1. Introduction

1.1. This procedure sets a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the process of communication, collaborative action and information sharing following the unexpected death of a child.

1.2. The procedural response begins at the point of death and ends with the completed Record of Child Death being sent to the Child Death Review (CDR) Programme, following the Case Review Meeting when the final results of the post mortem examination have been shared or the inquest or trial has taken place.

1.3. This procedural response will be followed when:

- a decision has been made that the death of a child is unexpected or
- there is a lack of clarity about whether the death of a child is unexpected or
- the cause of a child's death is not apparent and it is not possible to issue a death certificate

1.4. The aim of the PRUDiC is to ensure that the response is safe, consistent and sensitive to those concerned, and that there is uniformity across Wales in the multi-agency response to unexpected child deaths.

1.5. This is a multi-agency procedural response intended to ensure consistency across Wales, and is not agency or discipline specific. It outlines what needs to be achieved and gives broad suggestions about the roles of agencies. It does not replace existing internal agency or professional procedures.

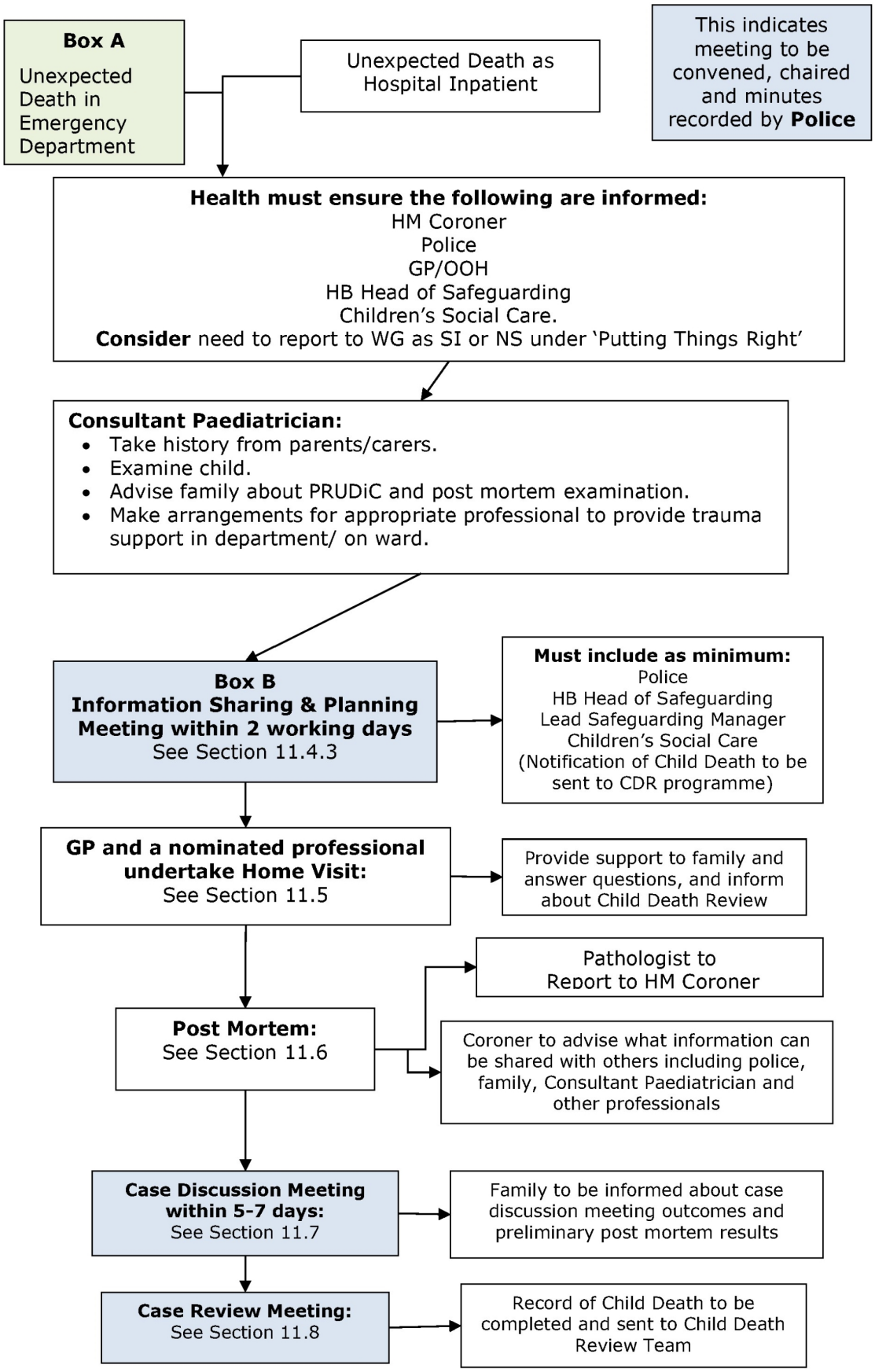
1.6. The procedural response sets out a structure within which reasoned judgements can be made when evaluating an unexpected child death on the basis of all available information. It is important therefore that all staff remain open-minded when considering any death and avoid reaching conclusions inappropriately outside of the agreed processes.

1.7. The procedural response on behalf of HM Coroner will be coordinated by the police. The PRUDiC recognises that HM Coroners are independent judicial officers and it does not create any legally enforceable rights, obligations or restrictions upon them.

1.8. All child deaths that are unexplained or unnatural are notified to HM Coroner as soon as the fact of death has been confirmed and consideration is given to the need for a full police/coroner's investigation, including an inquest.

1.9. HM Coroner has a duty to conduct an investigation into any violent or unnatural death or where the cause of death is unknown, to ascertain how when and where the deceased came by his or her death. The scope of PRUDiC is wider than this (see Appendix 4 The Seven Key Strands) and the procedure will be implemented in all unexpected child deaths.

1.10. The procedural response will enable the capturing of immediate information about unexpected child deaths. A number of templates have been developed to assist in the collection of information regarding child deaths for the Child Death Review Programme: a Notification of Child Death form and a Record of


Box A
Unexpected Death in Emergency Department
Unexpected Death as Hospital Inpatient
This indicates meeting to be convened, chaired and minutes recorded by Police
Health must ensure the following are informed:
HM Coroner
Police
GP/OOH
HB Head of Safeguarding
Children's Social Care.
Consider need to report to WG as SI or NS under 'Putting Things Right'
Consultant Paediatrician:
Take history from parents/carers.
Examine child.
Advise family about PRUDiC and post mortem examination.
Make arrangements for appropriate professional to provide trauma support in department/ on ward.
Box B
Information Sharing & Planning Meeting within 2 working days
See Section 11.4.3
Must include as minimum:
Police
HB Head of Safeguarding
Lead Safeguarding Manager
Children's Social Care
(Notification of Child Death to be sent to CDR programme)
GP and a nominated professional undertake Home Visit:
See Section 11.5
Provide support to family and answer questions, and inform about Child Death Review
Pathologist to Report to HM Coroner
Post Mortem:
See Section 11.6
Coroner to advise what information can be shared with others including police, family, Consultant Paediatrician and other professionals
Case Discussion Meeting within 5-7 days:
See Section 11.7
Family to be informed about case discussion meeting outcomes and preliminary post mortem results
Case Review Meeting:
See Section 11.8
Record of Child Death to be completed and sent to Child Death Review Team

3. Unexpected Death of a Child

3.1. The unexpected death of a child has been defined as:

'The death of a child which was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death'.[1]

and as

'The death of a child where there is no known antecedent condition that might be expected to cause the death at that time, and the child dies either immediately or subsequently from the consequences of the precipitating event or collapse'.[2]

The second part of this definition is especially relevant when there is a significant time delay between the collapse of the child and the eventual death.

3.2. The PRUDiC applies to all unexpected deaths in children from birth until their 18th birthday, whether from natural, unnatural, known or unknown causes, at home, in hospital or in the community. This includes road traffic collisions, apparent suicides and murders. This does not include stillbirths and the death of pre-viable babies born before 24 weeks.

3.3. If a baby dies within 24 hours of birth before discharge from hospital but with no immediate medical explanation apparent for the death, the situation will be discussed by the Consultant Neonatologist and a Named Professional for Safeguarding Children. They will make a decision, informed by the circumstances surrounding the death and information available to them within health, as to whether the case should be regarded as an unexpected death and so fall within the PRUDiC.

3.4. If a baby dies within 24 hours of birth after discharge from hospital, the death will be treated as an unexpected death and fall within the PRUDiC process.

3.5. If a baby dies within 24 hours of a home birth with no immediate medical explanation apparent for the death, the death will be treated as an unexpected death and fall within the PRUDiC process.

3.6. If a baby dies within 24 hours of birth whilst under medical supervision, (whether in a medical setting or not), and there is a clear medical explanation for the death, this will **not** be treated as an unexpected death.

3.7. Where professionals are uncertain about whether the death is unexpected, the death will be treated as unexpected and this procedure will be followed.

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[1] Fleming et al.
[2] American Academy of Paediatrics

4. Children with an All Wales Emergency Care Plan (AWECP)

4.1 Children who are known to have a life limiting or life threatening illness may have an All Wales Emergency Care Plan in place. This plan should facilitate multi-professional communication before and around the time of death in the event of the child dying in an expected way. The existence of an AWECP should reduce the number of events where a child dies and a PRUDiC being inappropriately triggered.

4.2 If a child who has a life limiting or life threatening illness dies in an unexpected way, or professionals are surprised that death has occurred then the PRUDIC should be triggered. The AWECP (if one is in place for that child) will facilitate the PRUDiC and ensure a timely and sensitive investigation.

5. Expected Death of a Child

5.1. Deaths identified from the outset as falling outside the definition of an unexpected death need not be subject to this PRUDiC but must be notified to the CDR Programme by the professional who confirms the fact of death, using the notification form (see Appendix 5 for a link to Forms).

5.2. Initial bereavement care and support should be provided to the family by the Health Team involved with the child, and the family should be informed at an appropriate time of the Child Death Review process.

6. When a Child Dies Unexpectedly in Another Area

6.1. Whenever a child dies unexpectedly in Wales there is an expectation that the PRUDiC process will be implemented. However, it is recognised that there may be occasions when the principles of the PRUDiC process and the family will be better served by another process such as the English Child Death Overview Panel.

6.2. When a child dies in Wales, but outside of their normal area of residence in Wales, the PRUDiC will occur wherever the family and the principles of the PRUDiC process will be best served. There should be communication between the Senior Investigating Officer (SIO) and the relevant Heads of Public Protection, the Lead Managers for Safeguarding in Children's Services and the HB Heads of Safeguarding in both areas to decide how to proceed.

6.3. When a child dies in England, but is normally resident in Wales, the PRUDiC or the English Child Death Overview Panel process may occur wherever and however the family and the principles of the PRUDiC process will be best served. There should be communication between the SIO and the relevant Heads of Public Protection, the Lead Managers for Safeguarding in Children's Services and the HB Heads of Safeguarding in both areas to decide how to proceed.

6.4. If a child dies in Wales, but is normally resident outside of Wales, the PRUDiC will occur wherever and however the family and the principles of the PRUDiC process will be best served. There should be communication between the SIO and the relevant Heads of Public Protection, the Lead Managers for Safeguarding in Children's Services and the HB Heads of Safeguarding in both areas to decide how to proceed.