1. INTRODUCTION

1.1 All Local Safeguarding Children Boards (LSCBs) are required to have arrangements in place to review the reasons for all child deaths. This is done through the Child Death Overview Panel (CDOP).

1.2 This guidance provides a framework for the investigation and care of families after an unexpected death of an infant or child.

1.3 The guidance details a multi-disciplinary approach that will ensure to achieve:

- Sensitive care and support to all affected by the death.
- Preservation of evidence at the place of death.
- Full documentation of all interventions by paramedical and medical staff, including resuscitation prior to the certification of death.
- The completion of a full medical history by medical staff.
- A full review of all the medical records of the deceased.
- A paediatric pathologist (and if necessary a forensic pathologist) investigating the cause of death.
- A multidisciplinary case discussion.

1.4 This guidance should be used for the sudden and unexpected death of a child under the age of 18 years irrespective of place of death:

- At home or in the community
- In the hospital Emergency Department or in the Ward

1.5 It is essential that every professional involved in a Sudden Unexpected Death in Infants and Children (SUDIC) case must be fully aware of the guidelines and should keep meticulous records.

1.6 The sudden and unexpected death of any person demands the most thorough investigation of the highest standard. A sudden and unexpected death of an infant or a child (SUDIC) is no exception.

1.7 Unexpected death refers to the death of a child that was not anticipated as a significant possibility 24 hours before the death or where there was an unexpected collapse leading to or precipitating events that led to the death. This would also include unexpected death of a child with disabilities and/or chronic medical conditions (see *Working Together to Safeguard Children, 2015)*.

1.8 Factors in the environment, history or examination may give rise to concern about the circumstances surrounding the death. These SUDIC guidelines should be followed where non-accidental injury is suspected to have resulted in the death of a child.

1.9 PRINCIPLES

When dealing with sudden unexpected child death (SUDIC), all agencies need to follow common principles as follows:

- A sensitive, caring, open-minded and balanced approach
- An awareness of religious and cultural differences
- An inter-agency response
- Sharing of information
- Appropriate response to the circumstances
- Preservation of evidence

Investigation of a SUDIC case is a multi-agency task and all the professionals who are involved in the case are inter-dependent for sharing of information with the proficient level of expertise. It is strongly advised that the text should be read as a whole and not just the section related to the reader's own particular role.

1.10 DEFINITIONS

1.10.1 Expected and Explained

Child expected to die and cause of death explained.
Example: A child with malignancy who dies in appropriate circumstances. **This guidance does not need to be followed in these circumstances**.

Death in a hospice is generally expected and explained. However, if there have been concerns raised about the circumstances around the death, it should be discussed with the Coroner.

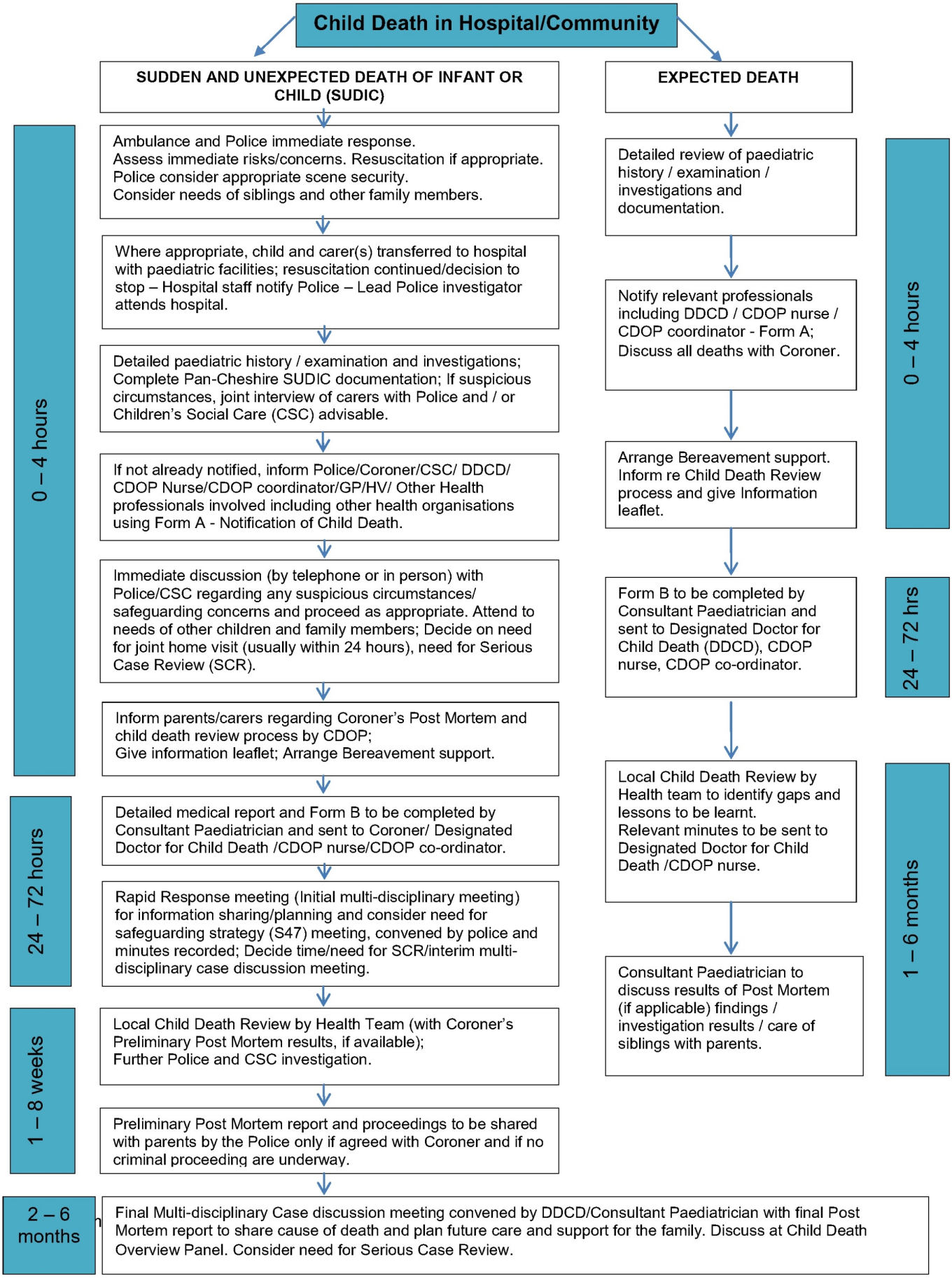
NB: "Form A – Notification of a Child Death" must be completed.

1.10.2 Expected and Unexplained

Child expected to die and the cause of death is not explained by the condition.
Example: A child with malignancy who dies earlier than is expected or in unexplained circumstances. Concerned clinician (General Practitioner, Consultant Paediatrician or the Emergency Department Consultant) is advised to discuss the case with the Coroner to decide as to whether a complete investigation is indicated as per the SUDIC guidelines.

NB: "Form A – Notification of a Child Death" must be completed.

2.2 Pathway Following the Death of an Infant or Child under 18 years



2.3 INTER-AGENCY WORKING

2.3.1 The Duty Consultant Paediatrician and SIO from the Police will inform the Coroner of any deaths of infants or children that meet the criteria for applying this procedure and ensure that a full multi-agency investigation will take place.

2.3.2 Every infant or child shall be taken to the Emergency Department unless the SIO after discussion with the Duty Consultant Paediatrician decides otherwise. The body will then be transferred to the mortuary before being transported to the hospital where the post mortem will take place (usually Alder Hey Children's Hospital, Liverpool or Manchester Children's Hospital). The SIO will liaise with the Coroner to decide whether a post mortem will take place and who will undertake it. In most cases the Coroner's Office will arrange transportation of the body. However, in cases deemed suspicious, this process will be managed by the SIO in order to preserve evidence.

2.3.3 In circumstances where the death of the child has been confirmed outside of hospital, North West Ambulance Service (NWAS) will not transport the deceased child to the respective hospital. This is achieved through contact with the Coroner's Removal Service and is arranged by the Police, using the Coroner's Removal Service.

2.3.4 The following documentation needs to accompany the body to the hospital where the post mortem will take place for the attention of the Paediatric Pathologist:

- Hospital case records.
- Ambulance notes.
- Emergency Department notes.
- SUDIC guideline forms, duly completed (Appendices 1 to 8).
- Obstetric delivery notes of the mother if the child is less than three months old.
- Police Report on Sudden Deaths (Form 92 in East Cheshire).
- General Practitioner's notes.

2.3.5 The SIO shall initiate the **immediate information sharing and planning** discussion with the Duty Consultant Paediatrician as soon as possible. This discussion usually takes place in the Emergency Department. A check with the Local Authority's Children's Social Care service must always be made at this stage.

2.3.6 The purpose of the discussion is to:

- Share information to identify the cause of death and/or those factors that may have contributed to the death.
- Identify any at-risk factors and/or suspicious circumstances.

2.3.7 **Joint Death Scene Visit**

When an infant or child dies unexpectedly in a non-hospital setting, the SIO from the Police discusses with the health professional whether a joint visit should or should not be undertaken, depending on local arrangements.

2.3.8 **Rapid Response Meeting (Initial Multi-Disciplinary Meeting)**

A Rapid Response Meeting (Initial Multi-Disciplinary Meeting) **should take place within 72 hours where possible or no later than five working days** after the child's death. This should be arranged and chaired by the SIO, in conjunction with the attending paediatrician, along with the Designated Paediatrician for Child Deaths. The SIO will ensure that the meeting is recorded in writing and the minutes are circulated to appropriate agencies within five working days of the meeting.

2.3.9 **The purpose** of the Rapid Response Meeting (Initial Multi-Disciplinary Meeting) is to:

- Share information to identify the cause of death and/or those factors that may have contributed to the death, including information from any home visits.
- Plan future care of the family, including who will provide the family with information about support groups, bereavement, etc.
- Identify any lessons to be learned from this process.
- Gather further information for the inquest.
- Share information from each agency from previous knowledge of the family and records. In particular. any reference to the circumstances of the child's death; previous or ongoing child protection concerns, previous unexplained or unusual deaths in the family; neglect, failure to thrive, parental substance abuse, mental illness or domestic violence. Information is also required about family members and others involved with the child.
- Decide what should happen next.
- Share information about any subsequent joint agency investigation.
- Enable consideration of any child protection risks to siblings/any other children living in the household and to consider the need for child protection procedures and any other action, for example health overview for other children in the family.
- Agree when a follow-up case discussion meeting will be held within the subsequent ten to twelve weeks.

2.3.10 **The SIO will also ensure that the meeting is minuted and the minutes are circulated to appropriate agencies within five working days of the meeting.**

2.3.11 **Final Multi-Disciplinary Case Discussion Meeting**

A final Multi-Disciplinary Case Discussion Meeting must be held as soon as the final post mortem results are available. This will normally take place within about ten to twelve weeks after the child's death. The meeting is a follow up meeting subsequent to the Rapid Response Meeting and will be convened and chaired by the SUDIC Paediatrician (see *Working Together to Safeguard Children 2013*); 25;82; WTSC 2015. The recommendations from this discussion will be submitted to the local CDOP, with a copy to the Coroner.