provision of support and guidance to the family.

Across the UK, there has been a great variance as to how a sudden death is handled by police and doctors. In recent years this has begun to change. The report of the working group of the Royal Colleges of Pathologists and of Paediatrics and Child Health led by Baroness Helena Kennedy called for a national investigation protocol. This followed public concern in 2003 raised by three high profile criminal cases involving the prosecution of mothers for causing the deaths of their babies. The overriding message has been to prevent miscarriages of justice while protecting the interests and safety of children. There is therefore a need for a more multi-disciplinary and multi-agency approach to sudden unexpected deaths, so that 'cot death' or 'sudden infant death syndrome' (SIDS), becomes a proper diagnosis of exclusion with proper regard being given to other causes.

The sudden death may be due to identifiable natural causes, which may be missed without a proper assessment. Sudden Infant Death Syndrome (SIDS) is a registerable cause of death, defined as - ***“the sudden death of an infant under one year of age, which is unexpected, and which remains unexplained after a careful review of the history, examination of the circumstances of death and the conduct of a full post mortem examination to an agreed protocol.”***

An important starting point is the acknowledgment that in the vast majority of cases where babies suddenly die, nothing unlawful has taken place. In a small number of cases death may be as a result of negligence or a deliberate act and it is important to identify accurately these cases, so that future children can be protected. However a diagnosis of SIDS reflects the clear admission by medical professionals that an infant's death remains completely unexplained.

There are likely to be a number of factors contributing to the sudden and unexpected death of a child and it is important to identify these factors by detailed investigation from the history, circumstances of death, medical examination, post mortem and liaison with professionals involved with the family. Many causes of death from genetic, metabolic or cardiac disorders previously unknown have more recently come to light with implications for genetic counselling for future pregnancies. The dead child deserves the same intense level of investigation as does the child who comes in collapsed and has intensive investigations to find a cause and is saved.

This best practice Protocol is not intended to be prescriptive but endeavours to provide guidance to practitioners who are confronted with these tragic circumstances. It is acknowledged that each such death has unique circumstances

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and each professional involved has their own experience and expertise, which, quite rightly, is drawn upon in their handling of individual cases. Nevertheless, there are common aspects to the management of unexplained child deaths, which it is important to share in the interest of good practice and of achieving a consistent approach.

In any sudden and unexpected death of a baby or child the lead lies with the coroner and the police. However this protocol sets out how **ALL** of the professionals and all of the partner agencies must work together.

The Protocol gives an insight into the priorities of those professionals involved, in an attempt to promote a mutual understanding of each agency's roles and responsibilities. Professionals need to strike a balance between the sensitivities of bereaved families, and ensuring a proper investigation is undertaken, to aid families in arriving at an understanding of why their child died.

This multi-agency, multi-disciplinary approach is supported by the Foundation for the Study of Infant Deaths (FSID).

1.2 WHAT IS IN THE BEST PRACTICE PROTOCOL?

The Protocol contains general advice and guidance in dealing with such deaths along with information concerning inter-agency working.

Section 1 contains general principles underpinning the advice and guidance contained within the protocol. It describes general advice for all professionals with a suggested pathway for interagency working. It also references the Avon Multiagency approach to sudden unexpected deaths in infancy and childhood.

Section 2 contains information on the roles to be adopted by individual professionals and agencies. The section concludes with useful information about organisations that may assist families following a sudden bereavement.

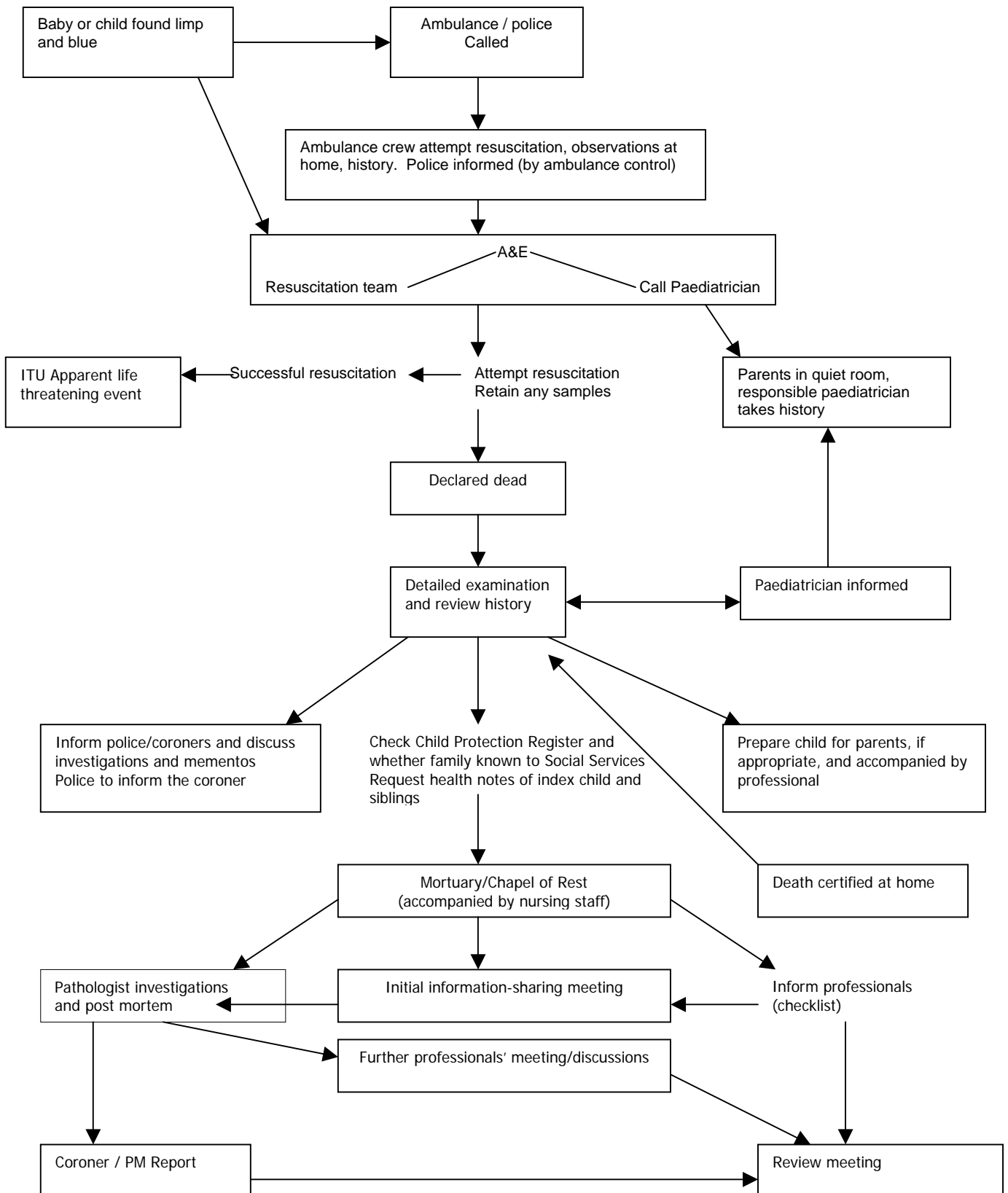
Section 3 contains the appendices. Appendices A1-A7 cover all aspects of the health agency response in more detail and provides web addresses for examples of care pathway. Appendices B1-B2 describe the role of the police in more detail adapted from the Association of Chief Police Officer's Infant Death Guidance (2002). The last appendix C describes some of the factors that should be considered about the circumstances surrounding the death. .

WHAT AGE GROUP IS COVERED BY THE PROTOCOL?

The Protocol should be applied to children up to the age of 2 years. With modification the same protocol is suitable for unexpected deaths up to the age of 18, recognising that many will be living outside the family home.

SUDI CARE PATHWAY

(See also RCPATH/RCPCH Report on Sudden Unexpected Death in Infancy 2004, Figure 1, p 46)



2.0 GENERAL ADVICE FOR ALL PROFESSIONALS

2.1 This is a very difficult time for everyone. The time spent with the family now 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. Any communication difficulties which the family might face should be considered and addressed at this stage before any serious dialogue takes place.

The behaviour of the first professionals to visit can have a lasting effect on the family's later feelings about the death.

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

2.3 All professionals must record the 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 accurately and contemporaneously.

2.4 It is normal and appropriate for parents/carers to want physical contact with their dead child. In all but exceptional circumstances (such as where the parents are obvious suspects and crucial forensic evidence may be lost or interfered with) this should be allowed, albeit with observation by an appropriate professional (Health or Police).

2.5 The child should always be handled as if he/she were still alive; remembering to use his/her name at all times as a sign of respect and dignity.

2.6 All professionals need to take into account any religious and cultural beliefs and communication difficulties, which may impact on procedures. Such issues must be dealt with sensitively but the importance of the preservation of evidence should remain paramount.

2.7 Following the death of their baby, the parents need to be consoled and supported. They need to understand the role of the coroner, and the need for a detailed multi-disciplinary investigation, which will include a comprehensive medical and post mortem examination and meetings between the professionals involved. They need very practical advice on what happens to their baby, on funeral arrangements and what to do with their other children. They will need to be informed of the immediate post mortem result and other information as it becomes available, but they will need to know that the final cause of death may not be established for a few weeks or even months. The parents need to know to whom they can turn for help and support in their bereavement.

2.8 Where possible, written contact names and telephone numbers should be given and the leaflet from the Foundation for the Study of Infant Death should be made available.

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2.9 The coroner must be informed of all such deaths and the parents and family must be made aware of this procedure and that a coroner’s post mortem and inquest may be necessary. The family also need to be made aware that a police investigation will take place and that it will be necessary for the police to speak to the family and to visit the scene of the child’s death as soon as possible. This information will obviously have to be given sensitively to the family. The family will need practical advice and information on what happens to their baby. All professionals involved in this process will need to be aware of the requirements of the law, but also very sensitive to the distress of the family.

2.10 Professionals from all agencies need to be aware that on occasions, in suspicious circumstances, the early arrest of the parent/carer may be essential in order to secure and preserve evidence and thus effectively conduct the investigation.

Professionals also need to be aware of the constraints placed on the police by the Police and Criminal Evidence Act (PACE) that determines how suspects may be questioned and the length of time they may be detained without charge.

2.11 Agency professionals will be requested to provide statements of evidence promptly in the above circumstances.

Pointers for all professionals in talking with bereaved parents

(taken from advice given by the FSID)

- 2.12 *When you arrive always say who you are and why you are there, and how sorry you are about what has happened to the baby*
- 2.13 *The parents will be in the first stages of grief and may react in a variety of ways, such as shock, numbness, anger or hysteria. Allow the parents space and time to cry, to talk together and to comfort any other children. These early moments of grieving are very important. Parents may want to hold their child and this can be facilitated, if appropriate, but may need to be supervised.*
- 2.14 *In talking about the baby preferably use the first name, or, if you don't yet know the name, say 'your baby', or 'he' or 'she'. Don't refer to the baby as 'it'.*
- 2.15 *Have respect for the family's religious beliefs and culture. If Welsh is the family's preferred language this should be used where possible and if English is not their first language an interpreter should be arranged.*
- 2.16 *Take things slowly, allowing the parents to gather their thoughts and tell the story in their own way.*
- 2.17 *Be prepared to answer practical questions, for example about where the baby will be taken and when they can next see him/her.*
- 2.18 *Most parents feel guilty when their baby has died. When talking to them try to ask questions in a neutral way, e.g. 'Would you like to tell me what happened?' Avoid questions that sound critical, such as 'Why didn't you?'*
- 2.19 *Don't use such phrases as 'suspicious death' or 'scene of crime', and try to avoid comments that might be misunderstood by, or distressing to, the parents.*

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3.0 INTER-AGENCY WORKING: THE PATHWAY

3.1 All sudden unexpected deaths in children are notified to the coroner and a full police/coroner investigation will take place. The coroner’s officer may be a police officer. In addition in such cases a divisional detective inspector will lead the investigation. However, all agencies will have a contribution to make.

3.2 Multi-agency working will always involve at least police, the coroner and health professionals.

The process is described in full in each agency section, and an outline is set out below and in the flow chart.

3.3 Each professional must be fully conversant with both their own agency’s responsibility and the responsibilities of the other agencies.

3.4 There should be collaborative working at all levels from the earliest call to the emergency services.

3.4.1 The initial call to the emergency services should trigger the pathway so that the police, coroner (if the child dies) and paediatrician are informed.

3.4.2 Police and Health will jointly ensure that the immediate needs of the family and of the investigation are met. Social services will be involved in the initial stages and then as necessary.

3.4.3 Police and Health will collate information, and arrange an **initial information sharing meeting which could be by telephone.**

3.4.4 Full information will be made available to the pathologist before the post mortem (see Health professionals section).

3.4.5 There should be a **further professionals’ meeting** or phone conversation after the post mortem, so that relevant professionals (responsible paediatrician, pathologist and police officer) are aware of the initial post mortem examination findings, and of future action. The senior investigating officer from the police will be responsible for arranging this..

A further **professionals’ review meeting** will be arranged a few weeks later when all results are available. (As all results may not be available for several months there may need to be another additional meeting.) The Responsible Paediatrician will play a major part in convening these meetings.

3.5 Details of initial information sharing meeting

3.5.6 An initial **information sharing/gathering** meeting should be convened as soon as possible and within 72 hours of a child’s death. The responsibility for calling this will usually lie with the Police but will depend on local

arrangements. **The Coroner should always be invited to this meeting and may attend in person or delegate this task to the coroner's officer depending on local circumstances.**

The purpose of the discussion will be:

- To collate all relevant information to share with the pathologist.
- For each agency to share information from previous knowledge of the family and records, with particular reference to the circumstances of the child's death. This would include details of previous or ongoing child protection concerns, previous unexplained or unusual deaths in the family, neglect, failure to thrive, parental substance misuse, parental mental ill health, domestic abuse etc.
- To enable consideration of any child protection risks to siblings/any other children living in the household and consider the need for child protection procedures.
- To ensure a co-ordinated bereavement care plan for the family which must address any particular needs of the family arising from communication difficulties, cultural or religious beliefs.
- To discuss any need for action in respect of other children in the family (e.g. health overview).

Those invited should include:

- i. **The Coroner**
- ii. **Health** – The doctor who certified death, the named health visitor for the child, the community midwife if appropriate, the general practitioner, the hospital consultant paediatrician (and/or the Responsible Paediatrician), and the named professionals for child protection.
- iii. **Social services** – A senior representative of the Children's Services.
- iv. **Police** – Divisional Detective Inspector and a representative from the Family/Child Protection Unit.
- v. **Other contributors** – Ambulance Service (if applicable) and Education (where the child was attending school or nursery) and any other agency/person that may have a contribution to make, e.g. Women's Aid.

It is imperative that all available information is shared with the pathologist **before** the post mortem examination. This is best done by the paediatrician, in consultation with the coroner's officer/police officer.

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4.0 NHS TRUST HEALTH PROFESSIONALS

- 4.1 The National Public Health Service for Wales (NPHS) has produced a comprehensive Protocol in respect of the health management of SUDI (Appendix A1), and each NHS Trust will develop its own protocol and care pathway based around the district general or teaching hospital. Two examples of care pathways are referenced at Appendix A7.
- 4.2 For the care pathway to be triggered it is imperative that the acute consultant paediatrician on call is informed by the Investigating Officer/Coroner's Office or the general practitioner if the child dies at home. In practice it is best for these children to be brought to the A&E Department, where the consultant paediatrician would attend.
- 4.3 Similarly if the child dies in the hospital, the coroner, police and acute consultant paediatrician on call must be notified, and agreement reached regarding the role of Health.
- 4.4 The role of the Health professionals will include:
- Sharing and pooling of information from all health sources, i.e. general practitioner, community midwife, health visitor, school nurse, community paediatrician, senior nurse child protection, any hospital child has attended, etc.
 - In association with the police, checking with social services whether the family are known.
 - The medical examination of the child, history taking, and liaison with the pathologist before and after the post mortem.
 - There should always be consideration of a home visit by a health professional. The importance of this visit is emphasised in appendix A1. Parents have commonly reported that this home visit has been an extremely important and very positive aspect of their care. This may, depending on circumstances, be an experienced and trained paediatrician, health visitor or general practitioner. It is desirable that this should either be done jointly with the investigating police officer or, if separate visits are made, they should confer in their assessment.
 - Any police video recording of the scene of death should be made available to the pathologist.
 - The **pathologists** will request a skeletal survey, which should be available and **reported by** a consultant radiologist experienced in interpreting paediatric x-rays **before** the post mortem takes place. The standard used should be that recommended by the BSPR (Appendix A5).
 - Attendance at the initial and subsequent information sharing meetings.
 - Ensuring appropriate counselling and support for the family.
 - Ensuring that the health needs of any siblings, especially a twin, are met.
 - Explaining to the family the role of the coroner and police and that a post mortem will be necessary.

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- 4.5 It is expected that the role of the **Responsible Paediatrician** will initially be taken by the consultant paediatrician on call in the district general or teaching hospital. At a later stage this responsibility may change to another hospital paediatrician or locality consultant paediatrician. The local Trust protocol should define which paediatrician adopts this role and when.
- 4.6 Each Trust should ensure that health professionals are aware of their own and others' role in the investigation and management of a child's death.
- 4.7 Health professionals need to understand the need of the family to be with and to nurse their dead child and need to ensure that this is facilitated, but with appropriate safeguards in place and consideration of the coroner's investigation. In this respect there should be liaison with the police and the pathologist.
- 4.8. The **initial information sharing meeting** will be convened by the investigating police officer. See paragraphs 3.4.3 to 3.5 which should be followed thereafter.
- 4.9 Detailed, accurate and contemporaneous records should be kept by all professionals of history taking, medical examinations and discussions with parents and other health professionals and professionals in other agencies.
- 4.10 Detailed information on the roles and responsibilities of health professionals is available in Appendix A1.

5.0 GENERAL PRACTITIONERS

- 5.1 This guidance for the GP needs to be read in conjunction with the Protocol for health professionals on sudden unexplained deaths in infancy at Appendix A1.
- 5.2 The GP may be the first to be called in the event of a child's death, or may be called by the ambulance team.
- 5.3 If there are still signs of life resuscitation measures will be started and an ambulance requested. The consultant in A&E and the consultant paediatrician at the district general hospital should be informed of the child's impending arrival.
- 5.4 If the baby has been dead for some time, the GP will inform the police (it is advised that this is best done via Police Control), who will inform the coroner.

The GP should also inform the consultant paediatrician on call at the hospital to which the child will be taken.

- 5.5 The GP should ensure that ambulance staff should wherever possible take the baby to the A&E department rather than to the mortuary, even when death has been determined at home. (It is preferable that verification of death is deferred until the child is transferred to the local A&E department.)
- 5.6 The GP should visit the parents at home as soon as is convenient and will be involved in providing ongoing advice (such as if necessary the suppression of lactation) and counselling for the family, in collaboration with other professionals.
- 5.7 The GP should make notes available to the responsible paediatrician and wherever possible attend the information sharing meetings.
- 5.8 Additional guidance for GPs and health visitors, particularly in relation to the longer term care of the family, is available from the Foundation for the Study of Infant Deaths. There is also a helpline: 0870 787 0554, 9am-11pm weekdays; 6pm-11pm at weekends.

6.0 AMBULANCE STAFF

6.1 Immediate notification to the police is required by the Ambulance Service when they are called to the scene of an unexplained child death. This will generally be undertaken by the Ambulance Control contacting the Police Control Room.

The Ambulance Service will need to clarify that it is the SUDI Best Practice Protocols that are being triggered.

6.2 The recording of the initial call to the Ambulance Services should be retained in case it is required for evidential purposes.

6.3 Ambulance staff should (adapted from national training manual):

- a) Not automatically assume that the death has occurred
- b) Clear the airway and if in any doubt about death, apply full CPR
- c) Inform the A&E department giving estimated time of arrival and patient's condition
- d) Transport the child to an A&E department at one of the district general hospitals
- e) Take note of the position and location of the baby or child
- f) Note any injury and any explanation offered
- g) Pass on all relevant information to the health professionals and/or A&E staff or investigating police officer
- h) The patient clinical record is to be completed in full as a record of attendance or treatment of the patient.

6.4 Ambulance staff should remove the baby to the A&E department of the local DGH, rather than to the mortuary, even if death has been determined at home.

6.5 The first professional on the scene (e.g. ambulance, GP) should note the position of the child, the clothing worn and the circumstances of how the child was found.

6.6 If the circumstances allow, note any comments made by the carers, any background history, any possible drug misuse and the conditions of the living accommodation. Any such information must be passed on to the receiving doctor, the police and the consultant paediatrician.

6.7 Any concerns should be reported directly to the police and to the receiving doctor at the hospital as soon as possible.

7.0 SOCIAL SERVICES

- 7.1 Social services (adult or children’s services) may hold information in respect of a child/family and should share this information with the investigating police officer and/or the Responsible Paediatrician.
- 7.2 Requests for information ‘out of hours’ which may only obtain basic information from the Child Protection Register **must** always be followed up with further more detailed record checks during office hours.
- 7.3 Where there are immediate child protection concerns, social services will become involved in their role as the statutory agency, and will then become the lead agency with the police. There may then be a particular need to ensure the protection of the remaining children in the family.
- 7.4 A senior social services representative (child protection co-ordinator, children’s services manager or team leader) will always be invited to the initial information sharing meeting and if appropriate to the follow-up meeting.
- 7.5 Arrangements need to be in place to notify the Chair of the Local Safeguarding Children’s Board of any sudden and unexpected death of an infant or child, so that consideration can be given to any indication to consider a (serious) case review.

8.0 THE ROLE OF THE CORONER AND THE POST MORTEM

- 8.1 After the death is determined, the coroner has control of the body.
- 8.2 The choice of pathologist is directed by the coroner but the recommendations of the RCPATH/RCPCH report 2004 should be noted, i.e. a paediatric pathologist, or a pathologist with appropriate and recent paediatric training and expertise (working with a forensic pathologist when maltreatment is suspected).
- 8.3 The generally agreed principle is that if after an evaluation of all the facts there are no grounds for suspecting anything other than a natural death, the post mortem can be conducted by a paediatric pathologist or by a pathologist with appropriate training and experience. If during the post mortem the pathologist becomes at all concerned that there may be suspicious circumstances, he/she must halt the post mortem and immediately notify the coroner.
- 8.4 If the coroner has any concerns, having been made aware of all the facts, that the death may be of a suspicious nature, a Home Office pathologist will be used. A paediatric pathologist may also be involved, if indicated.
- 8.5 Both the coroner and the pathologist must be provided with a full history at the earliest possible stage. This will include a full medical history, any relevant background information concerning the child and the family including that gained during the home visit and any concerns raised by any agency. The investigating police officer is responsible for ensuring that this is done in collaboration with the Responsible Paediatrician.
- 8.6 The investigating police officer should attend the post mortem. If this is not possible, then he/she must send a representative who is aware of all the facts of the case. A Scene of Crime Officer must attend all post mortems conducted by a Home Office pathologist. The consultant paediatrician **may** also attend. In all instances there should be a full discussion between the consultant paediatrician and the pathologist both before and after the post mortem examination to identify outstanding or unsuspected issues and to ensure accurate understanding of information. This discussion is authorised by the Coroner when part of an agreed standard in the SUDI Protocol as ratified by the Coronial service in Wales.
- 8.7 The Protocols of the Royal College of Pathologists and the recent recommendations of the RCPATH/RCPCH report 2004 regarding post mortem protocol in sudden unexpected deaths in infancy should be followed (see Appendix A6).

There should be a policy in place with clear information to the family about what organs and/or tissue samples have been retained to allow discussion of options for disposal. Within the scope of the Coroners rules, the period should be stipulated and authorised for which any further bodily material should be retained. The family's wishes regarding disposal must be made known to the pathologist. The body should be released for burial or cremation as soon as possible.

- 8.8 A number of investigations should be arranged by the pathologist. These are detailed in the Health Appendix A4.
- 8.9 If the paediatrician has arranged any similar investigations before death, these must be made available to the pathologist and the coroner prior to the post mortem.
- 8.10 All professionals must endeavour to conclude their investigations expeditiously. The funeral of the dead infant should not be delayed unnecessarily.
- 8.11 The interim findings of the post mortem examination should be provided in writing by secure fax or secure e-mail by the consultant pathologist to the coroner, the police and responsible paediatrician involved in the case review immediately after the post mortem examination is completed. A further multi-agency discussion, involving the paediatrician and the pathologist after the post mortem is particularly helpful.
- 8.12 The final result must be notified in writing to the coroner as soon as it is known. The final report should then be sent to the coroner immediately the final result is known and in any event no later than seven days.
- 8.13 If the death turns out to be ‘natural’, the coroner will notify the Registrar as to the medical cause of death to enable the death to be registered and a death certificate issued. If the death is not ‘natural’, this notification to the Registrar may be delayed pending the outcome of criminal proceedings or inquest.
- 8.14 A copy of the post mortem report should ***always*** be sent to the Responsible Paediatrician and the General practitioner, with the agreement of the coroner in the understanding that unless there are suspicious circumstances it will be discussed with the parents. The Coroner expects that this task will be carried out on his behalf by the consultant pathologist.
- 8.15 The RCPATH/RCPCH report 2004 recommends that inquests should be ordered in ***all*** cases of sudden unexpected death in infancy except where there are immediately recognisable natural causes. Inquests should be held in private if possible and where this is not against the public interest.
- 8.16 If the death meets the international criteria for sudden infant death syndrome (SIDS) that is the term that should be registered as the cause of death. Where possible the use of the term ‘unascertained’ should be avoided which carries implications that the death may have been the result of neglect or abuse. Where no sufficient cause of death has been established but there are gaps in the documentation, or for other reasons the death, whilst not known to be due to abuse or neglect, does not meet the definition of SIDS, a designation of ‘unascertained’ may be unavoidable.

9. THE ROLE OF THE POLICE

Detailed guidance in Appendix B is based on the Association of Chief Police Officers (ACPO) Infant Death Guidelines (2002). The full guidelines must be referred to during an investigation.

- 9.1 When a child/baby dies suddenly and unexpectedly the coroner and therefore the police will **always** lead the investigation.
- 9.2 Police officers should be familiar with the local protocol between the coroner, police and the local NHS Trust on the principles of how unexpected deaths in infancy and children should be handled.
- 9.3 Every child who dies deserves the right to have their **sudden and unexplained death** fully investigated in order that a non-accidental cause can be excluded and a cause of death identified. The police have a key role in the investigation of infant and child deaths, and their prime responsibility is to the child, as well as siblings and any future children who may be born into the family concerned.
- 9.4 Sometimes a child is found unexpectedly very ill at home and dies soon afterwards in hospital. Such cases should be investigated using this Protocol.
- 9.6 There are a number of guiding principles that must underpin the work of police officers dealing with a sudden unexplained child death.

These are:

- To maintain a sympathetic and sensitive approach to the family, regardless of cause of the child's death. Police action needs to be a careful balance between consideration for the bereaved family and recognising the potential of a crime having been committed
 - A co-ordinated and timely inter-agency response, particularly in respect of information sharing
 - To keep an open mind
 - To share information
 - Although the police and coroner will take the lead on investigation, they clearly need to liaise with professionals in other agencies and to be aware of their roles
 - While investigating the possibility that the death may have been unnatural, police officers should keep in mind that most SUDI arise from natural causes.
- 9.7 It is recommended that the principles of this Protocol are adhered to for all sudden and unexpected deaths for children of all ages. For the older child however, the probability of death by unascertained natural causes decreases with age.

Who should attend a sudden infant death?

9.9 A detective officer of at least inspector rank must immediately attend the scene and take charge of the investigation in all cases of sudden unexplained and unexpected infant/child deaths, whether or not there are any obvious suspicious circumstances. This is the case if the child is still at the scene **or** if the child has been removed to hospital. The policy in some forces may not allow for a detective inspector to attend every such case and although this is strongly recommended, the important principle is that a senior CID officer, who should have received SIO training, will attend and make a judgement whether or not a homicide investigation is required.

Such officers should also have the necessary investigative skills and knowledge within the field of child protection and inter-agency working.

9.10 The detective inspector will co-ordinate the investigation and retain an overview. He or she will also attend all strategy meetings, child protection and review conferences.

9.11 Police officers need to be aware of the responsibilities and roles of other professionals, e.g. resuscitation attempts, taking details from the parents, examination of the child and looking after the welfare needs of the family. They may need to wait until some of these things have happened and take details from other professionals before being introduced to the parents. The police also need to be aware that certain events may take place before they meet with the family.

9.12 **See Appendix B for full police Protocol.**

10. USEFUL CONTACTS

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

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

Enquiries: 0870 787 0885 (9am-5pm weekdays).

The helpline is also available for family and friends and those professionals involved with the death. The telephone advisers personally answer the telephone every day of the year.

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

Publications available:

- Protocols for A&E Departments
- Protocols for Ambulance Staff
- Protocols for General Practitioners
- Protocols for Midwives
- Protocols for Health Visitors
- Protocols for Police and Coroners' Officers
- Good Practice for Paediatricians
- Leaflet for bereaved parents: 'When a Baby Dies Suddenly and Unexpectedly'

Other sources of formation and support to bereaved children, young people and their families include the following;

The Childhood Bereavement Trust

Tel no: 01494446648

www.childbereavement.org.uk

Winstons Wish

Tel no: 01452 394377

www.winstonswish.org.uk

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APPENDIX A1

Protocol for Health Professionals Regarding The Management of Sudden and Unexpected Infant and Child Deaths (SUDI)

Recent Serious Case Reviews, the CESDI 2000 report and Baroness Helena Kennedy's report on behalf of the working group of RCPATH and RCPCH (2004) have highlighted the need for a more integrated approach to sudden and unexpected deaths in infancy. A more multidisciplinary and multi-agency approach is required so that 'cot death' or 'sudden infant death syndrome' (SIDS), becomes a proper diagnosis of exclusion with proper regard being given to other causes.

Following an unexpected death of an infant, the parents feel a profound sense of loss often followed by feelings of guilt, anger and depression. Each professional needs to know their role and the role of others in the investigation of the death and the provision of support to the family.

This guidance has been drawn up to assist in this process and should be used in conjunction with the local Trust protocol and the full All Wales Best Practice Multi-Agency Protocol.

In these deaths the coroner has a lead role and all such cases are notified to his department. The coroner's officer and the police will then become involved.

This protocol is intended for the death of a child under 2, but with modification the same protocol is suitable for unexpected deaths up to the age of 18, recognising that many will be living outside the family home.

There will however be some deaths, for example in profoundly disabled children, who have a reduced life expectancy, but where the death at that time is unexpected. In these cases it will be important for the health professionals involved to come to a professional and competent decision on whether or not the use of this Protocol would then be appropriate.

1. There should be a multidisciplinary and multi-agency approach to the sudden and unexpected death of a child. This will also place the emphasis on support for the family at the time of the event and afterwards in the form of information giving and counselling. From the very beginning any particular needs arising from communication difficulties, religious or cultural beliefs of the family should be addressed
2. (a) Each Health Trust should have a care pathway in place, which reflects all aspects of this guidance, so that all relevant staff are aware of their roles and of actions to be taken. Particular emphasis is placed on the care pathway offering access to advocacy services or interpreters where required. This care pathway will be centred on a district general or teaching hospital. Exemplars of care pathways via web links are provided at appendix A7.

- (b) In developing the care pathway there needs to be a clear understanding that the consultant paediatrician on call at the district general hospital will be the initial **Responsible Paediatrician**.

There should also be later involvement of the locality consultant paediatrician/senior community paediatrician with responsibility for Child Protection in the Trust.

Trusts may, in addition, wish, at an early stage, to use the expertise of the Named Nurse/Named Doctor Child Protection.

- (c) The regional Designated Doctor/Nurse should be kept informed, by the Trust Named Doctor/Nurse, of all SUDI deaths.

3. (a) The coroner must be informed of all such deaths, and the parents and family must be made aware of this procedure and need to understand the role of the coroner and the need for a comprehensive medical and post mortem investigation and that a coroner's inquest may be necessary. The family also need to be made aware that the coroner's investigation is carried out by the police, and that it will be necessary for the police to visit the scene of the death and to talk to the family as soon as possible. This information will obviously have to be given sensitively to the family. The family will need practical advice and information on what happens to their baby.

<p>All professionals involved in this process will need to be aware of the requirements of the law, but also to be very sensitive of the distress of the family.</p>

- (b) The police and /or coroner's officer will have their own protocol and procedures to follow in respect of such deaths in addition to the All Wales Multi-Agency Protocol (2006).

4. There is a need for explicit pathways and a clear understanding of the multi-agency Protocol, that are reflected in local protocols, so that the same process is followed wherever the baby/child arrives, i.e.

- A&E department
- Paediatric ward
- Community hospital
- General practitioner at home/surgery
- GP deputising service
- Hospital mortuary
- Other.

All contact/intake points for sudden unexpected deaths in children **must** be aware of the need to notify the coroner, the police and the consultant paediatrician on call at the district general hospital.

It is particularly important that the investigating police officer and/or coroner's officer notify the consultant paediatrician (hospital on call at this stage) so that the health Protocol can be actioned. This is essential on any occasion and particularly where the child is taken directly to the mortuary.

It is also useful to ensure, if the child has been attending a local hospital paediatrician, that the child is taken to that hospital where possible.

If the baby or child is brought to the A&E department, resuscitation may still be ongoing and the consultant paediatrician will be notified immediately.

5. If the general practitioner is called to the home address to an apparently dead child, unless the death is obviously suspicious, rather than certifying death he/she should arrange transfer to the local A&E department, and in addition to informing the coroner and the police, he or she should also notify the consultant paediatrician on call (at the hospital to which the child will be taken).
6. Once life has been pronounced extinct the responsibility for the body falls to the coroner. In agreement with the police and the coroner, the paediatrician will undertake a careful **medical examination** and arrange to meet the parents/carers at the earliest opportunity to take, with appropriate sensitivity a **careful history** (see Appendices A2, A3, A4, and A5).

All findings must be carefully documented in writing and child protection body diagrams used as necessary, with metric measurements recorded of any marks/bruises.

Consideration should be given to photography of any visible, apparent injuries. Such photographs should include metric and colour scales and should be properly labeled and stored (to provide continuity of evidence). See Investigation section (A3) for temperature recording.

Records should be signed, timed and dated. Abbreviations should not be used.

(There are also other **investigations**, which may be carried out in association with the pathologist. In addition any investigations performed before death e.g. during resuscitation, should be checked and made available to the pathologist (see Appendix A4).

Skeletal survey. This needs to be performed in all cases and is requested in conjunction with the pathologist and should be reported before the post mortem, examination, by a consultant radiologist experienced in interpreting paediatric X-rays. Ideally the skeletal survey and post mortem examination should take place in the same hospital. If the surveys have to be performed out of hours and reported on by the local consultant radiologist, it is recommended that the X-rays be reviewed by a specialist paediatric radiologist before the post mortem examination.

This MUST be a full skeletal survey, to the recommended standards of the BSPR, never a babygram (see Appendix A5).

7. The coroner's officer, investigating police officer and the Responsible Paediatrician need to liaise regarding collecting relevant information. There should be a clear agreement in each case on specific roles and responsibilities. The care pathway should define how these tasks can be carried out.

The following should be checked, contacted and informed:

- General practitioner
 - Senior locality/community paediatrician
 - Named/lead trust and LHB child protection professionals
 - Designated child protection professionals
 - Health visitor and/or school nurse
 - Child Protection Register (and more information from social services if needed, i.e. via duty team and child protection co-ordinator)
 - Other relevant health professionals involved in the previous care of the child
 - Police Family Protection Unit
 - Education, if indicated.
8. Consideration should be given to a home visit by a health professional, as soon as possible after the death. The RCPATH/RCPCH report 2004 states that the home visit is the best way of identifying or eliminating areas of concern early on. The working group recommended that the role be filled by a paediatrician but recognised that this needed to be a dedicated, specially trained and experienced health professional who has the confidence of the family and the authority of the Police. Consideration should be given to this role being undertaken by an experienced Health Visitor, Midwife or General Practitioner in the absence of a suitable paediatrician. The investigating police officer will also want to visit; this could therefore be done jointly or, if separate visits are made, the relevant professionals should confer in their assessment.
9. (a) All information needs to be brought together at the initial information sharing meeting, in particular any issues of concern as detailed in section 10 of the main protocol, and must be available to the pathologist before the post mortem examination.

Inadequate briefing may result in failure to carry out the tests that might lead to the identification of a cause of death, whether natural or unnatural.

This briefing is best done by the paediatrician, in consultation with the investigating police officer/coroner's officer, and should indicate a full medical report based on the history, given by the parents in hospital, immediate examination of the baby, information obtained during the home visit and perusal/consultation of all relevant medical and social records. In very young babies this might include obstetric records. Any video recording at the death scene or photographs of the child at presentation or in the A+E department should be viewed by the pathologist to have the opportunity to discuss these with the responsible paediatrician and the police officer prior to starting the post mortem.

- (b) The choice of pathologist is directed by the coroner (see para 8.2 and 8.3 of main protocol).
 - (c) It is recommended that the paediatrician speak directly to the pathologist before and after the post mortem examination, to identify outstanding or unsuspected issues and to ensure accurate understanding of information.
10. The attendance of the paediatrician at the post mortem examination may be invaluable, and the coroner, investigating police officer and pathologist should facilitate this attendance. It is a parental right to be represented at the post mortem by a medical practitioner of their choice provided they have notified the coroner of their wishes.

Where this is not possible there *must* be adequate discussion between the paediatrician and the pathologist both *before* and *after* the post mortem.

11. (a) The Protocol of the Royal College of Pathologists and the recent recommendations of the RCPATH/RCPCH 2004 report regarding post mortem examination in SUDI should be followed (see Appendix A6).
- (b) *Death certificate*: the coroner will notify the Registrar of Deaths to enable a death certificate to be issued. It may be helpful for the coroner to liaise with the consultant paediatrician and consultant pathologist before issuing the cause of death.
- (c) With the agreement of the coroner, a copy of the post mortem report (*including any interim report*) will be sent to the paediatrician and to the general practitioner by the consultant pathologist, as soon as available with the understanding that this will be shared with the parents unless there are suspicious circumstances.
12. (a) The family should be offered initial counselling and be fully informed of the role of the coroner, the police and the pathologist. Counselling at this stage should be 'separate and uninvolved' and 'no blame', i.e. 'neutral'.

This does not preclude support offered by the Primary Health Care Team. It is helpful for the family to be given a copy of 'When a baby dies suddenly and unexpectedly', available from the Foundation for the Study of Infant Deaths. They also have a helpline 0870 787 0554 (9am-11pm weekdays; 6pm-11pm weekends).

Further counselling should be planned, and the initial information-sharing meeting and the professional review can be used to co-ordinate this. Bereavement care for siblings and close members of the wider family network is very important. With the sudden death of an older child this consideration needs to be extended to friends and classmates.

- (b) If the baby/child is a twin the other twin should be assessed **immediately** and admitted for a period of observation and investigation. It must be emphasised to the family that the admission of the surviving twin is because of the possibility of a natural medical condition.

If the family decline the offer of admission, this should prompt an urgent reconsideration of the family's needs and the health needs of the surviving twin.

- (c) The Trust care pathway needs to reflect the parents' wish to see and nurse their dead child.

- 13 (a) In each case, there should be an **initial information-sharing professionals meeting** which should be arranged by the senior investigating police officer in association with the Responsible Paediatrician. This meeting should be arranged within 72 hours of the death of the child where possible. It is expected that a senior officer from social services will also attend. The Coroner will always be invited. Health professionals expected to be present are:

Consultant paediatricians (acute and community where possible), community midwife, health visitor and/or school nurse, named nurse child protection, general practitioner, and a representative of any other health service involved e.g. Drugs and Alcohol Service.

If there are child protection concerns this meeting may become a strategy meeting under child protection procedures.

It is expected that the named child protection professionals in the Trust will become involved at this or an earlier stage. The designated professionals should also be kept informed by the named professionals.

- (b) There should be an additional meeting or sharing of information shortly after the post mortem examination, and this should include at least the paediatrician and the pathologist, to discuss the findings and interpret their relevance. The protocol agreed by the coroner should include this as standard so that specific approval is not required on each occasion.
- (c) In addition a few weeks (probably 8-12 weeks) after the death of the child, there should be a multi-disciplinary, multi-agency review i.e. **a professional review**. The professionals should meet when all the information has been collected, and the investigation and post mortem examination results are complete. This meeting should specifically include the pathologist and the coroner or representative depending on local circumstances.

Unless there are ongoing suspicious circumstances this meeting could be convened by either the responsible paediatrician or the Senior Investigating Officer. In either case it is imperative that the coroner and pathologist be invited.

The purpose of this professional review meeting is:

- i. To examine all details of the death and discuss likely causes of death and contributory factors. The Avon clinicopathological classification of sudden unexpected infant deaths has been suggested as a helpful structure in which to consider all the potentially contributory factors (RCPath/RCPCH report 2004, page 47 Table 2).
 - ii. To consider further the need for child protection procedures.
 - iii. To see whether the support and guidance for the family is adequate and to plan for counselling and further services.
If the cause of death is non-accidental, counselling is still needed for other family members, including siblings.
 - iv. In all cases there should be a plan for future pregnancies.
 - v. To ensure that accurate and appropriate information is given to the parents regarding the investigation findings.
 - vi. This meeting may recommend further tests or opinions which may shed light on the cause of death.
- (d) Following the professionals meeting a final case report should be provided to the Child Death Review team (once established) in order to collate and compare data on all sudden unexpected deaths in Wales.

14. Where there are ‘concerns’ regarding the death of a child, social services as the statutory agency will be involved and possibly child protection procedures followed in respect of other children in the household. Where concerns evolve during the course of any SUDI investigation social services must be informed. Where the child is an only child social services should still be involved because of the possible implications for future children.

All further meetings would then be led by social services and would become strategy meetings.

15. There should be arrangements in place to offer short- and long-term support and information to the parents. Such arrangements should consider how health inequalities can be reduced to maximise outcomes for the family. The initial information-sharing meeting and the later professional review can be used to plan these services (parents should be made aware that such meetings are taking place). This could include, with the agreement of the general practitioner, the Responsible Paediatrician (acute or community) arranging an appointment with the family. This could be in association with the general practitioner and/or the health visitor or CONI (Care of Next Infant Scheme) health visitor.

The discussion with the parents should include:

- (a) The complete results of the post mortem.
- (b) The final conclusion regarding the cause of death and contributory factors.

- (c) Addressing specific anxieties raised by the parents or other members of the family.
 - (d) Consideration of referral to clinical genetics for counselling about future pregnancies and genetic screening.
 - (e) Discussion of other specific problems within the family related to the death of the baby or child. Particular consideration should be given to the separate needs of siblings for counselling.
 - (f) Raising, as appropriate with the parents, the further support available from the Foundation for the Study of Infant Death, and the CONI (Care of Next Infant Scheme) and how this can be put into action in a subsequent pregnancy or in a current twin or younger sibling.
16. The Trust/LHB needs to have safeguards in place to ensure that the appropriate relevant bodies are informed of the death of the child, in order that other health professionals are notified and appointments cancelled.
17. Each Trust's care pathway should clearly show whose responsibility it is to inform the parents of the post mortem findings. This would normally be the Responsible Paediatrician (acute or community) in collaboration with the General Practitioner.
18. Each Trust/LHB should ensure that where health notes (including obstetric records) are requested by the pathologist and/or the police or coroner there are arrangements to ensure that the originals are made available or clear, legible complete copies.
- However where X-rays are requested these should be the originals only.
19. Where the death is definitely non-accidental, or the child was a 'looked after child' or on the Child Protection Register, the Local Children's Safeguarding Board will need to consider a Serious Case Review.

APPENDIX A2

Information to be collected by the paediatrician at the first interview and the home visit

Introduction

The importance of the history being taken by an experienced paediatrician, with knowledge and understanding of the care of infants and sensitivity to the needs of the family, cannot be over-emphasised.

The list is meant as a guide. It cannot be comprehensive, as additional specific questions may arise as a consequence of information by the parents.

Encouraging the parents to talk spontaneously with prompts about specific information is likely to be better than trying to collect a structured history in the more usual way. In recording parents' accounts of events, it is important to use their own words as far as possible. (Ideal, information should be recorded *verbatim*).

Much of the information is very sensitive. Parents may feel very vulnerable when asked about their sleeping arrangements, alcohol intake or drug use, so great skills is needed in asking the questions in a non-threatening way, with no implication of value judgement or criticism. Parents may ask directly if their alcohol intake has contributed to the baby's death; it is very important that the interviewer does not jump to conclusions about such questions, whilst not being dishonest when asked direct questions.

The baby

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

Mother

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

Mother’s partner and/or father of baby

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

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

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

Family medical history

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

Social and family history

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

Detailed medical history of mother

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

Detailed medical and developmental history of the baby who has died.

To include:

- gestation
- birth weight

- perinatal or neonatal problems
- type of feeding (and date and reason for changing type of feeding)
- growth, development and past assessments (e.g health visitor or GP routine, well-baby checks)
- immunisations
- any known contact with infection
- medication (either prescribed or over the counter)
- if possible, obtain the parent-held child health record to copy (return this to the parents after copying it); plot the weight record onto a centile chart.

A detailed narrative account of the baby’s feeding, sleeping, activity and health over the two-week period prior to the death

This should include information on:

- changes in feeding or sleeping patterns
- changes in place of sleep
- changes in individuals responsible for providing care to the baby
- any social, family or health related changes in routine practices over the past two weeks
- any illness, accident or other major event affecting other family members in the past two weeks.

A detailed (hour-by-hour) narrative account of events within the 48 hours prior to the infant being found dead

A detailed description of:

- precisely where the baby was placed for sleep
- duration of sleeping period
- position at the end of the sleeping periods
- any changes in routine care or routine activity levels
- any disruptions to normal patterns
- information on the activity and location of all significant members of the household
- information on alcohol intake and recreational drug use by members of the household during this period.

The final sleep

A very careful description of when and where the baby was place to sleep, including:

- the nature of the surface
- clothing
- bedding
- arrangement of bedding
- precise sleeping position
- who was sharing the surface on which baby was sleeping (e.g. bed or sofa)
- how often the baby was checked

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- when he or she was seen or heard
- the time at which the baby awoke for feeds
- whether feeds were given
- whether they were taken well
- who else was in the room at each stage
- what were the activities of others in the room
- were they awake
- where, when and by whom was the baby found
- what was the position of the baby when found
- where was the bedding
- were there any covers over the baby
- had the covers and the position of the covers moved
- were there other objects in the cot or bed adjacent or close to the baby (e.g. teddies, dolls, pillows)
- was the heating on
- what type of heating was there
- were the windows and/or doors open?
- Room temperature if available - or whether a room thermometer was regularly used.

Action after baby was found

A detailed narrative account of events that followed the discovery of the baby collapsed or apparently dead, to include details of:

- when, how and by whom the emergency services were called
- who was with the baby at each stage
- was resuscitation attempted and if so by whom
- were any responses obtained from the baby
- how long did it take for the emergency services to arrive?

Further specific questions

In addition to the information outlined above, information should be collected on the parents' perception of:

- whether the baby was feeding as well as, or less well than, usual in the past 24-28 hours
- any vomiting
- any respiratory difficulty, noisy breathing, in-drawing of the ribs, wheezing or stridor
- excessive sweating
- unusual activity
- unusual behaviour
- level of alertness
- difficulty sleeping
- difficulty waking the baby
- passage of stool and urine (how often and how much)

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

Whilst most of the medical and social history will be obtained during the initial discussion with the parents in the A&E department, a very careful and detailed account of the final 24-48 hours will almost always be considerably supplemented by information collected at the time of the initial home visit and close examination of the circumstances of death.

The home interview and visit to the place where the baby died can be very difficult, but may also be of great value in understanding the sequence of events leading to the death. Parents commonly find this home interview, whilst stressful and sometimes painful, very helpful – the fact that the paediatrician is willing to spend this time with them, helping to understand what has happened to their baby may in itself be very important to the family and many questions commonly arise out of this visit (in particularly in relation to the factors that may have contributed to the death).

At the end of the interview, it is essential that the paediatrician spends some time with the family ensuring they know that will happen next, when they will next be contacted by the paediatrician, when and where the post mortem will take place, and how they will be informed of the preliminary results.

Time will also be needed for the paediatrician to help the parents deal with the very powerful emotions that are commonly brought out by this discussion. If conducted sensitively and with awareness of the parents' needs, this interview can have a therapeutic 'debriefing' value for the family – commonly allowing them to talk about some of their feelings for the first time. Parents have commonly reported that his home visit has been an extremely important and very positive aspect of their care.

APPENDIX A3

Medical examination

The child should receive a full, detailed and documented paediatric examination with particular attention being paid to the following

- weight, supine length and head circumference and plot on centile chart
- general condition including hygiene and nappy rash
- nutritional state
- ear temperature (care should be taken to examine the ear and record the findings, **before** the temperature is taken)
- mouth, pharynx, larynx (larynx ONLY if intubation attempted during resuscitation)
There must be no laryngoscopy after death has been determined
- fundoscopy for retinal haemorrhage (preferably by an ophthalmologist)
- bruising, abrasions, lacerations or rash
- enlargement of liver and spleen.

APPENDIX A4

Routine samples to be taken immediately after sudden unexpected deaths in infancy.

Blood samples should be taken from a venous or arterial site (e.g. femoral vein). Cardiac puncture should be avoided as this may cause damage to intrathoracic structures and make post-mortem findings difficult to interpret.

If the post mortem is to be conducted within 24 hours of the death, it may be best for the samples to be taken by the pathologist.

Sample	Send to	Handling	Test
Blood (serum) 1-2 ml	Clinical chemistry	Spin, store serum at -20°	Toxicology
Blood cultures – aerobic and anaerobic 1 ml	Microbiology	Insufficient blood, aerobic only	Culture and sensitivity
Blood from Guthrie card	Clinical chemistry	Normal (fill in card; do not put into plastic bag)	Inherited metabolic diseases
Blood (Lithium heparin) 1-2 ml	Cytogenetics	Normal – keep unseparated	Chromosomes (if dysmorphic)
Cerebrospinal fluid (CSF) (a few drops)	Microbiology	Normal	Microscopy, culture and sensitivity
Nasopharyngeal aspirate	Virology	Normal	Viral cultures, immuno-fluorescence and DNA amplification technique
Nasopharyngeal aspirate	Microbiology	Normal	Culture and sensitivity
Swabs from any identifiable lesions	Microbiology	Normal	Culture and sensitivity
Urine (if available)	Clinical chemistry	Spin, store supernatant at -20°C	Toxicology, inherited metabolic diseases

*Samples must be sent to an appropriate virological laboratory.

NB Optimal microbiological and virological investigation after SUDI is currently the subject of a review by the Health Protection Agency, which will aim to produce definitive, evidence-based recommendations within the near future. The current recommendations should be seen as an interim minimum standard.

1a Additional samples to be considered after discussion with consultant paediatrician

1. Skin biopsy for fibroblast culture.
2. Muscle biopsy if history suggestive is of mitochondrial disorder.

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1b Forensic considerations

- Ensure you have the permission of the coroner to take samples.
- Document all samples taken, label and ensure an unbroken 'chain of evidence'.
- This may mean handling samples to a police office directly, or having the laboratory technician sign on receiving them in the laboratory.
- Samples given to police or coroner's officer must be signed for.
- Record the site from which all samples were taken.

APPENDIX A5

Skeletal survey

Each **radiology** department must have a protocol in place in respect of the requirements for a full skeletal survey on a baby or child.

The skeletal survey should preferably be performed at the same hospital as the post mortem examination, but this is not always possible.

The British Society of Paediatric Radiology, have developed standards for skeletal surveys in suspected non-accidental injury (NAI) in children and these should be followed.

- Skull - Skull AP and lateral and a Towne's view if indicated for occipital injury
- Body - AP and frontal chest including clavicles
Oblique views of right and left ribs
AP Abdomen with pelvis and hips
- Spine - Lateral view of whole spine (cervical and thoracolumbar)
- Limbs - AP humeri, AP forearms ,AP femurs, AP tibia/fibula
PA hands, AP feet

Supplemented by lateral views of any suspected shaft fracture and lateral coned views of the elbows/wrists/knees/ankles for metaphyseal fractures.

The X-rays should preferably be reported by a paediatric radiologist or at least a radiologist with paediatric expertise, *before* the post mortem examination.

APPENDIX A6

Autopsy protocol for sudden unexpected deaths in infancy

The role of the autopsy

To establish the cause of death and to address the issues related to the circumstances of death:

- whether the death is attributable to a natural disease process
- to consider the possibility of accidental death (trauma, poisoning, scalding, drowning)
- to consider the possibility of asphyxia/airway obstruction
- to consider the possibility of non-accidental injury
- to document the presence/absence of pathological processes and to contribute to the multidisciplinary clinicopathological evaluation of the death.

Clinical information relevant to the autopsy

The pathologist should have available a comprehensive history and report on the circumstances of death prior to starting the post-mortem examination.

Ideally, available information should include:

- detailed history, including details of pregnancy, delivery, post-natal history, ante-mortem history and precise circumstances of death including family history (previous sibling deaths, consanguinity, drug use, sleeping arrangements)
- event-scene investigation report from paediatrician and/or police officers if available
- report of the coroner's officer
- GP records
- reference to the child protection register
- reference to resuscitation procedures
- results of examination by a consultant paediatrician
- results of septic screen, if done in an A&E department
- details of any other investigations sent from the A&E department, and any results available so far. All results from such investigations should be reviewed by the pathologist as well as by the responsible paediatrician.

The autopsy procedure

- If there is any suspicion of abuse contributing to the death, consider requesting a joint post-mortem examination with a forensic pathologist.
- Consider close adherence to the rules of evidence from the outset of involvement (e.g. identification and corroboration of evidence).
- Full autopsy (external and internal examination), with attention to weights, measurements, presence/absence of secretions or blood around nose and mouth and petechial haemorrhages on face, conjunctivae or oral mucosa (consider photography for documentation of dysmorphism and/or evidential purposes).

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- Any evidence of injury (a full skeletal survey reported by a paediatric radiologist is mandatory in such cases).
- Weights of all major organs.
- If suspicious of intracranial injury, no needles should be placed within the skull or the eye until the scalp, skull and intracranial contents have been examined and injury excluded.

Specific organs to be systematically examined.

Organ retention

- If trauma to the brain/spinal cord is suspected, consider retaining these organs: also consider retaining the eye for specialist neuropathological referral.
- In general, if the clinical history and pathological findings require any particular organ to be retained for further assessment, this should be discussed with the coroner's office.
- If the family has given consent for organs or tissues to be retained for research purposes these should be retained (with the agreement of the coroner).

Minimum blocks for histological examination

- Five lobes of lung (H&E, and Perls' method for iron)
- Heart (free wall of left and right ventricle, interventricular septum)
- Thymus
- Pancreas
- Liver
- Spleen
- Lymph node
- Adrenal glands
- Kidneys
- Costo-chondral junction of a rib to include bone marrow sample
- Muscle
- Blocks of any lesion, including fractures ribs
- Brain: four to six blocks including cerebral hemisphere, brainstem, cerebellum, meninges and spinal cord: dura if there is haemorrhage.

(In cases with no clinical evidence or macroscopic autopsy findings explaining death, it is strongly recommended that the brain is examined only after adequate fixation, for one to two weeks).

If any organ is to be retained for fixation and more extensive sampling, this must be discussed with the coroner and the appropriate authority obtained. This may necessitate in delay in the funeral arrangements to allow return of the organ(s) to the body after fixation and sampling.

Other samples required (if not already taken in the A&E department):

- Bacteriology (blood, cerebrospinal fluid, respiratory tract, any infective lesion).

- Virology (post-nasal swabs or nasopharyngeal aspirate, lung, cerebrospinal fluid and faces if indicated).
- Consider agreeing protocols with local medical microbiology departments to use modern DNA amplification techniques for organism recognition.
- Biochemistry (urine, if present, for metabolic investigations or toxicology; blood and bile spots on Guthrie card for acylcarnitines by mass spectrometry if metabolic disease suspected or if fat stains on frozen sections are positive).
- Frozen section – stained with Oil Red O for fat on liver and kidney, skeletal and cardiac muscle (mandatory in all unexplained unexpected infant deaths).
- Consider toxicology (peripheral blood, whole unpreserved in fluoride bottle, urine, sample of liver, stomach content; request an illicit drug/alcohol screen, specify other drugs as indicated from the history).
- Skin sample for fibroblast culture.

Clinicopathological summary and report to the coroner

- Summarise the clinical history and main pathological findings.
- Consider whether the pathology satisfactorily explains the clinical circumstances of the death.
- Consider whether there are features indicating a familial/genetic disease requiring screening and counselling of the family.
- Consider whether there are features sufficient to suggest non-accidental injury or neglect.
- If a complete and sufficient natural explanation of the death is identifiable at the initial post-mortem examination, the coroner must be informed of this and usually no inquest will be required.
- If, during the initial post mortem, findings emerge that clearly identify neglect or abuse as the most likely explanation for the death, the coroner must be immediately informed and the police will become the lead investigating agency. The provisions of normal criminal investigations will be set in motion, including the requirements of the Police and Criminal Evidence Act 1984.
- If, in the light of initial post-mortem findings (including careful consideration of the circumstances of the death), there is no clear or sufficient natural cause of death – *whether or not there are some concerns about the possibility that abuse or neglect might have contributed* – the initial ‘cause’ of death should be given to the coroner as “unexplained pending further investigation”. In these circumstances, the continued close cooperation of all agencies will be of great importance, and the nature and content of any further investigations by the police or social services department will be determined by the strategy discussion immediately after the initial post-mortem results are available.
- *The use of the term “unascertained”, which although it really does mean that no cause has been found, does unfortunately appear to carry for the family, implications that the death may have been the result of neglect or abuse, and should generally be avoided.*
- The report must include details of any samples taken or kept and instructions for their further retention or disposal, as authorised by the coroner.
- A full report, including the results of all further investigations undertaken (e.g. histology, microbiology, toxicology, radiology, virology, histochemistry, biochemistry

or metabolic screening of blood or other samples), should be prepared and made available to the coroner and to the multi-professional local case discussion meeting, usually held 8-12 weeks after the death and chaired by the SUDI paediatrician.

- The pathologist should, if possible, attend and take part in the multi-professional local case discussion meeting.

APPENDIX A7

CARE PATHWAYS

Each Trust is encouraged to develop a care pathway centred on the DGH.
Two examples of such care pathways can be found by following the appropriate links.

Gwent Healthcare NHS Trust

www.gwent-tr.wales.nhs.uk

Search 'Care Pathway for the Management of SUDI under 2 years of age'.

North West Wales Trust

www.nww-tr.wales.nhs.uk

Search care pathways and follow the link to 'Sudden Unexpected Deaths in Infancy'.

Both are available via the HOWIS website.

APPENDIX B1

PROTOCOL FOR THE POLICE REGARDING THE MANAGEMENT OF SUDDEN AND UNEXPECTED INFANT AND CHILD DEATHS (adapted from the ACPO guidelines of 2002)

This police section starts at Section 9 of the full document (9.1-9.12).

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

However the first police officer to arrive, or any other professional, may be expected by the parents to try and revive the baby, even if it is hopeless, and should be prepared for this.

The pathologist will need to be informed of any attempted resuscitation.

9.14 The first officer at the scene must make a visual check of the child and his/her surroundings, noting any obvious signs of injury. It must be established whether the infant/child has been moved and the current position of the infant should be recorded. This information must be passed to the SIO.

9.15 The coroner's officer must be notified as soon as possible. As well as the usual functions they perform, their experience in dealing with sudden deaths and bereaved families will be invaluable in explaining to the parent/carer what will happen to their child's body and why. If the coroner's officer asks to attend the scene, this should be allowed without the necessity of further consultation. They will also be able to liaise directly with the coroner. The investigating officer and the coroner's officer should continue to liaise closely throughout the investigation.

9.16 The senior detective attending will be responsible for deciding whether to request the attendance of a Scene of Crime Officer (SOCO). Certainly, if items are to be removed or photographs or a video are to be taken, their attendance will be essential.

9.17 In some forces it may be considered appropriate for a family liaison officer (FLO) to attend to assist the investigating officers. The role of the FLO is dealt with in the Murder Investigation Manual.

9.18 Police officers should review the 'Factors which may cause concern' section in this document (see page 21).

9.19 If, after considering the above factors and anything else significant, the death is thought to be of a suspicious nature, then attending DI must inform a Senior Investigating Officer (SIO) immediately.

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

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Visiting officers, so far as possible, should not be in uniform, and should not arrive in marked cars.

- 9.21 Attending officers should at all times be sensitive in the use of personal radios and mobile phones, etc. If at all possible, the officers liaising with the family, whilst remaining contactable, should have such equipment turned off. Care should be taken to avoid terms, such as referring to ‘scenes of crime’ and ‘suspicious death’.
- 9.22 As with all sudden deaths, in children and babies there should be immediate consideration of transferring the child to the A&E department, where the attending paediatrician will certify death. However, when the child/baby is obviously dead and has not been removed from the scene, a doctor must attend to certify death. When the circumstances are obviously suspicious, this must be a Police Surgeon. However, even if a Police Surgeon (FME) attends the scene, the Responsible Paediatrician should be informed so that the All Wales Protocol can be effected.

INITIAL ACTION BY SENIOR DETECTIVE ATTENDING

- 9.23 First, make a visual check of the child and his/her surroundings, noting any factors as described above. It must be established whether the child has been moved and the current position of the child should be recorded. All other relevant matters should also be recorded.
- 9.24 Sensitively explain the process to the parents, covering the role of the police, and the purpose of a thorough post mortem (this may determine the cause of death or help in giving reasons for death). If the child is under 2 years old, refer grieving relatives to the Foundation for the Study of Infant Deaths (a support agency for the bereaved family).
- 9.24 As soon as possible, ensure a full history is taken from the carers. Consideration should be given to the carers’ being interviewed separately to avoid the possibility of each contaminating the others’ version of events.

There should always be consideration of conducting a joint interview with the paediatrician.

The relevant history will depend upon the age of the child, but where applicable should at least include the questions in Appendix B2.

- 9.25 Clearly someone who has knowingly killed a child is likely to cover up their actions so any conflicting accounts should raise suspicion. It must not be forgotten, however, that any bereaved person is likely to be in a state of shock and possibly confused. Repeat questioning of the parent/carer by different police officers should be avoided at this stage if at all possible. However officers should always consider the behavioural response of the parents and take particular note of inappropriate or unusual response to their child’s death e.g. remoteness, insensitivity to circumstances, indifference to the death, disposal of articles.

9.26 **In all cases ensure the following is done:**

- Check police records for all family (and household) members including PNC, Force Intelligence System, Crime Recording System, Incident Logs, Command and Control Records, Domestic Abuse Logs.
- Contact the Child/Family Protection Unit to check C/FPU database. SIOs should consider involving C/FPU officers on any investigation.
- Liaise with the relevant social services department to ensure their records are checked, including the Child Protection Register (and previous registrations if possible), and to involve them in a strategy/planning/professionals' meeting.
- Obtain all details of family members e.g. siblings and foster children (history of illness etc).
- Consider other children in the family, both as potential sources of information and as an indicator of standards of care given by the parents.
- Ensure that the investigating police officer and/or relevant paediatrician obtain all relevant information.

9.27 The preservation of the (sleep) scene and the level of investigation will be relevant and appropriate to presenting factors.

Consideration should be given to:

- Commencing a scene log
- Preservation of the scene
- Arranging for photographs and video of the scene/other rooms, etc (this is highly recommended)
- Retaining bedding and clothing, but only if there are signs of forensic value such as blood, vomit or other residues. (The child's nappy and clothing should remain on the child but arrangements should be made for them to be retained at the hospital.)*
- Retaining items such as the child's used bottles, cups, food, medication, which may have been administered.*

(*See paragraphs 6.1 and 6.2 of full ACPO guidance.)

The above is NOT an exhaustive list of actions and should be treated only as a guide. They will not be necessary in every case.

9.28 If it is considered necessary to remove items from the house, do so with consideration for the parents. Explain that it may help to find out the cause of their child's death. Before returning the items, the parents must be asked if they actually want them back. If articles have been kept for a while, try to ensure they are presentable and that any official labels or wrappings are removed before return. Return any items as soon as possible after the coroner's verdict or the conclusion of the investigation. The term investigation will include any possible trial or appeal

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process. The articles must not be returned in an inappropriate container e.g. black refuse sack.

- 9.29 Consideration must be given to evidencing any factors of neglect, which may be apparent, and have contributed to the death, such as temperature of scene, condition of accommodation, general hygiene and the availability of food/drink.
- 9.30 Details of death must be notified to the coroner. It may be appropriate for an officer who has already built a rapport with the parent/carer to obtain details on the appropriate form. A copy should be sent to the Child/Family Protection Unit in order to update C/FPU records.
- 9.31 Often the first notification to the police occurs when the child is already at hospital. In such cases consideration should be given to designating scenes, both at the hospital and at the location where the child was first discovered to be unwell.

The ‘scene’ as referred to in these Protocols is the child’s home. This is assuming that the child died at home and is still there when the police and other professionals attend. However, on many occasions the child will already have been taken to the hospital. If this is the case, the principles remain the same. However, in such a situation, there may be two scenes and resources will need to be allocated accordingly. It is important to note that if the child has already been moved from home, this does not negate the need for professionals to visit the home.

- 9.32 Often medical staff interview parents before the police arrive at hospital in an effort to establish the circumstances surrounding the child’s collapse. This account should be sought by investigators, as it may prove useful should a different version be provided later.
- 9.33 If police are aware of the death before the child has been taken to a hospital, the child’s body must be accompanied to the hospital for the purpose of continuity of identification. It is recommended that the body should be taken to a hospital A&E department rather than to a mortuary, firstly to enable any chance of resuscitation and secondly to make it easier to get an early expert physical examination by a paediatrician. This should be done appropriately and sensitively. The body will normally be transported by ambulance but it may be appropriate to use the services of an undertaker.
- 9.34 A physical external examination recorded by way of photographs should be undertaken by medical staff and police at the earliest possible stage in order to record any suspicious or unidentifiable marks.
- 9.35 It is entirely natural for a parent/carer to want to hold or touch the dead child. Providing this is done with a professional (such as a police officer, nurse, doctor or social worker) present, it should be allowed in most cases, as it is highly unlikely that forensic evidence will be lost. If however, the death by this time is considered suspicious, the SIO should, where possible, be consulted before a parent/carer is allowed to hold the child.

9.36 If the parents/carers wish to accompany their child to the hospital/mortuary, this should normally be facilitated, ensuring that they are accompanied by a police officer, family liaison officer, child protection or coroner’s officer as appropriate.

The issues of the continuity of identification must be considered. This should be carried out appropriately and sensitively.

The child should be handled as if he/she were alive.

9.37 Hospitals often wish to supply bereaved parents with a lock of hair, or foot or handprints. Police should only refuse these considerations if there is good reason to believe it would jeopardise the investigation, and it is highly unlikely that this would be the case.

9.38 If there is any lack of agreement between medical staff and police about the handling of the child’s body, the coroner’s officer must be informed at once in order that the coroner can decide on the appropriate course of action.

9.39 The investigating police officer should facilitate the medical investigations required as per Section 7 and Appendix A1 of these Protocols.

9.40 In all cases, the police should request a post mortem be carried out by a paediatric pathologist or a pathologist with some paediatric expertise.

In any case where the death is suspicious, a forensic post mortem must take place and if the Home Office pathologist does not have paediatric experience, they should be encouraged to work alongside a paediatric pathologist or pathologist with paediatric experience to maximise the opportunity for the recovery and interpretation of evidence.

Whether or not the post mortem reveals physical signs of injury it is important that extensive toxicological tests are carried out.

9.41 It is good practice for the SIO to call upon the services of the National Crime & Operations Faculty (NCF), who can provide an up-to-date list of experts as well as knowledge of the latest investigative techniques. NCF helpline 01256 602443.

9.42 CONCLUSION

Whilst it is felt the investigation of infant deaths is of such a specialised nature as to warrant the inclusion of a separate chapter in the Murder Investigation Manual, in every case where the death is felt to be suspicious, the same thought processes, vigour, expertise and professionalism, which are always applied to adult homicides must also be employed. Children are citizens who have the same rights as any other people to the protection offered by the criminal law as well as the expert services of the police.

See Appendix B2 for Police History Taking.

APPENDIX B2**POLICE HISTORY TAKING**

- Who saw the child last?
- What condition was the child in?
- Was the child breast-fed?
- When was the child last fed, with what, and by whom?
- Who put the child to bed and how?
- Who found the child to be dead?
- How did the child look when found (blue, pink, stiff etc.)?
- Who else was in the house at the time of discovery?
- Who was there/with the child in preceding 24 hours?
- Where was the child sleeping in relation to the parents/carers and in what?
- Who was in the child's room/bed?
- Who else was in the child's bed?
- What was the sleeping position of the child?
- In what position was the child put to sleep?
- Detailed account of child's behaviour 48 – 72 hours prior to death, i.e. health of the child the day before.
- Do the parents, other members of the household or carers smoke? If so, was the child in a smoke-free environment or not?
- How much clothing or wrapping was used on the child and what was the room temperature where the child was found?
- Was bedding over/under the child?
- Was bedding tucked?
- Was an electric blanket used?
- Was there heating in the house?
- Was there heating in the child's room?
- What type of heating?
- Has there been any previous child death in that or the extended family? If so full details.
- Have either of the carers been involved in earlier relationships where they have had children? If so, obtain full details of any significant events in the lives of those children.
- Has the child had any illness since birth or been seen by a Doctor for a health problem?

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- Has the child received immunisations? If so, for what and when?
- Has the child attended clinic or been medically examined? If so, date and venue.
- Has the child been admitted or taken to a hospital or clinic? If so, which hospital/clinic, when, what for?
- Was the family provided with a booklet detailing medical checks, examinations, dates etc? (the parent-held Child Health Record often known as the Red Book). If so, where is that?
- Full details of parents/carers contact addresses, telephone numbers, etc. (furnish with your contact details).
- What guidance have the parents received with regard to SIDS from the medical profession prior to or since the birth of their child?
- Was an infant intercom in place?
- Was the child born prematurely and what was his/her weight at birth?
- What type of delivery?
- Did the child require special treatment after birth?
- Was child discharged from hospital with mother? If not, did he/she require special treatment?
- Who is the child and family's GP?

APPENDIX C

FACTORS WHICH MAY CAUSE CONCERN

- 10.1 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.
- 10.2 Previous child deaths: two deaths occurring within the same family is extremely unusual. The possibility of genetically determined natural disease or environmentally determined natural disease or accident must be emphasised.
- Where there are two sudden infant deaths in the same family, it is more likely that an underlying cause will be found, but this may be a genetically determined natural disease or child abuse.
- 10.3 Previous episodes of unexplained illness, such as cyanotic episodes or acute life threatening events (ALTE).
- 10.4 Previous and current child protection concerns within the family relating to this child or the siblings.
- 10.5 Inappropriate delay in seeking medical help.
- 10.6 Inconsistent explanations: the account given by the parents/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.
- 10.7 Evidence of drug/alcohol abuse – particularly if the parents/carers are still intoxicated.
- 10.8 Evidence of parental mental health problems.
- 10.9 Evidence of physical abuse/unexplained injuries, e.g. unexplained bruising/burns/bite marks. However, it is very important to remember that a child may have serious internal injuries without any external evidence of trauma.
- 10.10 Although the presence of blood may arouse suspicion, it can be found in cases of natural death. A pinkish frothy residue around the mouth or nose is a normal finding in some children whose deaths are due to Sudden Infant Death Syndrome (see 9.12).
- 10.11 Neglect: observations about the condition of the accommodation, hygiene, cleanliness, availability of food, adequacy of clothing and bedding and the

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temperature of the environment where the child is found are important. This will assist in determining whether there may be any underlying neglect issues involved.

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

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

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