

Isle of Man
Safeguarding Board

Protocol for Dealing with

**SUDDEN UNEXPECTED
DEATH IN INFANTS AND
CHILDREN (SUDIC)**

**THIS PROTOCOL HAS BEEN DRAWN UP
IN CONSULTATION WITH:**

Manx Care

Department of Health & Social Care

Police

The Isle of Man Safeguarding Board

The efforts of all who have contributed to the preparation of this document are acknowledged and appreciated. This document has been informed by:-

1. HM Government Child Death Review & Operational Guidance (England), 2018
2. Sudden Unexpected Death in Infancy & Childhood, multi-agency guideline for care & investigation (Royal College of Pathology and Royal College of Paediatricians and Child Health) 2016
3. Children & Young Persons Amendment Act 2020 Isle of Man

This protocol has been agreed by the Coroner

Coroner: JAYNE HUGHES

Signature: Jayne Hughes

Date: 10 August 2022

Reader Information	
Protocol Title	Protocol for Dealing with Sudden Unexpected Death in Infants and Children
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CONTENTS

	Page
1 Introduction	3
2 Definitions	3
3 Why the need for the Protocol	4
4 Principles	4
5 General Advice for Professionals	4
Recommended Sequence of Events Flowchart	6

Agency Guidelines (listed alphabetically):

6 Immediate Medical Response (Emergency Department/Paediatric Department)	8
7 Inter-agency working	11
8 Contact details	14
9 Ambulance	15
10 Coroner & Coroner's Officer	15
11 General Practitioners	16
12 Health Visiting Service	17
13 Hospital Wards/Maternity Units	19
14 Midwifery Service	20
15 Pathologist & Post Mortem Examination	23
16 Police Service	24
17 Social Care (Children & Families)	29

1 INTRODUCTION

1.1 This protocol is an essential part of the response to child deaths within the Isle of Man. The responsibility for reviewing all deaths of children normally resident in the island sits with the Child Death Review Partners (CDRP) under the Children and Young Persons (Amendment) Act 2020. The operational process that the Isle of Man has adopted follows the Statutory and Operational Guidance (England), 2018 which references the Royal College of Pathology and Royal College of Paediatrics and Child Health Guidance, 2016.

1.2 All child deaths are reviewed following a two stage process

A case review by a group of key professionals who

- A) were involved in the death and any investigation held after it; and
- B) An overview of all deaths of children aged 17 and under (carried out through CDRP and Merseyside and Isle of Man Child Death Overview Panel).

1.3 The process for the case review will vary depending on the circumstances and context of the death.

1.4 Where the definition of 'sudden unexpected death' is met, the case review process will follow the Sudden Unexpected Death in Infants and Children protocol which is set out in this document.

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

1.6 All SUDICs are under the remit of the Coroner who has exclusive jurisdiction over the body of the deceased child.

1.7 Adherence to the terms of this protocol by professionals is essential. However the Coroner/ Coroner`s Officer will always be willing to discuss specific arrangements at any time, day or night.

2 DEFINITIONS

AGE:

2.1 A child is defined as any boy or girl aged 17 years and under according to the Isle of Man Children and Young Persons Act .Therefore the use of the SUDIC Protocol should be considered up to child`s 18th birthday.

Definition of an unexpected death of a child

- 2.2 **An unexpected death** is defined as the death of a child that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to death.
- 2.3 The views of the responsible on-call Consultant Paediatrician or ED Consultant should be sought where professionals are uncertain about whether the death was unexpected. However, if in doubt the senior professional from any agency can advise that the procedures for an unexpected child death be followed until available evidence enables a different decision to be made.

3 Why the need for The Protocol?

- 3.1 The unpredictability and infrequency of SUDIC's on the Isle of Man means there is a need for clear inter-agency guidance for staff which can be accessed and used in tragic, emergency situations.
- 3.2 This Protocol seeks to:
- promote a mutual understanding between agencies about respective roles and responsibilities and
 - help professionals strike a balance between the sensitivities of handling the bereaved families and securing and preserving anything that may be relevant and aid in understanding of why the child died.

4 PRINCIPLES

- 4.1 Each unexpected death of a child is a tragedy for his or her family. Subsequent enquiries/investigations should maintain an appropriate balance between forensic and medical requirements and the family's need for support. The families of children with a known disability should be responded to in the same way as other families.
- 4.2 A minority of unexpected deaths are the consequence of abuse or neglect, or are found to have abuse or neglect as an associated factor. The purpose of the enquiry is to ascertain the reasons for the child's death, address the possible needs of other children in the household and the needs of all family members. In addition, lessons may be learnt about how to safeguard and promote the welfare of children in the future.

5 GENERAL ADVICE FOR ALL PROFESSIONALS WHEN DEALING WITH THE FAMILY

- 5.1 An unexpected death will be traumatic. Although the time professionals spend with the family may be brief their actions may greatly influence how the family deal with the bereavement process. A sympathetic, supportive and professional attitude towards the investigation is essential.

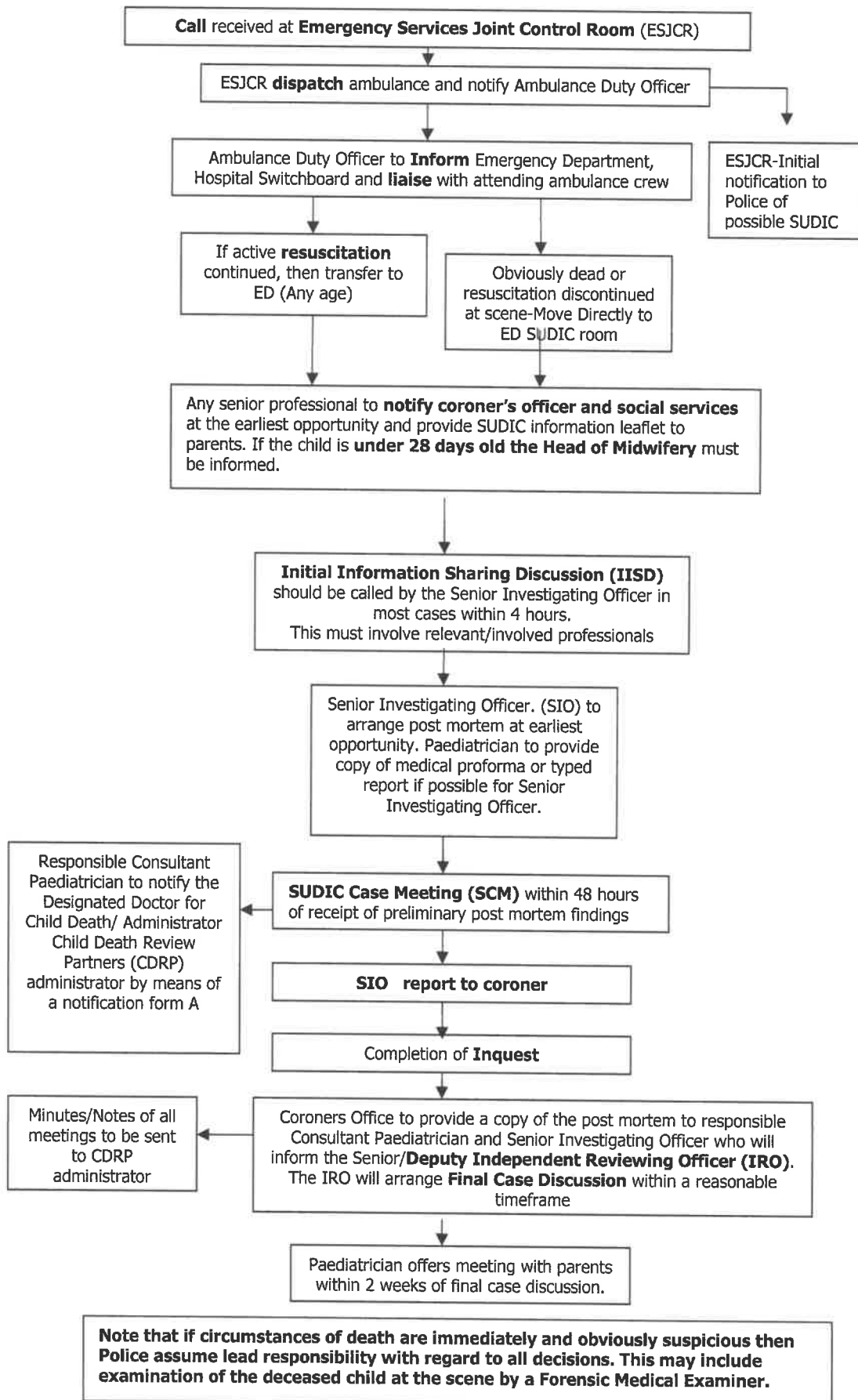
- 5.2 The experience of grief can involve a range of feelings, including numbness, disbelief, anger, sadness, emptiness and denial for all concerned.
- 5.3 All professionals must record the history and background information given by parents/carers in as much detail as possible. The initial accounts about the circumstances including timings must be recorded verbatim.
- 5.4 It is normal and appropriate for a parent/carer to want physical contact with his/her dead child. In all but exceptional circumstances, such as when crucial forensic evidence may be lost or interfered with, this should be allowed, albeit with observation by an appropriate professional.
- 5.5 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.
- 5.6 All professionals should take into account any religious and cultural beliefs which may impact on procedures. These must be dealt with sensitively whilst ensuring the preservation of evidence.
- 5.7 The parents/carers should be allowed time to ask questions about practical issues; this includes telling them where their child will be taken, when they are able to see him/her again and that a post mortem will be required.
- 5.8 Staff supporting parents at this time should provide information but must not be drawn into conversation or give an opinion about what may have happened.
- 5.9 Where possible, written contact names and telephone numbers for relevant agencies and personnel should be given to the family.
- 5.10 In all unexpected child death cases there will be an inquest conducted by the Coroner to establish the cause of death.
- 5.11 Staff from all agencies need to be aware that on occasions, in suspicious circumstances, the early arrest of the parents/carers may be essential in order to secure and preserve evidence.
- 5.12 Agency professionals must be prepared to provide statements promptly if requested.
- 5.13 Where relevant the Isle of Man Safeguarding Board (SB) Procedures will be followed.
- 5.14 The Chair of the Isle of Man SB (or their nominated deputy) must be informed when there is concern or suspicion that the child and/or their siblings have been subject to abuse or neglect in order to consider whether or not a Serious Case Review should be commissioned.

Near miss SUDIC

An infant or child may be subject to a catastrophic event of such severity that

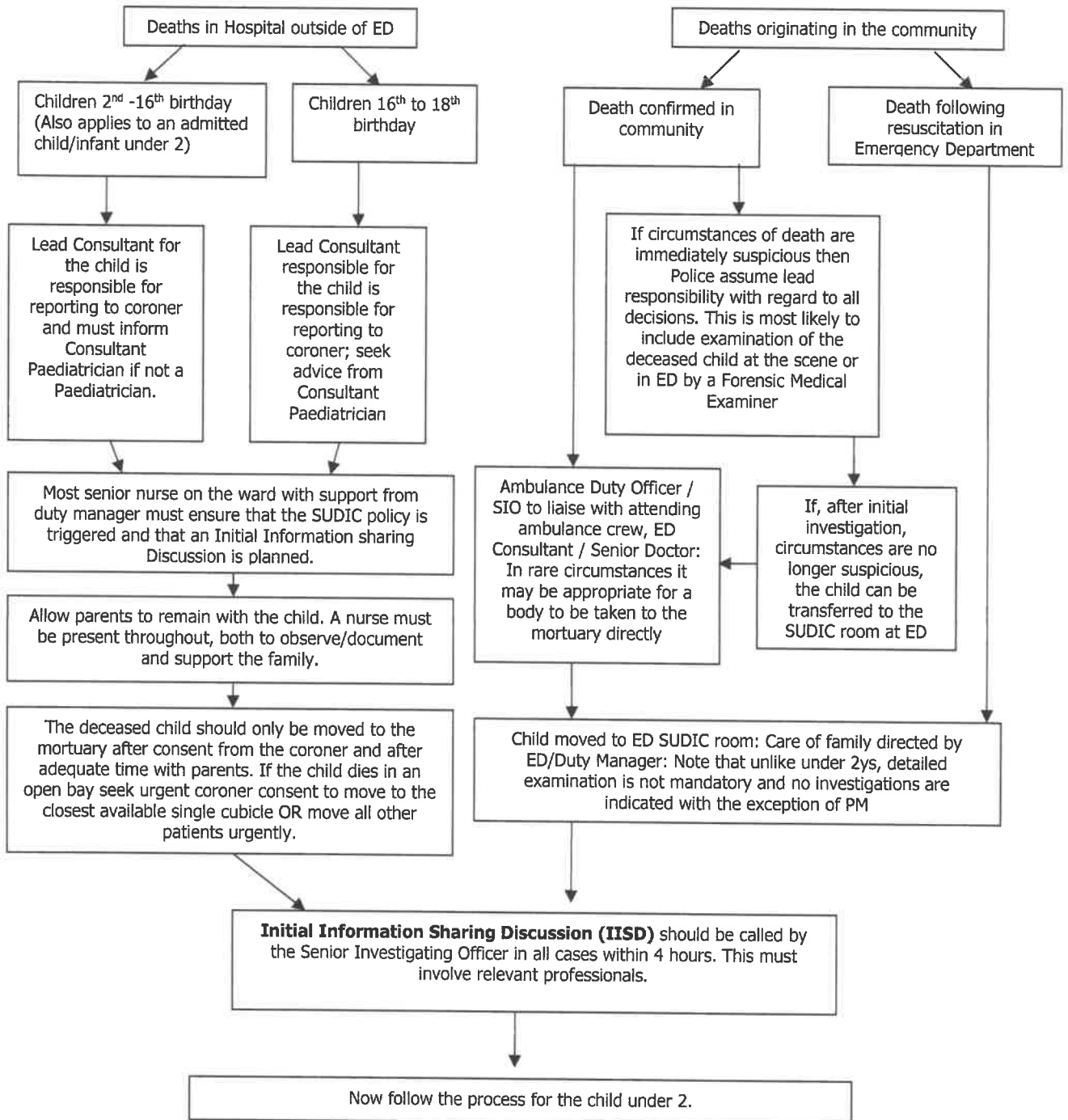
the responsible Paediatrician/ Senior ED Consultant may consider convening an Initial Information Sharing Discussion to facilitate information sharing from a safeguarding children perspective.

Sudden/Unexpected Death in Infancy and Childhood, Under 2 years Process Pathway



Sudden/Unexpected Death in Infancy and Childhood, Process Pathway from 2 years old to 18th B`day

Royal College of Paediatricians and Child Health Guidance: 'The level of detail of an investigation needs to be proportionate to the potential learning about future preventability of deaths, the need for gathering information in order to understand the cause and circumstances of death, the support needs of the family and any forensic requirements'. Note that a proportionate response may also be appropriate under 2 years.



6 Immediate medical response (Emergency Department / Paediatric Department)

6.1 The responsibility for managing SUDIC's for all children below 2 years lies with the on call Paediatric Consultant. For children over 2 years this responsibility is shared between the Emergency Department Consultant and Consultant Paediatrician (see diagrammatic pathway). In some cases no involvement of the Consultant Paediatrician is required.

6.2 Resuscitation/Immediate actions

6.2.1 The majority of infants and children found collapsed will be brought immediately to the Emergency Department at Nobles Hospital where resuscitation will be continued. Nothing in this protocol should interfere with the absolute priority of effective resuscitation if this is possible.

6.2.2 The family should be given the option to be present in the resuscitation room throughout the resuscitation procedure and when the collective decision of the resuscitation team is made to stop active resuscitation. A nurse should be identified to support the family throughout the process (see separate Nobles Hospital Pathway).

6.2.3 The standard APLS or EPLS procedures should be followed in terms of discontinuing resuscitation.

6.2.4 Once the child has been pronounced dead the Consultant Paediatrician or Emergency Department Consultant should break the news to the parent. This interview should take place in the privacy of an appropriate room. If possible the nurse allocated to care for the family should also be present. The family should be provided with the **Lullaby Trust Child Death Review Leaflet** and an explanation as to what will happen next should be given in simple and understandable terms.

6.2.5 Elsewhere than in hospital, where it is apparent to the attending doctor or ambulance staff that the child has been dead for some time and attempted resuscitation is inappropriate the police shall be informed and a police sergeant or senior detective constable shall attend the scene to authorise removal of the body to the designated SUDIC room in the Emergency Department. Such authority shall be given unless, in the opinion of that officer, the circumstances of the death are immediately and obviously suspicious. ***This protocol provides authority for removal to take place without contacting the coroner.***

6.2.6 Where the circumstances of the death are immediately and obviously suspicious then the police assume lead responsibility with regard to all decisions. This may include examination of the deceased child at the scene by a forensic medical examiner. In this situation advice on timing of application of the SUDIC Protocol will be determined by Police as they have lead responsibility.

6.2.7 Where the child has been brought to hospital for resuscitation but such has not been successful and death has been confirmed, after an examination and appropriate removal of medical devices as described below the child shall be removed to the designated SUDIC room. ***This protocol provides authority for this to take***

place without contacting the coroner or coroners officer provided a police officer is present (this does not have to be the senior investigating officer).

- 6.2.8 A child over 2 years will be accommodated in the ED SUDIC suite where appropriate support for the family will be coordinated by the ED/Duty manager.
- 6.2.9 Notification of the SUDIC to the Coroner should take place as soon as possible after the confirmation of death.
- 6.2.10 Medical devices attached to the child should normally be removed **PROVIDED THAT** the removal of the devices and the sites of attachment are carefully recorded. Endotracheal tubes need to be removed only after correct placement in the trachea has been independently confirmed by direct laryngoscopy (by someone other than the person inserting the tube and preferably also independent of the resuscitation attempts). If an intravascular cannula has been inserted and it is thought that it may have contributed to failed resuscitation (e.g. by causing a pneumothorax), then it should not be removed.
- 6.2.11 Post mortem blood samples should be taken as soon after death as practically possible along with an examination of the body (Before and/or after moving to the SUDIC room). The mechanism and site of blood sampling (e.g. cardiac puncture) must be clearly documented. If blood samples are not taken this must be clearly documented along with the reason. Any stool or urine passed by the child together with any gastric or nasopharyngeal aspirate should be sent for culture and Virology PCR film array panels. If the nappy is wet or soiled it should be removed, bagged, labelled and frozen. Consider Lumbar Puncture and other investigations if clinically indicated. NB: Authority for these actions is conferred by this policy; specific consent in an individual case is not required in advance from the Coroner. However, accurate documentation is essential.

6.3 Investigations, History and Examination

N.B Please use the medical record proforma when completing records.

- 6.3.1 A detailed examination of the body is carried out. The Paediatrician/ ED Consultant should liaise with the SIO regarding the need for Police Forensic photographs.
- 6.3.2 All samples including urine, stool, gastric aspirate and secretions obtained during resuscitation (or following transfer) should be clearly labelled and sent to the laboratory for bacterial culture and virology. All samples taken should be taken to the laboratory by any member of the medical team who was present and witnessed their collection. Request forms should be signed by the medical professional taking the samples. Samples should be received by a member of the laboratory staff.
- 6.3.3 **Blood samples:** (as listed on the medical record proforma). The site of blood sampling should be carefully documented noting any difficulty in obtaining samples, particularly if taken from the left ventricle.
- 6.3.4 **Urine:** Supra pubic aspiration may be attempted after death has been certified, but again clearly documenting the site and location.

6.3.5 It is important to attempt to collect blood and urine samples in children under 2 years as the delay between death and the post mortem examination is almost certainly likely to be longer than 24 hours and possibly longer than 48 hours.

6.3.6 It should be clearly indicated on request forms that this is a case of 'SUDIC'.

6.3.7 The following actions will usually take place:

- Staff should allow the parents to hold and spend time with their child. Ask parents if they would like photographs, lock of hair. ***The protocol provides authority for this. Consent in individual cases is not required.***
- If not already done, explain the routine nature of the Police and Coronial involvement and the requirement for a post mortem examination to be conducted.
- The parents are required to meet with the SIO prior to leaving the Hospital. It may be useful in some cases for the Doctor and SIO to record the history of events at the same time.
- In the case of a SUDIC (under 2 year) the Paediatrician and /or SIO will discuss the possibility of a home visit by a Health Professional separately or together with the SIO depending on the circumstances of the individual case. The family must be advised by the Paediatrician that this is routine and aims to explain circumstances that may have given rise to a natural or accidental death and to ensure that the pathologist is fully informed.
- The health records will be secured immediately following a SUDIC by the Designated and Named Professionals, as a precautionary measure until the situation is clarified. Prior to the Initial Information Sharing Discussion (IISD) the responsible Paediatrician and Designated Nurse or Named Nurse will request and review all health records of the child and siblings (whenever possible) in preparation for the IISD.
- The Paediatrician (ED Consultant) should provide either a copy of the medical records and/or a copy of the medical record proforma and/or a typed report to the SIO for the Pathologist.
- Consideration should be given to further investigation of the family history, (e.g. ECG, genetics referral) particularly if this is a second death.
- The nurse present will liaise with mortuary staff as soon as possible. The mortuary staff are available to meet the family prior to transfer of the body to the mortuary if requested.
- The nurse will appropriately label the child in preparation for transfer to the mortuary. All clothes, nappies and any other relevant items should be kept in a bag for the Police.
- The timing of the transfer of the body to the mortuary should be agreed between the SIO and mortuary staff.

6.4 Contacting Professionals in other Agencies

6.4.1 The Paediatrician or any Senior Clinician must notify Initial Response Team Children and Families Team Social Care at the earliest opportunity.

6.4.2 The Paediatrician, ED Consultant or any attending nurse must contact the Designated Nurse /Named Nurse for Safeguarding Children who will co-ordinate contact with other professionals and collate information from Primary Care Health Services.

7 INTER AGENCY WORKING

7.1 All unexpected child deaths require a multi-agency response for several reasons:

- To manage the SUDIC process including a co-ordinated bereavement care plan for the family
- For each agency to share information which may shed light on the circumstances leading to the child's death including; child's previous health, neglect or failure to thrive, unusual behaviours/ presentations of the child, parental substance misuse, deaths in the family etc. Information is also required about family members and others involved with the child. This information will usually need to be shared with the Pathologist/Coroner.
- To enable consideration of any safeguarding risks to siblings/any other children living in the household with appropriate referral according to Child Protection Procedures as necessary. In such circumstances the Chair of the SB, (or nominated deputy) must be informed of the death in order to consider commissioning a Serious Case Review.
- To consider staff welfare and support, including provision of Trauma Risk Management (TRiM).

7.2 Initial Information Sharing Discussion (IISD)

7.2.1 In all cases of SUDIC an initial information sharing discussion should take place within **four** hours of the death, co-ordinated by the Police Senior Investigating Officer (SIO). The meeting should involve a relevant Senior Manager from the Children and Families Division Social Care, the Responsible Consultant, (Paediatrician/ED Consultant) and other relevant professionals if appropriate. The meeting should be chaired by a senior manager from the Children and Families Division Social Care –the out of hours duty manager or the Senior IRO from the Safeguarding and Quality Assurance Unit and will be formally minuted by an administrator.

7.2.2 Where appropriate this discussion can be facilitated by telephone or MS Teams. Any decisions made during the initial information sharing discussion will be recorded in the minutes of the meeting.

7.2.3 The following are areas that must be covered in the **IISD**. However, this is not meant to be exhaustive and each case should be considered on its own merits.

7.2.4 SUDIC Case Meeting

- Background information/presentation to the SUDIC
- Background information of the Child, Family & Significant others (Social Services to check if the child is subject to a Child Protection Plan)
- Consideration of safeguarding issues of surviving children
- Outstanding/Immediate Child Protection Issues
- Nature of Suspicions
- Consideration of requesting blood samples from parents/carers
- Scene Management
- Contact with the Coroner

- Timing of Post Mortem and briefing of Pathologist
- Restrictions on viewing the child – full explanation must be provided to parents.
- Ensure parents have access to the **Lullaby Trust Child Death Review Leaflet** and understand what will happen next.
- Significant Police action (e.g. arrest of suspect, obtaining statements).
- Immediate support of the bereaved (e.g. allocation of Family Liaison Officer (FLO) or named other)
- Co-ordination of professional's contact with the family including the Paediatrician meeting with the family. It may be considered appropriate for the contact to be made jointly with Police
- Agreed point of contact with Coroners Officer
- Status of the enquiry/investigation (criminal/Section 46)
- Time and date of SUDIC strategy meeting
- Staff Welfare, including provision of TRIM
- Ensure Education are informed if indicated

Confirmation of agreed decisions and actions (to be recorded by each party within existing systems).

7.3 SUDIC Case Discussions (SCD)

A case discussion should take place within **48 hours** of the preliminary results of the post-mortem examination becoming available.

7.3.1 Chairing the Meeting

The Senior Independent Reviewing Officer (IRO) / (IRO) Safeguarding and Quality Assurance Unit Social Care will be responsible for convening and chairing the meeting.

Professionals in attendance should decide whether or not the death should be reported to the Chair of the SCB for consideration of a Serious Case Review. The referral will be completed by the SIRO.

7.3.2 Attendance

It is the responsibility of all agencies to manage attendance at a SUDIC case discussion and ensure that those attending are able to provide the relevant information and make decisions on behalf of their respective agency.

7.3.3. Each SUDIC will be unique but in considering appropriate attendance the following may assist:

Health

The Paediatrician, GP, Designated Nurse/Named Nurse and Named Midwife for Safeguarding Children, the responsible ED Consultant and the Mortuary Manager.

Social Services

Senior Social Worker and assigned Social Worker if appropriate.

Police

Detective Sergeant or Senior Investigating Officer, Family Liaison Officer.

Hospice

Head of Children and Young Peoples Services or Deputy

Others

May include the Ambulance Service and Education.

7.4 Minimum Agenda for SUDIC Case Discussion (SCD)

- Introductions
- Apologies
- Confirmation of Chair/Recorder of recommendations/actions
- Background information to the SUDIC
- Background information of the Child, Family & Significant others (including domestic abuse, mental health, substance abuse, health issues, cultural & religious issues)
- Consideration of safeguarding children issues of surviving children
- Contact with Coroner
- Results of Post Mortem
- Changes to restrictions on viewing the body of the child.
- Plan of investigation (criminal, Section 46)
- Scene management
- Timing of arrests
- Timing and form of statement taking from witnesses (including children)
- Co-ordination of professional's contact with the family including the Paediatrician meeting with the family. This may be considered appropriate to be done jointly with Police.
- Support Strategy for Bereaved (FLO/Social Worker/Primary Health Care staff/Hospice staff)
- What information from the strategy meeting will be fed back to the family by whom and when
- Feedback arrangements between professionals with timescales including the need for a further SUDIC Strategy meeting or child protection conference
- Staff Welfare (Police/SSD/Health)
- Media Strategy

7.4.1 Minutes from the SCD and agreed actions must be signed by the chair and copies must be distributed immediately to a representative of each agency present.

7.4.2 Each agency has a responsibility to ensure decisions are communicated to all relevant individuals.

7.5 Final SUDIC Case Discussion

7.5.1 A final case discussion will take place when the **full** post mortem results are available. The purpose of this meeting is to discuss all information available and to ensure no issues have been overlooked. This should also include future planning for the family.

- 7.5.2 The Senior Investigating Officer/Coroners Officer on receipt of the full post mortem results **must** inform the IRO who will convene the Final SUDIC Case Discussion.
- 7.5.3 Within this meeting there should be an explicit discussion of the possibility of abuse or neglect either causing or contributing to the death. Where there is no evidence to suggest maltreatment this also should be documented as part of the minutes of the meeting.

7.6 Records

- 7.6.1 Minutes of any such SUDIC meetings should be forwarded to all and the Child Death Review Panel Administrator within 10 working days.
- 7.6.2 Files relating to SUDIC cases should be retained by all agencies involved for 25 years from the date of death.

7.7 Multi-Agency Communication

- 7.7.1 The Police, Paediatrician (ED Senior Clinician), Social Worker and any other relevant professional must convene an IISD as set out in the first part of this protocol.
- 7.7.2 A clear initial multi-agency plan must be established and documented as soon as possible. This plan may change at any point when additional contributory information comes to the attention of any agency.
- 7.7.3 Upon completion of the Final Case Discussion the responsible Paediatrician will meet with the family (and other professionals as necessary) to explain the outcome of the post-mortem and multi-agency investigation.

8 Contact Details:

The Coroner's Office: 685474 – (Or phone Police Headquarters out of hours 631212)
Police Headquarters: 631212
Social Services: Duty Social Worker: 686179 out of hours via Police Headquarters: 631212
Consultant Paediatrician, Emergency Department Consultant/Associate Specialist on call:
Contact Hospital Switchboard: 650000

Professional Roles

9 AMBULANCE SERVICE

- 9.1.1 When the ambulance service is called to the scene of a sudden unexpected death or collapse in infants/children, the attending crew must notify the Emergency Services Joint Control Room (ESJCR). The ESJCR Supervisor must notify the Police, Ambulance Duty Officer and the Duty Paediatrician/ED Senior Clinician at Noble's Hospital.
- 9.1.2 The recording of the initial call for ambulance services should be retained.
- 9.1.3 The first ambulance crew on scene should:
- Make appropriate observations regarding the environment and circumstances including those present, for example the position of the child, clothing, bedding, feeding bottles, room temperature and general condition of the room/house and record it as soon as possible on the Patient Report Form (PRF).
 - Obtain a history surrounding the death.
- 9.1.4 Ambulance staff should **not** assume death has occurred and therefore attempt resuscitation unless it is clear that the child has been dead for some time.*

The following actions are then necessary:

- Transport the child to the Noble's Hospital Emergency Department except in cases where the Police are treating the death as suspicious, in which case, the body should only be removed with the permission of the Coroner and/or the Police.
- All information including history, observations of the scene and resuscitation details should be shared appropriately.
- Anything suspicious should be reported directly to both the Police and the receiving Doctor at the hospital.
- A copy of the PRF should be left with Police or in Noble's Emergency Department with a senior nurse or the Doctor dealing with the child.
- The parents should be kept informed

* The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Guidelines state that, 'there are clear circumstances where resuscitation should not be commenced' namely: decomposition, decapitation, massive cranial and cerebral destruction, hemi corporectomy or similar massive injury, incineration, rigor mortis, putrefaction or foetal maceration.

10 CORONER & CORONER'S OFFICER

10.1 Role of the Coroner

- 10.1.1 A coroner inquires into sudden and unexpected deaths.. It is the Coroner's duty to establish the cause of the death. If the medical cause of death is not known then a

post mortem examination conducted by a specialist pathologist will be required and an inquest will be held.

- 10.1.2 The inquest is an inquiry to find out who has died, when and where he or she died and by what means. It also considers in what circumstances the medical cause of death arose, together with information needed by the registrar of deaths, so that the death can be registered.
- 10.1.3 It may take several weeks for the the results of a post mortem examination to be made available to the Coroner. The Coroner will open the inquest as soon as possible after the death is reported, this will allow the Coroner to release the body to the child's family and for the funeral to take place. Once the post mortem report and other evidence has been provided the Coroner will resume and conclude the inquest.
- 10.1.4 An inquest is **not** a trial. It is a limited inquiry into the facts surrounding a death. It is not the job of the coroner to establish blame simply to establish the facts of the death.

10.2 Role of the Coroner's Officer

- 10.2.1 The Coroner's Officer works under the direction of the Coroner. The Officer liaises with all persons having an interest in the death (ie bereaved families, witnesses, police, doctors, pathologists, funeral directors, solicitors, social workers, registrars etc) with a view to investigating all those matters to be determined at the inquest (see above). **In the case of a SUDIC the Police may take the lead on the investigation.** The Officer reviews and collates all the required reports and statements relating to the death so as to formulate an inquest file for the Coroner's attention.

11 GENERAL PRACTITIONERS (GPs)

- 11.1 A GP may be first on the scene. In such circumstances they should adhere to the same general principles as for the Ambulance staff (see section 8). An ambulance must be called immediately.
- 11.2 The GP should contact the Police or Coroner's Officer if they are the first on the scene (taking into account the primary responsibility of saving/certifying death). It is advised that the best route for this is via the Emergency Services Joint Control Room.
- 11.3 The GP will be required to attend the SUDIC Initial Information Sharing Discussion and the subsequent SUDIC case discussion.
- 11.4 Additional guidance for GPs and Health Visitors, particularly in relation to the longer term care of the family, can be obtained from the Lullaby Trust at www.lullabytrust@org.uk : Information is available for "Professionals on how to support a bereaved family"
- 11.5 Parents will be given additional guidance and information at the hospital.

12 HEALTH VISITING SERVICE/SCHOOL NURSE

12.1 Introduction

- 12.1.1 These guidelines will inform Health Visitors/School Nurses of the procedures which they will be expected to follow in the event of the unexpected death of a child.
- 12.1.2 Health Visiting and School Health Records will be recalled and held securely by the Designated/Named Nurse as soon as possible after the death has been notified.
- 12.1.3 All Health Visitors/School Nurses should have a level of competence to deal with bereavement.

12.2 If the Health Visitor/School Nurse is First on the Scene:

- 12.2.1 Dial 999 and ask for an Ambulance to attend the scene immediately. The Police will be notified by the Emergency Services Joint Control Room.
- 12.2.2 Attempt resuscitation if trained or as instructed by the Ambulance Service. If the indications are that the child is dead and no active resuscitation has been attempted, the body should remain in situ pending the arrival of the Police.
- 12.2.3 The position of the child and the condition in which it was found must be noted together with any comments/explanations of the mother or any other person at the scene.
- 12.2.4 When the Paramedics arrive, spend time listening to the parents and offering support.
- 12.2.5 If the parent/carer goes to the hospital with the child, ensure that appropriate arrangements are made for the care of the siblings if necessary.
- 12.2.6 If the parent/carer is alone, ensure that he/she has the appropriate family support. Give the parents a contact telephone number.
- 12.2.7 As soon as possible after the incident make a precise and thorough record of the event in the child's record, making particular reference to:
 - a) Any inappropriate delay in seeking help
 - b) The position of the child and the condition in which it was found
 - c) Inconsistent explanations - accounts should be recorded verbatim in quotes where appropriate
 - d) Evidence of drugs/alcohol abuse
 - e) Parents reaction/demeanour

- f) Unexplained injury e.g bruises, burns, bites, presence of blood
- g) Evidence of neglect
- h) General condition of the accommodation
- i) Evidence of high risk behaviour e.g domestic violence

NB If the records have already been secured, make notes on a continuation sheet and forward to the Designated/ Named Nurse.

12.3 Acute Life Threatening Event (ALTE) if the Health Visitor/School Nurse is First on Scene:

12.3.1 If the child has been resuscitated and is transported to hospital, inform the Service Manager/Designated Nurse as soon as possible.

12.3.2 Ensure the record keeping steps outlined in 12.2.7 are actioned.

12.3.3 In the event that the child is less than 28 days old, the Head of Midwifery must be informed.

12.4 If the Health Visitor/School Nurse later learns that a Child has died:

12.4.1 Check that the following Agencies/Professionals have been informed of the child's death.

- a) Medical records department and maternity at Nobles Hospital to avoid follow up appointments being sent
- b) The family GP
- c) Midwife if still visiting
- d) Designated Nurse for Safeguarding Children
- e) Named Nurse/the relevant Service Managers
- f) School Nurse if there are older siblings in the family
- g) Any other department or organisation to which the child has been referred/seen if follow up appointments are possible e.g. audiology, Alder Hey.

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

12.4.3 The Health Visitor/School Nurse may be asked to accompany the responsible Paediatrician and/or a Police Officer on an initial home visit. This will be in a supportive capacity the Health Visitor/School Nurse should take any approved relevant information for the parents.

12.4.5 Discuss the nature of the support that the parents/carers/grandparents and the extended family require. If there is inadequate support available consider the need for more intensive support or alternatives, such as a bereavement counsellor.

12.4.6 If the mother was breast feeding, discuss and advise on the suppression of lactation and give appropriate support. Refer to the GP as necessary.

12.4.7 Be prepared to provide a statement if requested and seek advice from the Designated Nurse or Service Manager.

12.5 In the months following the death:

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

12.5.2 Make sure that the parents have a contact number.

12.5.3 Assess whether additional help is required to assist parents cope with their grief and arrange the appropriate support as necessary.

12.5.4 The Health Visitor/School Nurse may wish to remember the first anniversary of the child's birth and death and consider a visit at that time.

12.5.5 Offer support to any siblings of the deceased child.

12.5.6 The staff counselling service/ Designated/Named Nurse, TRiM should be available to the Health Visitor/School Nurse if they are required.

12.6 The next pregnancy:

12.6.1 Professional judgement should be exercised to ensure that subsequent pregnancies are managed effectively and sensitively. Good communication between health professionals is essential.

12.6.2 Note important anniversaries when the family may need additional support, eg the age at which the previous child died.

12.6.3 Ensure with consent from parents that the CONI (Care of the Next Infant) co-ordinator is informed to enable appropriate advice and support.

13 HOSPITAL WARDS/MATERNITY UNITS (Only applicable in cases of sudden unexpected deaths in infants)

13.1.1 When a child is found collapsed, a resuscitation team will be called and resuscitation attempted.

13.1.2 When death is pronounced the family will be supported by a senior member of staff.

13.1.3 The senior person on duty/call will inform the police and Paediatrician on call.

13.1.4 The location where the child was found collapsed should be treated as a 'scene' and processed accordingly, (ie don't touch, move or disturb anything around the bed/cot).

- 13.1.5 A Police Scene of Crimes Officer will attend and exhibits will be recorded and taken as appropriate, (e.g. bedding, clothing, feed, medical equipment).
- 13.1.6 All information and records must be updated and maintained. Health records will be secured by the Designated Professionals until the situation is clarified.
- 13.1.7 Staff should be offered support and de-briefing wherever possible.
- 13.1.8 The most appropriate member of staff should attend the SUDIC Initial Information Sharing Discussion. This must be considered a priority.
- 13.1.9 Ensure the GP, Health Visitor, Duty Officer Social Services and Designated Nurse for Safeguarding Children are notified.

14 MIDWIFERY SERVICE

14.1 Introduction

These guidelines will inform Midwives of the procedures which they will be expected to follow in the event of the unexpected death of a child.

- 14.1.1 Records will be secured by the Named midwife as soon as possible after the death has been notified. A copy will be made available for the Midwives. This is a precautionary measure until the situation is clarified.
- All Midwives should have a level of competence to deal with the issues of bereavement, but they should make reference to the approved leaflet.
 - There is an expectation that on-going care and support will be provided by the Midwife until the end of the postnatal episode of care unless, the family specifically request another member of the team. If the midwife is a witness in the case the employing agency may advise against their continuing involvement.

14.2 If the Midwife is first on the scene outside the hospital

- 14.2.1 When an unexpected fresh stillbirth or SUDIC has occurred without the presence of a health professional, or if the birth has been concealed, the Midwife must assess the child and the mothers medical condition and immediately send for the Paramedic Services. The ESJCR will inform the Police.
- 14.2.2 CPR should be attempted if deemed appropriate by the attending Midwife. If the indications are that the child is dead and no active resuscitation has been attempted, the body should remain in situ pending the arrival of the Police.
- 14.2.3 The position of the infant and the condition in which s/he was found, must be noted together with any comments/explanations of the mother or any other person at the scene.
- 14.2.4 When the paramedics arrive, spend time listening to the parents and offering support.

- 14.2.5 If the parent/carer goes to the hospital with the child, ensure that appropriate arrangements are made for the care of the siblings if necessary.
- 14.2.6 If the parent/carer is alone, ensure that she has the appropriate family support.
- 14.2.7 Give the parents/family a work telephone number where you can be contacted.
- 14.2.8 If the mother's condition requires obstetric intervention, she should be transferred to the Jane Crookall Maternity Unit. A Midwife must accompany the mother in the Ambulance.
- 14.2.9 If the infant could not be resuscitated, and there are no suspicious circumstances the child's body will be taken to the Maternity Bereavement Suite for examination by the Paediatrician and to allow time for the family to be together. This will occur after the Police, the Coroner and the Divisional Manager have been informed.
- 14.2.10 Parents and family members may have access to the child's body in circumstances as agreed at an Initial Information Sharing Discussion (IISD). An appropriate professional **MUST ALWAYS** be present.
- 14.2.11 If the Midwife has any relevant information about the pregnancy or the family, this should be reported directly to the Police and receiving Doctors at the hospital as soon as possible.
- 14.2.12 As soon as possible after the incident and within 24 hours, make a precise and thorough record of the event in the child's record, making particular reference to:
- a) Any inappropriate delay in seeking help
 - b) The position of the child and the condition in which it was found
 - c) Inconsistent explanations - accounts should be recorded verbatim in quotes where appropriate
 - d) Evidence of drugs/alcohol abuse
 - e) Parents reaction/demeanour
 - f) Unexplained injury e.g. bruises, burns, bites, presence of blood
 - g) Evidence of neglect
 - h) General condition of the accommodation
 - i) Evidence of high risk behaviour e.g. domestic violence
- NB** If the records have already been secured, make notes on a continuation sheet which can be added to the child's records at a later date.
- 14.2.13 As soon as possible the Head of Midwifery and Designated Nurse must be informed.
- 14.2.14 Midwifery staff involved in the case should be offered support and the opportunity to speak to their Supervisor of Midwives.
- 14.2.15 The family GP, Health Visitor and Social Services must be informed as soon as possible.

14.3 Acute Life Threatening Event (ALTE) if the Midwife is first on scene

14.3.1 If the child has been resuscitated and is transported to hospital, inform the Designated Nurse and Named Midwife as soon as possible.

14.3.2 Ensure the record keeping steps outlined in 14.02.12 are adhered to.

14.3.3 Ensure the GP and Health Visitor is informed as soon as possible.

14.4 If the Midwife later learns that a child has died

When a case of sudden child death occurs, best practice requires that the Midwife should:

14.4.1 Check that the following agencies/professionals have been informed of the child's death.

- a) Medical records department and maternity at Nobles Hospital, children's hospitals to avoid follow up appointments being sent
- b) The family GP
- c) Health Visitor
- d) Designated Nurse for Safeguarding Children
- e) Named Midwife/relevant Service Managers
- f) School Nurse if there are older siblings in the family
- g) Any other department to which the child has been referred/seen if follow up appointments are possible e.g audiology, Alder Hey

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

14.4.3 Discuss the nature of the support that the parents/carers/extended family require. If there is inadequate support available, consider the need for more intensive midwifery intervention.

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

14.4.5 Ensure that the Midwifery records are available to the nominated Paediatrician and Designated Nurse as required and be available to attend the Initial Information Sharing Discussion (IISD).

14.4.6 Be prepared to provide a statement if requested and seek advice from the Designated Nurse/Named Midwife.

14.5 The next pregnancy:

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

14.5.2 Scrutinise previous records to ascertain whether it is necessary to inform any other professional/agency of the pregnancy eg Social Worker.

- 14.5.3 Ensure that the history of the sudden child death is highlighted in the maternity records.
- 14.5.4 Ensure that the family receives appropriate support during the pregnancy, delivery, and post-natal period.
- 14.5.5 Ensure evidence based practice is shared with carers in respect of the following more specific risk factors such as, co-sleeping following the ingestion of prescribed medication and substances, sleep positions, smoking, temperature control.
- 14.5.6 Ensure with consent from parents that the CONI co-ordinator is informed of subsequent pregnancies to enable appropriate advice and support.

15 PATHOLOGIST AND THE POST MORTEM EXAMINATION

- 15.1.1 After the death is certified, the Coroner has control of the body. The Coroner has authorised that certain samples and mementos may be taken by the Paediatrician without reference to him (see section 6). Prior authorisation must be sought from the Coroner before obtaining any other samples or removal of mementos.
- 15.1.2 In any case of SUDIC a Paediatric Pathologist will undertake the post mortem examination/autopsy in conjunction with the Home Office Pathologist at the discretion of the Coroner.
- 15.1.3 Both the Coroner and the Pathologist must be provided with a full history at the earliest possible stage. A copy of the completed SUDIC medical proforma and a copy of hospital records or typed report should be made available to the Pathologist prior to the post mortem. This will include a full medical history from the Paediatrician, any relevant background information concerning the child and the family and any concerns raised by any agency. The Senior Investigating Officer is responsible for ensuring that this is done.
- 15.1.4 The Coroner's Officer must ensure that all relevant professionals are informed of the time and place of the post mortem examination. The post mortem should be held as soon as it is reasonably possible.
- 15.1.5 The Senior Investigating Officer should attend the post mortem examination. If this is not possible, then he/she must send a representative who is aware of all the facts of the case. A Scene of Crime Officer must attend all post mortem examinations conducted by a Home Office Pathologist.
- 15.1.6 Several investigations will be arranged by the Pathologist at post mortem examination. These include but are not limited to; a post mortem skeletal survey, samples for virological, microbiological and toxicological investigations and tissue samples for metabolic investigations.
- 15.1.7 In cases in which there is circumstantial evidence or strong suspicion of non-accidental injury or other form of child abuse, the paediatric pathologist may require the consultant paediatric radiologist's report on skeletal survey before the commencement of the autopsy.

- 15.1.8 A paediatric post-mortem examination will always involve the taking of tissue samples to produce blocks and slides for routine microscopic examination. This will be explained to the family by the Senior Investigating Officer.
- 15.1.9 If the pathologist carrying out the post mortem examination wishes to retain a whole organ (solely for the purpose of establishing the cause of death) they will ask the permission of the Coroner first. The Coroner, through their Officer, will discuss with the family their wishes in relation to the future storage or disposal of blocks and slides as well as any organs or tissues retained. The family's decision should be communicated to the pathologist(s) in a written format by the Coroner's Officer.
- 15.1.10 If the Paediatrician has initiated any investigations before the child's death the results should be shared with the SIO and must be also sent to the pathologist(s).
- 15.1.11 *All professionals must endeavour to conclude their investigations expeditiously in order to facilitate the finalisation of the post mortem examination report. The funeral of the deceased must not be delayed unnecessarily.*
- 15.1.12 The interim findings of the autopsy will be discussed with the SIO immediately after the completion of the autopsy and they will be updated as to significant results as they are available. These findings should be shared in subsequent multi-agency discussions.
- 15.1.13 The final report should be sent to the Coroner when all investigations are completed and the results of all tests made available to the pathologist. If, for any reason, there will be any undue delay then the pathologist will discuss it with the Coroner.
- 15.1.14 Once available to the Coroner a copy of the post mortem report will be sent by the Coroner's Office to the SIO and Paediatrician for the purposes of concluding the multi-agency investigation and for discussing with the parents at a final meeting.

Upon receipt of the post mortem report the SIO or paediatrician must notify the IRO who will convene the Final SUDIC Discussion meeting.

16 POLICE

- 16.1.1 It is important for Police officers to remember that in the majority of unexplained child deaths, the cause has been natural. Actions therefore need to be a careful balance between consideration for the bereaved family and the potential of a crime having been committed. The principles of the 'Golden Hour' still apply.
- 16.1.2 The 'Scene' is referred to in this Protocol as 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. In this 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 the home, this does

not negate the need for professionals to visit the home, and treat as a potential 'scene'.

In ALL cases, whether immediately suspicious or not, this protocol will be followed.

16.2 Deployment

- 16.2.1 Police attendance should be kept to the **minimum** required.
- 16.2.2 If the Police are the first professionals at the scene then urgent medical assistance should be requested as an urgent priority.
- 16.2.3 An officer of at least the rank of Detective Sergeant must attend the scene. S/he will initially be the Senior Investigating Officer (SIO).
- 16.2.4 Levels of Police attendance should be subject to constant review by the senior detective present who should also be aware of the need to explain the need for attendance to family members when appropriate. In most cases parents/carers will welcome any assistance in obtaining an explanation for their child's death and will wish to assist this process.
- 16.2.5 Consideration must be given to obtaining an early account of the facts from the family and avoiding repeated questioning by professionals.
- 16.2.6 Officers should at all times be sensitive to 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.

16.3 Initial Action & Investigation

- 16.3.1 The provision of medical assistance to the child is obviously the first priority. If an ambulance is not already in attendance then one must be immediately requested unless it is absolutely clear that the child has been dead for some time. If this is the case then a Police surgeon will need to be called to the scene to certify death. (If the child has already been removed to hospital, death will be certified by a hospital doctor). Consideration should also be given to requesting the attendance of the on-call Consultant Paediatrician to assist the initial investigation.
- 16.3.2 The first officer at the scene must make a visual check of the child and its surroundings, noting any obvious signs of injury. It must be established whether the body has been moved and the current position of the child must be recorded. All other relevant matters should also be recorded. The senior officer is responsible for ensuring that this is done.
- 16.3.3 Officers attending the scene should be aware of cultural issues and the needs of the family but primacy must be given to the investigation of the death.
- 16.3.4 A record of events from the parent/carer is essential, including details of the child's recent health. All comments should be recorded. Any conflicting accounts should

raise suspicion, but it must not be forgotten that any bereaved person is likely to be in a state of shock and possibly confused. Repeat questioning of the parent/carer by different police officers should be avoided at this stage if at all possible.

- 16.3.5 A Senior Investigating Officer (SIO) must be appointed and s/he will decide on the appropriate investigation team.
- 16.3.6 The Coroner must be notified as soon as possible. The Coroner will direct the SIO as appropriate. If the death is not suspicious then following authorisation from the Coroner the baby will be removed by ambulance staff to the Women and Children's out-patients suite.
- 16.3.7 The Notification of Sudden or Violent Death form (Blue Form) must be completed at an early stage. This will normally be initially completed by the doctor/paramedic certifying death and then completed by the reporting officer. It is the duty of the SIO to ensure completion of this form expeditiously.
- 16.3.8 Police officers need to be aware of other professionals' responsibilities, ie resuscitation attempts, taking details from the parents, examination of the dead 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 these professionals before being introduced to the parents. This is where liaison and joint working is essential as there may be urgent reasons why the police need to take urgent action.
- 16.3.9 The Senior Detective attending the scene will be responsible for decisions regarding:
- a) The attendance of a Scenes of Crime Officer (SOCO)
 - b) The allocation of a Family Liaison Officer (FLO)
 - c) The co-ordination and attendance at any subsequent inter-agency strategy discussion/meeting. All policy decisions will be appropriately recorded including whether it is appropriate to conduct a joint police/paediatrician visit to the family
 - d) Any questioning of family members ensuring that it is sensitive and avoiding, where possible, repeated questioning by Officers
 - e) The seizure of any salient evidence which may assist in identifying the cause of death and explain the reasons for doing so to the family (see initial investigation considerations list)
 - f) Evidencing factors of neglect which may have contributed to the death such as temperature of the scene, condition of the accommodation, general hygiene and the availability of food/drink. Feeding bottles and child food should be retained
 - g) Obtaining written statements from the family members at appropriate venues. If the family are at the hospital then the facilities of the Women & Children's Out-Patients department may be used
- 16.3.10 In cases where the death has occurred at the hospital Emergency Department then, if not already present, a Consultant Paediatrician (or the senior ED doctor in the case of a child over 2 years) must be informed of the child's death, so that an appropriate examination of the body can be made prior to post mortem.

- 16.3.11 The SIO should give early consideration to informing the Public Protection Unit of the death. The PPU may have access to information which may assist the investigation i.e previous child protection concerns, domestic violence reports.
- 16.3.12 Ambulance staff will complete a proforma statement of their involvement and provide a copy to the police. This will not preclude a further more detailed statement being obtained if required.
- 16.3.13 The issues of the continuity of identification must be considered. This will preferably be the police officer at the scene, but could be done by the Coroner's Officer, appropriately and sensitively. The child should be handled as if s/he were alive and should be referred to by his or her first name.
- 16.3.14 If the parents/carers wish to view the child at the mortuary, then this should normally be facilitated by the Coroner's Officer, or Family Liaison Officer if appropriate.
- 16.3.15 In most cases delay in the release of the body by the Coroner is routine. This is to allow toxicology and other testing to take place. This should be explained sensitively to the family.

16.4 Initial Investigation Considerations

- 16.4.1 The senior detective present should consider obtaining evidence to cover the following points:
- a) Basic medical history of the child and family including previous child death
 - b) Where the child was and the sleeping position/if covered state what with
 - c) What the child was wearing
 - d) When last fed, by whom and food content
 - e) When nappy last changed and by whom/where it is now
 - f) Has the child been well up until the time of death
 - g) Last seen alive by whom
 - h) What caused the adult to look/check the child
 - i) Temperature of the scene
 - j) Condition of accommodation
 - k) General hygiene and availability of food and drink
 - l) Parents any alcohol/tobacco/medication – last taken/current state
- 16.4.2 Where no suspicious circumstances arise as a result of initial actions, no further action in respect of scene preservation will be required. Consideration should be made to retain bedding (but only if there are obvious signs of forensic value, such as blood, vomit or other residues) or articles from the child's last meal, used bottles, cups, food and any relevant medication. Consideration should be given to taking bin contents, home videos, personal diaries etc. Where items are removed from the house, it must be explained to the parents that this may help to find out why their child has died.
- 16.4.3 The Personal Child Health Record should also be removed. **(The red book is a parent held record of the child's development completed by health**

professionals.) The Health Visitor may maintain separate records which are confidential. This information should be requested separately via the Designated Nurse.

16.4.4 **The child's nappy and clothing must remain on the child.** The hospital will remove and retain them at a later time.

16.5 Post Mortem

16.5.1 The SIO must attend the post-mortem examination and fully brief the pathologist with the following:

- a) A copy of the completed medical pro-forma
- b) Continuity/sequence of all events leading to the death, preferably with photographs/video with the following information:
 - The position in which the child was found by the person or in relation to the person if there was 'bed sharing'
 - The child's clothes
 - Details of the bedding
 - Room temperature and type of heating
 - Any history of smoking/alcohol consumption/drug use in the house with details of amounts and timing
 - Time of last feed including details of food given, by whom and when and if feeding the bottles have been retained
- c) Copy case notes of obstetric and paediatric period
- d) Copy of GP/Health Visiting/Midwifery records
- e) Copy of ambulance attendance sheet
- f) Details of any resuscitation attempts including by whom and when
- g) List of investigations initiated or samples taken by the ED Doctors or Paediatrician and any results when available

If the post mortem examination reveals suspicious circumstances, then it will be halted and the post mortem continued jointly with a Home Office pathologist.

16.6 Recovery & Removal of Property

16.6.1 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 why their child has died.

16.6.2 Any articles, including clothing and feeding bottles, recovered from the scene should be secured and documented.

16.6.3 Before returning any items, the parents must be asked if they actually want them back.

16.6.4 If articles have been kept during the investigation and the family have indicated that they want them returned, try to ensure that they are presentable and that any official labels or wrappings are removed before return.

16.6.5 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 process.

16.7 Welfare

16.7.1 Police involvements with bereaved and traumatised families are amongst the most difficult of any situations an officer is called upon to deal with. It requires extreme sensitivity and may have a significant emotional impact on anyone coming into contact with the family including investigators. The SIO must provide appropriate levels of support for every officer involved in this type of investigation regardless of outcome.

16.8 Documentation

16.8.1 All police files and documentation in relation to a Sudden Unexplained Death in Infants and Children must be kept for a minimum of 25 years from the date of death.

16.9 Additional Information

16.9.1 Further information to assist the SIO is available within the ACPO Guidance on 'Infant Deaths' contained in the Murder Investigation Manual.

17 SOCIAL CARE (CHILDREN & FAMILIES)

17.1 The Children and Families Team Social Care via the Initial Response Team must be informed whenever a child dies in infancy and whenever a child dies and the death is unexpected.

17.2 When the Children and Families Team Social Care are informed that a child has died and the death is unexpected, they will check whether any member of the family is known. This will include a check to determine whether the child is subject to a Child Protection Plan or has historically been subject to a Child Protection Plan

17.3 The Initial Response Team Social Care will, in all cases report the death to the relevant Duty Team Manager and at the earliest possible time to the Senior IRO who will oversee the processes and inform the Director of Children and Families.

17.4 The senior member of the Initial response Team will be responsible for liaising with the investigating Police Officer and agreeing an appropriate course of action. They will instigate an Initial SUDIC Information Sharing Discussion to include all relevant other professionals. From this point on and at any time it may be appropriate to initiate Section 46 inquiries, if so, roles and responsibilities must be clarified in the normal way. There must be an accurate record of the decisions reached and a copy sent to the SIO who is responsible for any correspondence with the coroner.

- 17.5 At this stage post mortem results are usually not known and regular contact must be kept with key personnel, to ensure that no further information or concerns have been raised.
- 17.6 A SUDIC Case Discussion should be held when the preliminary results of the post mortem are available. This will be chaired by the Senior IRO/IRO. The results of the post mortem belong to the coroner and will be shared with the Paediatrician and the Senior Investigating Officer from the Police. If there are concerns as a result of the post mortem a further strategy meeting should be convened following the Isle of Man Safeguarding Children Board Policies and Procedures. The strategy meeting in SUDIC cases should be chaired by a Senior Manager from Social Services.
- 17.7 SUDIC Case Discussions must always include detailed discussion on surviving children of the family/household. These discussions should take account of any possible needs for safeguarding such children and in all cases an initial assessment should be completed. Where a section 46 inquiry has been instigated this requires that any surviving siblings are fully assessed. This assessment will include speaking directly to any siblings, visiting the home and assessing the parenting capacity of the carers.
- 17.8 Normal practice would be to inform parents and carers of any decisions and discussions made. A decision will be made at the initial strategy discussion meeting regarding what information will be shared with parents/carers.
- 17.9 The conclusion of any Section 46 Enquiries should be recorded fully on the form NARRATES s46 Assessment Template.
- 17.10 The Senior IRO is responsible for facilitating the immediate inquiry of all SUDIC's for the Isle of Man in line with this protocol. (See Appendix A SUDIC Monitoring Form.) This includes providing all relevant details to the Serious Case Review Panel and the Administrator of the Child Death Overview Panel.

Staff must ensure that full and accurate contemporaneous notes are kept throughout the inquiry and any inconsistencies brought to the attention of the police.

Throughout the course of any inquiry or investigation it is important that the lead agencies agree on informing the parents/carers on the outcome of each stage. If the police are conducting criminal investigations it is important that they lead this aspect of the investigations. The criminal investigation may be run in conjunction with a child protection inquiry but the criminal investigation will take priority.