

# CHILD DEATH REVIEW ARRANGEMENTS

Multi Agency Protocol  
for the Management of Unexpected Childhood Deaths.

**Revised Summer 2010**



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## **1.0 General**

### **1.1 Introduction**

The Cambridgeshire and Peterborough Safeguarding Children Boards have combined to adopt this protocol. Its purpose is to support professionals and organisations to work together in a coordinated way when a child has died unexpectedly. The document 'Child Death Overview Panel Arrangements and Terms of Reference' details how information about all child deaths in Cambridgeshire and Peterborough are collated and analysed by the Child Death Overview Panel, or CDOP. All professionals in conjunction with any relevant policies, procedures or protocols of their own agency, should follow the protocol. This protocol will be reviewed subject to further governmental advice.

The unexpected death of a child is traumatic for everyone involved. The family will experience extreme grief and shock and professionals will need to support them sensitively. Unexpected deaths deserve to be fully investigated to identify contributory factors and prevent future deaths. The investigation needs to balance medical management with care and support of the family, plus an understanding of the cause of death. It may require information collected for forensic purposes.

### **1.2 Aims**

Professionals work together in a coordinated way;

- Establish the cause of death
- Support the family
- Identify contributory factors which might prevent future deaths
- Gather information to contribute to the LSCB Child Death Overview Panel arrangements

Knowing how and why a child died may offer comfort to parents and families and lessen a natural tendency to blame themselves. Professionals who understand about contributory factors may be able to use this information to prevent future deaths. 5000<sup>1</sup> children die in the UK each year, a very small number of these will have a malicious or non-accidental cause. Examining all childhood deaths will help to highlight these cases and help inform us about the risk factors.

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<sup>1</sup> Warwick University quoting ONS 2004

The LSCBs have a responsibility to ensure a coordinated response by partner agencies to the unexpected death of a child. Together with reviewing all child deaths, this information can advise local strategic planning about the modifiable factors, which may prevent future deaths.

### **1.3 Processes**

When a child dies unexpectedly, several processes are instigated;

- CDOP have a responsibility to review all deaths up to the age of 18
- Whenever an unexpected death occurs, the Coroner is notified in order that he may investigate and establish the cause
- In the event of an on-going criminal investigation the Crown Prosecution Service must be consulted
- If the abuse or neglect is suspected to be a contributory factor in the death the respective LSCB chair must be informed to consider if a serious case review is appropriate.
- If there are concerns about the needs of surviving children in the household, Social Care should be consulted.
- All Trusts, including Primary Care Trusts, should follow their agreed procedures for reporting and handling serious patient safety incidents.<sup>2</sup>

### **1.4 Statutory Implications**

The protocol is based on the guidance in Chapter 7 of Working Together, 2010. An agency departing from the protocol may be required to justify their actions to the LSCB. The relevant professionals still need to refer to the source guidance documents in order to fully appreciate their responsibilities.

### **1.5 Definitions**

#### **Child;**

All young people who have not yet reached their 18<sup>th</sup> birthday, including those living independently, in further education, employment, a member of the armed services, in hospital, in prison or a Young Offenders Institute. It includes the death of all children where a birth certificate has been issued, but excludes all planned terminations.

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<sup>2</sup> NPSA website: [www.npsa.nhs.uk](http://www.npsa.nhs.uk) and for core standard on patient safety see 'Standards for Better Health' (2004) [www.dh.gov.uk/publications](http://www.dh.gov.uk/publications)

**Parent;**

The adult or adults with legal “care and control” of the child at the time of death with ‘parental responsibility’ (PR) for the child. PR may be shared with the Local Authority through a care order, or given to an adult through legal process such as adoption. Any person with PR whether caring for the child or not at the time of death will be deemed to be a ‘parent’.

**Sudden Infant Death Syndrome (SIDS);**

The sudden death of an infant less than one year of age, which remains unexplained following thorough case investigation, including complete autopsy, examination of the death scene and a review of the clinical history.

**Sudden Unexpected Death in Childhood (SUDC);**

The sudden death of a child over 1 year, up to 18 years, which was not anticipated as a significant possibility 24 hours before death. Alternatively, where there was an unexpected collapse leading to, or precipitating, the events that led to the death.<sup>3</sup>

**Sudden Unexpected Death in Infancy (SUDI);**

The sudden unexpected death of a child under the age of 12 months.

**2.0 Responsibilities****2.1 Joint responsibilities**

Agencies are required to identify staff to undertake their normal tasks as well as working together as a multiagency team following the death of a child. This team will be coordinated by either a police officer or health professional to;

- Ensuring that bereaved families are treated with sensitivity and respect, offered appropriate support and kept fully informed
- Adopting an open minded and proportionate and professional approach to circumstances
- Ensuring that evidence is preserved and that the death is thoroughly investigated
- Providing a prompt response and ensuring that the investigation is completed expeditiously

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<sup>3</sup> W2G Para 7.6 P.156 (quoting Flemming et al 2000)

- Respond quickly to the unexpected death of a child.
- Undertake immediate enquiries into the death and evaluate and interpret the available information.
- Make enquiries or investigations, which relate to the responsibilities of their organisations when a child dies unexpectedly including liaising with those who have ongoing responsibilities for surviving family members.
- Collect information to inform the Coronial process.
- Collect information for the Child Death Review process
- Maintain close liaison with family members and other professionals working with surviving family; ensure they are appraised of results of enquiries.

## **2.2 Evidence of Criminality**

In most situations professionals will have no reason to suspect a death involves a criminal act. However, should there be **any** suspicion a child has died from an unlawful act, then the presumption shall be that the child's body and the place of death are both crime scenes. These will need to be secured pending the arrival of a Police Senior Investigating Officer. Whilst every effort will always be made to resuscitate a child, if it is clear no medical intervention can help, the crime scenes must be secured as soon as possible.

## **2.3 Notifications to Coroners**

The Coroner must be notified of a body lying within his jurisdiction when:<sup>4</sup>:

- ◆ The child died a violent or unnatural death.
- ◆ The death was sudden death or of unknown cause.
- ◆ The child died in prison.

A body cannot be moved across jurisdiction boundaries without the coroner's permission. However, with prior permission Coroners will accept the removal of a body to a Emergency Department in accordance with this protocol.

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<sup>4</sup> Sn 8(1) Coroners Act 1988

The Coroner must be notified by the Police or attending clinician depending on circumstances of death. Both must assure themselves that the notification has been made, or undertake the notification themselves.

All information about the circumstances of the death, including a review of all medical, social and education records, must be included in the report for the Coroner.

The LSCB Child Death Review Form B (see Appendix B) should be used as basis for the report. This should reach the Coroner within 28 days of the death unless awaiting some crucial information in cases where there is a Post Mortem. An interim report may be forwarded to the coroner if appropriate.

## **2.4 Record Keeping**

Records are essential to the learning process and potentially for court proceedings; therefore accurate records must be kept of all tasks undertaken as directed by this protocol.

- ◆ Decisions must be recorded, together with reasons.
- ◆ All records must be legible, timed dated and signed by the author.
- ◆ A record of what was said by parents and carers will need to be made and remarks attributed to a named person.
- ◆ Opinion needs to be distinguished from fact.

## **2.5 Coordination of Response**

- ◆ Working Together notes the 'Designated Paediatrician with responsibility for unexpected deaths in childhood' has lead responsibility for most of the processes detailed in the guidance. This is set out in 3.7 below.
- ◆ The Named Nurse and Rapid response Coordinator will support the designated paediatrician in ensuring that the child death review arrangements are followed.
- ◆ All agencies that have been involved with the child (before and after death) are expected to cooperate fully with the coordinator and the lead professional for the Rapid Response process.

## **2.6 Individual Agency Responsibility**

Individual agencies are encouraged to develop compatible guidance for their staff. This should be ratified by the Child Death Overview Panel to ensure that it is compatible and consistent with this protocol.

## **2.7 Adjoining Counties**

Occasionally children from Cambridgeshire or Peterborough are cared for, or hospitalised “out of County”, alternatively a child “out of County” is transferred to a Cambridgeshire or Peterborough hospital or carers. The principle to be followed is, whilst for the coroner the place of death determines responsibility, it is the child’s usual home address, which determines the responsible authority for the Child Death Review Process. When an unexpected child death occurs within the Cambridgeshire and Peterborough area, the police will be responsible for the initial notification of the death to the home area. Subsequently, the Named Nurse lead for unexpected child death process will notify the Designated Safeguarding Children Nurse for the area of resident and the Child Death Co-ordinator will liaise as appropriate.

## **3.0 Responding to the unexpected death of a child**

### **3.1 General Principles**

This protocol cannot predict all circumstances relevant to an individual death; rather it sets out guidelines and principles to follow as circumstances dictate. However staff must be mindful that most of this guidance is statutory, therefore departures from it will need to be documented with a rationale.

The principles applied are;

- ◆ This protocol is applicable to unexpected deaths in children, of any natural, unnatural or unknown cause, at home, in hospital or in the community.
- ◆ It excludes those babies who are stillborn and planned terminations of pregnancy carried out within the law.
- ◆ Where the cause of death is obvious, e.g. a road traffic collision, some consideration should be given to the events leading up to the death; for example a young unsupervised child who is killed may need further investigation.

- ◆ Children with Life Limiting of Life Threatening (LL/LT) conditions are as valued and important as those of any other child. The application of this protocol should be considered and the response should be appropriate and supportive.
- ◆ If a death is anticipated due to a known terminal condition, it should only be subject to this protocol if there are reasons to be concerned about the circumstances of their death.
- ◆ The rapid response team and CDOP coordinator are generally advised of deaths likely to occur shortly especially if the death is planned to take place at home. The rapid response team will keep these notifications under review at the rapid response team meetings. The circumstances of each death will be considered separately as they occur, as a rapid response may still be helpful if it is felt the death has not occurred as anticipated.
- ◆ The protocol is applicable for unexpected deaths of children across the Cambridgeshire and Peterborough area, irrespective of their home address. For an out of area child, prompt and close co-operation between the child death response arrangements of the respective Local Safeguarding Children Boards is essential to ensure a co-ordinated approach and agree appropriate management of the response.
- ◆ To achieve a balance between forensic and medical requirements with the family's need for support.
- ◆ Children with an existing disability or medical condition where the death is not anticipated, have the same level of review as any other child.

### **3.2 First Response, Ambulance staff, GP, Fire & rescue**

At the scene of an unexpected death, the first responsibility is the preservation of life; the second is a duty to safeguard other children. Resuscitation should always be initiated unless it is clearly inappropriate to do so. As soon as practicable, the child should be removed to the nearest Emergency Department. Ambulance staff should;

- ◆ Attempt resuscitation in all cases unless there is a condition unequivocally associated with death or a valid advance directive. That is, not to automatically assume death has occurred.
- ◆ Clear the airway and, if in any doubt about death, apply full Cardio Pulmonary Resuscitation.
- ◆ Inform Emergency Department of estimated time of arrival and patient condition

- ◆ Take notes about how body was found, including anomalies/inconsistencies of accounts and marks/injuries and discuss these with the police and a senior investigating officer

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Where resuscitation is inappropriate it is still preferable to take the child to hospital. The only exception to this may be the designation by the police of a crime scene. Most other actions from this protocol follow the child's removal to hospital, if it is an infant this should be to the emergency department where the SUDI protocol will be followed. For an older child this may be to the mortuary. Where there is a need to examine the body this will be done in the mortuary after a discussion with the police, this will be extremely rare and undertaken by a senior clinician. If a health professional, other than Ambulance staff, be the first to attend, they should follow the same principles as ambulance staff.

When the area and body has been determined a crime scene, the child must not be removed without prior discussion with the senior investigating officer.

Please note CDOP will shortly be issuing an addendum to this practice guidance regarding removal to the mortuary when a child is clearly dead and resuscitation is not appropriate. If you are reading a printed version of this protocol please check the LSCB website for the current guidance.

All professionals working with families during this very stressful process need to be mindful of the support of parents when they are not within the support structures available through the Emergency Department. This may involve with practical support to enable them to respond to the needs they may have to travel with their child, to ensure they have the best information possible about what is happening, and emotional support including contact details of professionals who can offer longer term support.

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(n.b. CDOP is seeking clarification from the coronial service of how to respond when a child is clearly dead and resuscitation is not appropriate. An addendum will be issued once this has been received)

### **3.3 When a child remains at home following death**

If a child dies unexpectedly at home or non-hospital setting, the professional confirming death should contact the Rapid Response team at the earliest opportunity through calling the police control room on 01480 426001. As soon as possible, the police should make telephone contact with the health professional named on the on-call rota. If unavailable the police should leave a message with their contact details, basic information regarding the death and the health professional should contact the police officer as soon as possible. Between the police and the health professional they will identify the person to instigate the information sharing meeting, home visit and information collection and provide support to family. If it is decided a home visit will not take place then the reason for this is taken at the information sharing meeting and recorded.

If it is necessary to leave the child in situ, most usually this is because of queries about the cause of death. As far as practicable the scene should be undisturbed so staff completing the home visit can interpret the scene as the child died. If there are suspicions the child had died from an unlawful act, the scene must be secured at the earliest opportunity, and 'handed over' to the first Police officer to attend. Any suspicions must be reported to the Police and the receiving Doctor at the earliest opportunity.

### **3.4 Hospital Staff in Emergency Department**

Most children will be taken to the nearest emergency department. The Emergency department staff will be responsible for assembling a paediatric resuscitation team, including on call paediatric staff and to promote ongoing care and family support. On arrival at ED;

- ◆ All information gathered by the Ambulance crew or GP should be shared with the medical staff taking over responsibility for the child.
- ◆ On arrival the child should be taken to an appropriate room for the continuation of resuscitation.
- ◆ Parents should be given the choice of remaining with their child whilst resuscitation is attempted or be allowed to go to a private room and be kept fully informed as to what is taking place.
- ◆ Staff should be sensitive to the needs of the parents and ensure they refer to the child by name and in the present tense.
- ◆ If possible a nurse is appointed to act as an interface between the family and the medical team attending to the child.
- ◆ The child should be immediately assessed and unless clearly inappropriate, resuscitation continued. However if it is clear the child is dead then this is declared.
- ◆ If possible the Doctor in charge will consult with parents about deciding how long resuscitation should continue.

### **3.5 Assessment and Investigation following admission to the Emergency Department**

In all cases

- ◆ A senior doctor should take a full history of events leading up to and immediately prior to death. This information may be collected on the Form B - see Appendix B
- ◆ Medical notes should record conversations with parents with particular attention paid to ensuring which comments are attributable to which parent. Ideally contemporaneous notes with a verbatim account.

- ◆ Responsibility for notifying the Coroner will fall to the doctor confirming death or the Police (Senior Investigating Officer).

In a SUDI case the following specimens must be taken;

- ◆ Nasopharyngeal Aspirate – Virology to be taken in ED
- ◆ Pharyngeal swab – Microbiology to be taken in ED

Plus the following sample may be taken;

- ◆ Two attempts should be made to obtain CSF samples in ED if it falls within the capability of ED staff. The sample should be taken from the lumbar – sacral region.

Any further investigations should only be commissioned following the initial case management discussion to meet an identified investigative or clinical need.

### **3.6 Family Support**

When the child has been pronounced dead;

- ◆ The most appropriate senior clinician should firstly review all available information, and then break the news to the family. The news should be delivered in a private room with the allocated nurse present.
- ◆ IV cannulae, ET tubes and other equipment may be removed from the child, but this should be documented clearly in the notes and countersigned by staff member to confirm that the items were removed as documented in the notes. The counter signatory should be a fellow professional not involved in the immediate care of the child.
- ◆ Any nappies or clothing should be removed and sealed in a plastic bag, and should accompany the body to the mortuary.
- ◆ The child's face should be cleaned and the child dressed in a clean nappy and wrapped in a shawl or blanket.
- ◆ The parents should be allowed to hold their child, unless the Police object to the proposal.
- ◆ Ask parents if they wish to have a footprint/handprint or a lock of hair by way of a keepsake. This should be offered early, but made clear to parents that they may not be able to receive this straight away. Whilst such a hair sample would technically be a sample under the Human Tissue Act (2004), common sense should prevail, but in all cases it will be necessary to discuss with the

police and coroner who will endeavour to meet reasonable requests wherever practicable. Care needs to be taken to handle the child gently. In rare cases when NAI is suspected DO NOT take hand or foot prints, the pathologist will do this later on request.

- ◆ If the family request that the baby be bathed for cultural reasons, permission should be gained from the coroner before agreement.
- ◆ The family should be advised the death will be reported to the Coroner and that for all unexpected deaths a post mortem examination may be carried out. The family should be informed that the cause of death will not be known until after the results of the post mortem are analysed.
- ◆ At this point the family should be given: The Foundation for Study of Infant Deaths (FSID) booklet – “When a child dies suddenly or unexpectedly”, the DOH leaflet – “Guide to the post mortem examination: brief notes for parents and families who have lost a child in pregnancy or early infancy”, the 24 hour helpline number for Foundation for Study of Infant Deaths, 0207 233 2090, and the CDOP leaflet “The child death review: A guide for parents and carers” .

See Appendix A for contact details for bereavement organisations and each hospital has its own bereavement department.

### **3.7 Role of Health professionals**

#### **3.7.1 On call Health Professional**

The health professional on the on-call rota for unexpected death in childhood will be a senior health professional with appropriate knowledge and training.

The on-call period is between 8am and 6pm each day for one week. The frequency of being on-call is determined by the number of health professionals engaged in this process.

The on-call health professional is to liaise with the SIO as soon as possible once they become aware of an unexpected death of a child, irrespective of where the information came from. The purpose of this discussion is to share information regarding the death and identity of the child, to discuss the planning of a joint scene of death visit with the police and discussion with the parents. The health professional also needs to inform the health coordinating team for unexpected childhood deaths

on 01223 725330 as soon as possible to enable further gathering of information and continuity of the process, and may need to attend a child protection strategy meeting if required. See section 3.0 for further details on scene of death visit.

Record management must be factual, completed contemporaneously, signed and dated. Documentation completed following a scene of death visit and discussion with the parents must be shared with the pathologist within 12 hours of the visit. Form B should also be completed. All information must be shared with the coordinating health team.

### **3.7.2 Designated Doctor for child death**

is at the heart of this process. In Cambridgeshire and Peterborough parts of this role may be delegated to health professionals on a rota. The responsibilities include ensuring systems are in place to:

- ◆ Advise PCT(s) on commissioning clinicians with expertise in undertaking enquiries into unexplained deaths plus availability of relevant investigative services of radiology, laboratory and histopathology services.
- ◆ Coordinate the team to respond to each unexpected child death in accordance with this protocol.
- ◆ Liaise with the consultant clinician dealing with the death.
- ◆ Ensure relevant professionals are informed of the death and begin to gather information (e.g.: police, social care, GP, health visitor or school nurse).
- ◆ Convene multi-agency case discussions potentially by phone when initial post mortem results are available.
- ◆ Ensure appropriate attendance at the multi-agency case discussions when the final post mortem results are known and ensure that the collection of information is completed for the data set form C (see Appendix B)
- ◆ Support the Named Nurse for NHS Cambridgeshire to work with the CDOP chair and the panel to support the functioning of the rapid response protocols; identify training and communication needs across Cambridgeshire and Peterborough professional staff.

### **3.7.3 Senior clinician dealing with the death** has responsibility to:

- ◆ Provide clinical care.
- ◆ Take a detailed history of events leading up to and following the child's death from the parents. Review all available information. Fully record all information.
- ◆ Inform the parents about the death.
- ◆ If appropriate, inform parents a post mortem will be carried out and that a Coroner's officer will be contacting them with more information.
- ◆ Liaise with the designated doctor/health professional/police about the death.
- ◆ Initiate an immediate initial information sharing and planning discussion (see 4.5 between the lead agencies<sup>5</sup> including:
  - other health professionals e.g. GP, professional certifying death
  - police
  - local authority children's services (social care)
  - consider the need to refer to the on call rapid response team
  - Coroner's Office
  - notify GP, Child health records and primary care registration services of the death.

### **3.8 Role of Police**

National Guidance<sup>6</sup> requires a Detective Inspector should attend all reported cases of sudden and unexpected deaths of infants. Within Cambridgeshire Constabulary this falls to a Detective Inspector upward, of the Public Protection Dept (PPD) whose area of responsibility includes the management of the Child Abuse Investigation Units. Every unexpected child death will be allocated to one of the 'on call' team, each of whom will be Senior Investigating Officer (SOI) trained.

The PPD run a 24/7 'on call' facility for the management of unexpected child deaths. The 'on call' Detective will be advised by the Force Control Room whenever they receive a report of a sudden unexpected child death. The Detective will attend the scene and/or the Accident and Emergency Department as circumstances require – but will always be contactable via the Force Control Room (0845 456 456 and ask for Force Control Room) in any circumstance where this protocol applies.

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<sup>5</sup> Alternatively this could be part of the designated paediatrician/health professional role

<sup>6</sup> ACPO National Guidance on Infant Deaths. Sept 2006

The SOI has responsibility for conducting a large number of 'fast track actions'. It is important that other partners are aware of these actions since they may be asked to assist in the discharge of these actions or, alternatively, they may benefit from knowing the nature of the information the Police will be collecting.

The Police will act with tact and sensitivity recognising that the huge majority of child deaths are not associated with any criminality. However the Police are encouraged to adopt an enquiring, challenging and probing mindset.

The ACPO National Guidance on Infant Deaths (2002) highlights factors that may arouse suspicions that the death was unnatural as well as providing a checklist of initial actions, which will include essential checks that ought to be carried out into background of carers and any case history of the deceased or siblings.

The SIO will contact the health professional on the on-call rota as soon as is possible, irrespective of time of day. The purpose is to inform health of the death and to coordinate a scene of death visit jointly performed by health and police professionals. If this does not occur, the reasoning for this decision should be documented and reported at the information sharing and management meeting. If further clarity is needed, the Designated Paediatrician with responsibility for the unexpected deaths in childhood process or the Named Nurse who supports the Paediatrician should be consulted.

### **3.9 Role of Coroner's Officers**

Coroners Officers have knowledge of the Coronial system and involvement with families when a child has died unexpectedly. They have a valuable contribution to the information sharing process and assist and advise with the management of samples and investigations. Once the Post Mortem report is available, the Coroner's Officer will share the findings with the parents, unless the Police request otherwise.

### **3.10 Role of Coroner and Pathologist**

After death the Coroner has control of the body and mementoes/medical samples must not be taken without their approval.

The post mortem will be carried out at Cambridge University Hospital NHS Trust, using either a specialist paediatric pathologist or a Home Office forensic pathologist.

If the Coroner is concerned about the nature of the death he may instruct that both a paediatric pathologist and a Home Office pathologist carry out the post mortem. The Coroner has the choice of pathologist.<sup>7</sup> If during the post mortem the paediatric pathologist becomes concerned about suspicious circumstances they must halt the post mortem and, with the Coroner's authority, contact a Home Office pathologist.

The post mortem will be conducted in accordance with the Addenbrookes Paediatric Post Mortem Protocol.

The Coroner's Officer will ensure that all relevant professionals are advised of the time/date/location of the post mortem. The SIO will arrange for a Scenes of Crime Officer (SOCO) to attend if the post mortem is being carried out by/with a Home Office pathologist. The Coroner's Officer will also advise the parents of the post mortem details and the right to be represented at the post mortem.

It is very important that the Pathologist receives a detailed history of the case in advance of the post mortem examination. As a minimum the 'History Record' (see Form B, Appendix B) should be provided to the pathologist. However, the Paediatrician and the SIO are also expected to notify the Pathologist of all and any matters that may be germane to the child's death. This might mean in some instances that a phone call/email will suffice, in other instances it might mean that photographs or video recordings are made available to the Pathologist.

At the post mortem the pathologist will arrange a number of investigations to be carried out. This will ordinarily include a full skeletal survey and the collection of samples for microbiology and metabolic investigations – as per Addenbrookes Paediatric Post Mortem Protocol. If the Paediatrician has commissioned any investigations prior to death the pathologist will need to be advised and the results forwarded to him/her when known.

See section 3.5 for details of specimens to be taken in A & E.

This protocol supports the Royal College of Pathologists' 'Guidelines on Autopsy Practice' (2002), which state that:<sup>8</sup>

- A provisional report (to include a preliminary cause of death where possible) should be sent out within 5 working days of the examination.

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<sup>7</sup> Rule 6(1) a Coroners Rules 1984

<sup>8</sup> Royal College of Pathologists Guidelines on Autopsy Practice (2002)

- Where there are no complex investigations the complete report should be sent out within one week of the examination.
- Results of further investigations with a commentary or conclusions and the stated cause of death should be sent out within one week of availability of those findings.

The provisional report to the Coroner will also include details of retained samples. Under Rule 10(1) Coroners Rules 1984, the person undertaking the post mortem must report to the Coroner. This means that the report will always be forwarded to the Coroner in the first instance, and only at his/her discretion will it be shared with partners. In practice, local Coroners will allow the post mortem report to be shared with the Police and Social Care once he/she has had an opportunity to review the findings and decide on any further course of action.

### **3.11 Role of Local Authority**

#### **3.11.1 Social Care**

It is important that Social Care are consulted at the beginning of this process to ascertain any prior knowledge of the child, siblings and family. If the family are known to social care or there are concerns regarding the needs or safety of other children social care will be involved in the multi-agency case management discussion. The level of involvement will differ markedly dependant on the circumstances, the case history and any safeguarding issues raised in respect of the siblings.

#### **3.11.2 Education**

Education services will be involved in the case management discussions if the child or siblings are of school age.

Other children and adult services may also be required to have input into the multi agency response (e.g. mental health or substance misuse workers, early years, children centres, the Youth Offending Service etc). Contact details are available in Appendix A.

## **4.0. Multi agency response**

### **4.1 General**

So far the protocol has detailed the actions of professionals who attend when a child is found dying or dead and the actions to be followed when the child is received at the Accident and Emergency Department.

Once the death has been confirmed, any specimens or samples taken and the history has been taken the following also need to be done;

### **4.2 Informing the Co-ordinator for Child Death Overview Panel (CDOP) Arrangements**

The LSCB must be informed about the child death via the CDOP Coordinator (see Appendix A for contact details). From this point the Child Death Review Form B (Appendix B) should be used to collect relevant details. See LSCB Protocol 'Child Death Review Arrangements'.<sup>9</sup>

### **4.3 Planning and undertaking the Initial Scene of death visit**

- The initial scene of death visit is most commonly at the home of the child, but may not be. However, the visit is an essential part of the multi agency investigation into an unexpected child death to establish the circumstances of death especially if a child has died in a non-hospital setting.
- Prior to the visit the Police Officer and Health professional should exchange any known information about the child and family, and plan how to conduct the visit. It is essential that any records completed surrounding the incident and particularly the recent health records are accessed. This will prevent duplication of questions to the bereaved parents/carers.
- The visit should almost always take place if a child is under 12 months.
- This is a joint health/police (SIO trained) visit and should take place as soon as possible after death is confirmed.
- Information from this visit or the reasoning for not completing a scene of death visit must be shared with the pathologist (when a post

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<sup>9</sup> [www.cambslscb.org.uk](http://www.cambslscb.org.uk) and [www.pscb.org.uk](http://www.pscb.org.uk)

mortem is to be undertaken), the health coordinating team and the CDOP co-ordinator.

#### **4.4 Plan of Scene of death visit**

The purpose of this visit and the discussion with the parents include the following and rely on the skills and knowledge of both the police and health professionals:

- To complete and clarify the history of events.
- Use of health knowledge and understanding of child development and childhood illnesses and their likely causes.
- Identify and contextualise factors that may have contributed to death.
- To provide information and support to the family.
- To identify suspicious circumstances.
- To identify inconsistencies in history.
- To take room measurements (temperature/volume) to assist the pathologist.
- To record observations on sleep environment.
- To consider video recording the environment for the benefit of the pathologist – not for evidential purposes.
- To ensure appropriate handling of evidence.
- To ensure legal provisions (principally PACE 1984) are observed.

Both Police and Paediatrician are required to use the LSCB Form B to record findings to date.

#### **4.5 Initial Case Management Discussion**

Information sharing is vital, therefore the appropriate health professional, Police and Social Care participate in an Initial Case Management Discussion, within 12 hours of the death being confirmed. This may be a meeting or telephone conference, to share information on the following:

- background information/presentation of child
- background information regarding child/siblings/carers
- safeguarding issues of surviving siblings
- immediate Child Protection issues
- nature of any suspicions
- consider request of blood samples from parents/carers

- scene management
- contact with Coroner
- timing of PM and briefing of pathologist
- restrictions on viewing of body
- significant Police action (arrests, statements)
- immediate support for bereaved – deployment of Family Liaison Officer
- coordination of Professionals Contact with family – home visit
- agreed point of contact with mortuary and Bereavement staff
- status of enquiry/investigation – criminal/Child in need or child in need of protection.
- time and date of SUDI case meeting
- press strategy
- staff Welfare
- notification to LSCB Coordinator for Child Death Reviews

If a referral has not already been made, and it is the view of this meeting that abuse or neglect is a factor in the death a referral must be made to social services for a Section 47 Child Protection Enquiry, and then to the LSCB for consideration by the Serious Case Review Panel.

This meeting must be minuted.

#### **4.6 Second Case Management Discussion**

The second case discussion is to be convened within five to seven working days of the unexpected death. This should occur when the preliminary results of the post mortem are available.<sup>10</sup> The meeting will be organised by the Health Coordination Team for Unexpected Deaths in Childhood. All known professionals who have knowledge of the family will be invited and it will be convened in a venue suitable for the majority of the professionals.

The aim of this meeting is to consider any child protection or other needs of surviving children and any other children; ensure the bereavement needs of the family are addressed any contributing factors to the death identified.

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<sup>10</sup> Para 7.41 W2G

To facilitate this, the meeting will review the information and the actions of the initial discussion and gather, in detail information from other professionals. The meeting will be minuted and any key actions identified to form a plan which will be reviewed at the final case discussion. A copy of the minutes taken will be distributed to all professionals involved, including the coroner and Coordinator for CDR. A provisional date for the third case discussion meeting is made for 12 weeks time.

#### **4.7 Third Case Management Discussion**

This is held when the final post mortem results are known.<sup>11</sup> This will normally be a meeting not a telephone discussion, however some flexibility is allowed given the differences between cases. Where the post mortem provides a conclusive cause of death with no contributory factors and little potential for learning, no meeting is necessary. Otherwise parties will meet for the third case management discussion which is arranged and chaired by the designated professional or by a member of the Rapid Response team.

There needs to be an explicit discussion about the possibility of abuse or neglect either causing or contributing to death. If no evidence of maltreatment is identified the minutes shall record this.<sup>12</sup>

The minutes of this meeting will be in the completion of the Form C (see Appendix B) with the approval of all attendees then sent to the Coroner and the Coordinator for Child Death Overview Panel arrangements.

If it is the view of this meeting that abuse or neglect is a factor in the death a referral must be made to the LSCB Serious Case Review Panel.

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<sup>11</sup> Para 7.43 W2G

<sup>12</sup> Para 7.46 W2G

## **5.0. Governance**

### **5.1 LSCB Audit Responsibilities**

The Cambridgeshire LSCB and Peterborough LSCB will:

- Observe the statutory obligations within Chapter 7 Working Together 2010
- Review this protocol in April 2011.
- Monitor and review audits, to comply with DCSF data collection and to demonstrate the protocol is being followed.
- Receive a report on a regular basis from CDOP
- Contribute to the annual report to the CCSB and PCSB executives that the protocol is proving effective.

### **5.2 Accountability**

Partner organisations will be accountable to the LSCBs for their organisation meeting its responsibilities under this protocol through representation on CDOP.

Accountability will be with named posts not an individual. To carry out its statutory child death review function, the LSCBs need to be informed of any changes to the identified posts. Therefore the following agencies are required to inform the LSCB Coordinator for child death arrangements of the relevant details for their representation:

- Cambridgeshire Constabulary
- NHS Cambridgeshire
- East of England Ambulance Service NHS Trust
- Cambridge University Hospital NHS Foundation Trust
- Hinchingsbrooke NHS Health Care Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust
- Peterborough Children's Services (Social Care)
- Cambridgeshire County Council - Children and Young People Services (Social Care)
- Coroner for Peterborough
- Coroner for North and East Cambridgeshire
- Coroner for South and West Cambridgeshire
- NHS Peterborough

The relevant CDOP member will assume responsibility for ensuring their agency is aware of:

- Awareness raising and publicity.
- Identifying and addressing internal agency training needs and advising the LSCB with regards to need for interagency training.
- Ensuring this protocol is observed within their organisation.
- Advising the LSCBs suggested amendments to the protocol.
- Highlighting and reconciling conflicts within their organisation arising from this protocol.
- Addressing the availability and accessibility of staff.
- Ensuring staff welfare needs are addressed.

## **References**

- ◆ 'Sudden Unexpected Death in Infancy' – report of a working group convened by Royal College of Pathologists and the Royal College of Paediatrics and Child Health, chaired by Baroness Kennedy, published 2004
- ◆ 'Working Together to Safeguard Children' – government guidance published 2006 updated 2010
- ◆ ACPO Practice Advice – Safeguarding Children Murder Investigation Manual Guidelines on investigating infant deaths
- ◆ 'Guidelines on Autopsy Practice' - Royal College of Pathologists, published 2002.

## **Appendix A**

### **Organisations Contact list**

Child Death Co-ordinator  
**Cambridgeshire Local Safeguarding Childrens Board (LSCB)**  
7 The Meadows  
Meadow Lane  
St Ives  
Cambs  
PE27 4LG

Tel: 01480 373581  
Secure fax: 01480 376377  
cdop@cambridgeshire.gov.uk

**Peterborough Safeguarding Children Board (PSCB)**  
2<sup>nd</sup> Floor  
Bayard Place  
Broadway  
Peterborough  
PE1 1FB

01733 863744

Rapid Response Administrator  
Lockton House  
Clarendon Road  
Cambridge  
CB2 8FH

Tel: 01223 725328

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**Cambridgeshire Constabulary**  
Police Headquarters  
Hinchingsbrooke Park  
Huntingdon  
PE29 6NP

Tel: 0845 4564 564

**NHS Cambridgeshire**  
Heron Court  
Ida Darwin  
Fulbourn  
Cambs  
CB21 5EE

Telephone: 01223 884008

**Cambridgeshire Community Services**

The Priory  
St Ives  
Cambs

Telephone: 01480 308223

**Cambridge University Hospitals NHS Foundation Trust**

Addenbrookes Hospital  
Hills Road  
Cambridge  
CB2 0QQ

Switchboard: 01223 245151

**Hinchingbrooke Healthcare NHS Trust**

Hinchingbrooke Hospital  
Hinchingbrooke Park  
Huntingdon  
Cambs  
PE29 6NT

Switchboard: 01480 416416

**Office of Children and Young People Service (OCYPS) Cambridgeshire**

Tel: 0845 045 5203 (8am – 8pm Monday – Friday)

Tel: 01733 234724 Out of office hours

**Peterborough Children's Services (Social Care)**

2<sup>nd</sup> Floor, Bayard Place  
Broadway  
Peterborough  
PE1 1FB

Tel: 01733 747474

**Peterborough and Stamford NHS Foundation Trust**

Peterborough District Hospital  
Thorpe Road  
Peterborough  
PE3 6DA

Tel: 01733 874000

**NHS Peterborough**

2<sup>nd</sup> Floor  
Town Hall  
Bridge Street  
Peterborough  
PE1 1FA

Tel: 01733 758500

## **Peterborough Community Services**

Town Hall  
Bridge Street  
Peterborough  
PE1 1FA

Tel: 01733 758500

## **BEREAVEMENT ORGANISATIONS**

East Anglia's Children's Hospices (EACH)  
Bereavement support for children and families in Cambridgeshire and Peterborough  
Church Lane  
Milton  
Cambridge  
CB24 6AB

Tel: 01223 815115  
Email: [reception@each.org.uk](mailto:reception@each.org.uk)  
Web: [www.each.co.uk](http://www.each.co.uk)

STARS Children's Bereavement Support Services (Cambridgeshire)  
42 High Street  
Milton  
Cambridge  
CB24 6DF

Tel: 01223 863511 Mobile: 07827 743497  
Email: [info@talktostars.org.uk](mailto:info@talktostars.org.uk)  
Web: [www.talktostars.org.uk](http://www.talktostars.org.uk)

## **The Child Bereavement Trust**

Aston House, High Street  
West Wycombe  
High Wycombe  
HP14 3AG

Tel: 01494 446648

Email: [enquiries@childbereavement.org.uk](mailto:enquiries@childbereavement.org.uk)

Website: [www.childbereavement.org.uk](http://www.childbereavement.org.uk)

**Child Death Helpline**

Child Death Helpline Administration Centre  
York House  
37 – 39 Queen Square  
London  
WC1N 3BH

020 7813 8416

0800 282986

[www.childdeathhelpline.org.uk](http://www.childdeathhelpline.org.uk)

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**The Foundation for the Study of Infant Deaths**

Artillery House  
11 – 19 Artillery Row  
London  
SW1P 1RT

Helpline: 0870 787 0554  
9am – 11pm Monday to Friday  
6pm – 11pm Weekends

General: 0870 787 0885

Local contact: Julie Nicholson  
Tel: 01480 812778

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## **Appendix B**

Form A - Notification Form

Form B - Agency report Form

B2 – Neonatal Death

B3 - Children with a known life limiting condition

B4– Sudden unexpected death in infancy

B5 – Road traffic Accident

B6 – Drowning

B7 – Fire

B8 - Poisoning

B9 -Other non-intentional injury

B10 – Substance misuse

B11 – Apparent Homicide

B12 – Apparent Suicide

B13 – Summary of autopsy findings

Form C – Analysis Proforma

FormD – Audit Tool for Rapid response

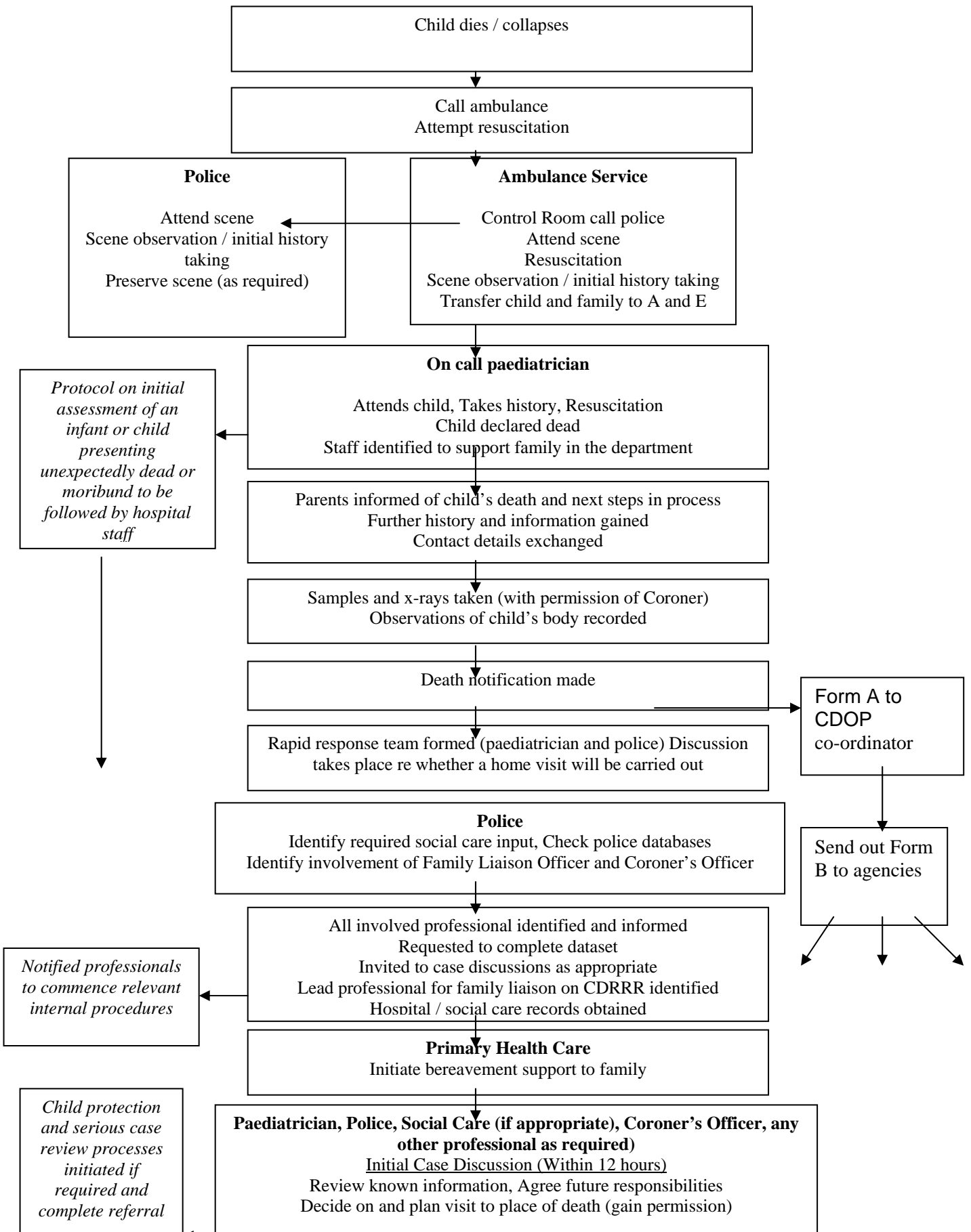
Form E – Audit Tool for the child death overview

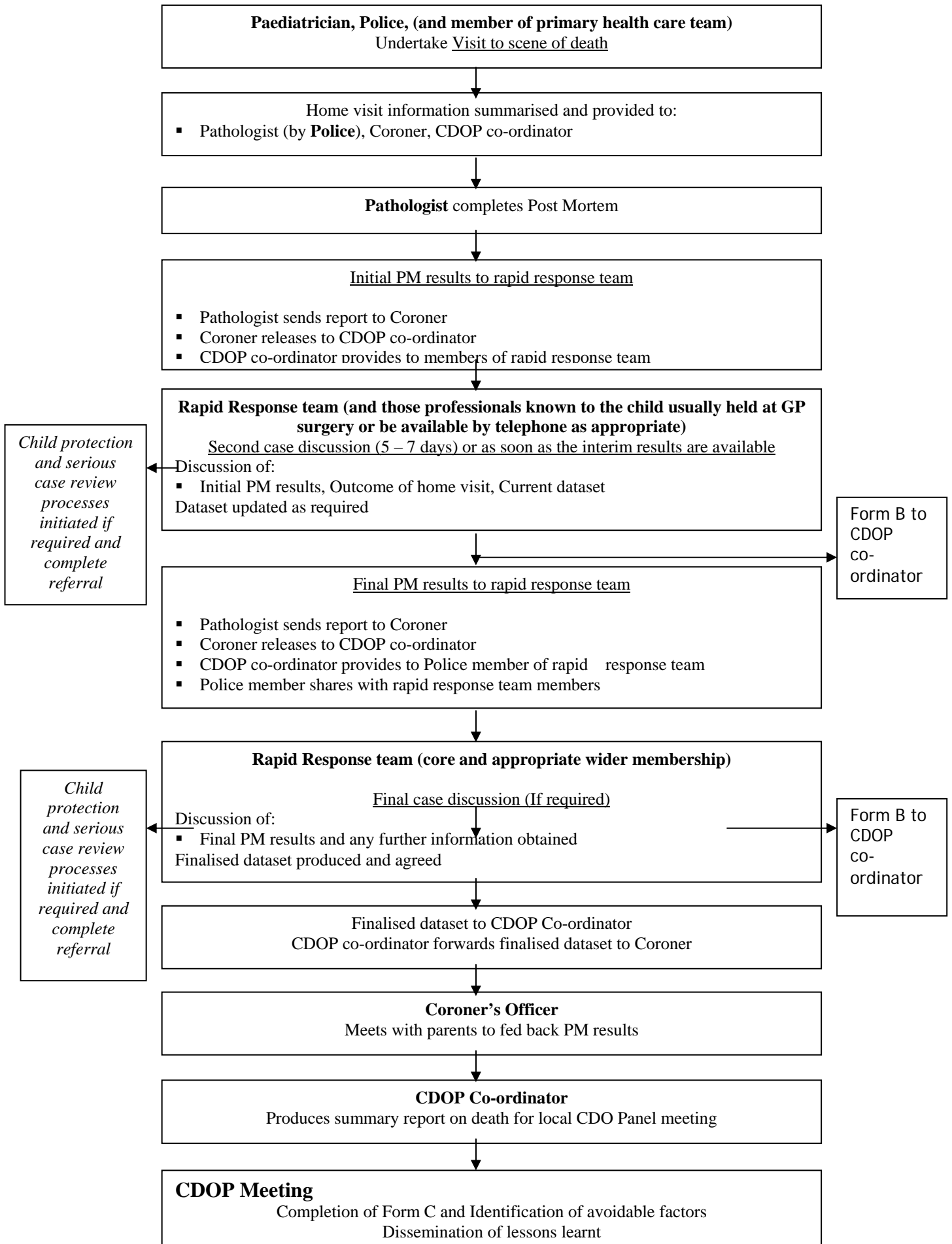
Forms can be downloaded at

<http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/TP00045/>

or contact the CDOP co-ordinator

## Appendix C





**Flowchart 2**

