

“RAPID RESPONSE” TO AN UNEXPECTED CHILD DEATH

NOTES AND DEFINITIONS

- “Childhood” is defined as the time from livebirth (irrespective of gestation) until the attainment of the age of 18 years. By far the largest group of child deaths occurs in the perinatal period (0 - 7 days). For “rapid response” procedures these infants will not be routinely included unless involved professionals express concerns about the circumstances of the pregnancy or the death.
- “Paediatrician” has been used to identify the senior involved clinician, but when the death is that of a young person (of over 14 years) the clinician will be an adult specialist and some interpretation of the protocol depending on age and mode of death may be required.
- “Unexpected” indicates that either the death or the collapse, which leads to the death, was not anticipated 24 hours prior to its occurrence.
- “Death” means the time that death is formally certified. It is clearly not appropriate to instigate this process whilst the child is alive and receiving medical care. However, in cases where the medical team have **any** concerns that there are issues of abuse or neglect when a child has presented in a critical condition, especially where there are other children in the household, then early discussion with Children’s Social Care (CSC) should take place. This will allow scrutiny of the CSC and Police databases as a minimum precaution and further inter-agency involvement as considered necessary. These preliminary enquiries can be made without informing the parents if it is considered that this will add to their distress.

AGENCY ROLES AND RESPONSIBILITIES

1. Once a child has been declared dead, the Coroner has jurisdiction over the body and all that pertains to it.
2. The majority of unexpected deaths in childhood are natural tragedies, but a minority are a consequence of ignorance, neglect, abuse or homicide. The investigation should keep an appropriate balance between medical and forensic requirements and the needs of the family in coping with the tragedy. Account should be taken of possible risks to other children in the household.

3. Professionals should approach the investigation with an open mind and families should be treated with sensitivity, discretion and respect. Professionals must be aware that as the number of child deaths due to natural causes decreases, the proportion of such deaths which could be attributed to neglect or abuse is likely to increase.
4. There should be a multi-agency approach involving collaboration among: accident and emergency (A&E) department staff, ambulance staff, named and designated doctors and nurses in child protection, Coroners, coroners' officers, general practitioners (GP's), health visitors, midwives, paediatricians, pathologists, police and social workers.
5. In each agency a senior person with suitable training and experience should be identified as having responsibility for implementation of the protocol, including continuing training for all relevant staff.
6. The Designated Doctor for Child Protection will take the strategic lead for rapid response within Health but the input from a consultant paediatrician in individual cases will be from the consultant involved in the initial event as at present (involved paediatrician).
7. The Detective Inspector for the CAIU together with the BCU Detective Inspector will lead for the police and the Team Manager (referral and assessment) for the local authority.

INVESTIGATING THE UNEXPECTED DEATH OF A CHILD

8. Children found dead at home should usually be taken into the A&E department, not to the mortuary, and resuscitation should be initiated unless clearly inappropriate. There are situations where it is obvious that a body is beyond resuscitation and needs either to remain at the death scene for forensic purposes or to be moved to a mortuary. This will be a decision for the police in consultation with the Coroner as outlined in the Murder Investigation Manual or in the case of road deaths, the Road Death Investigation Manual.
9. On arrival in the A&E department the parents should be allocated a member of staff to care for them and should normally be given the opportunity to hold and spend time with their child at a later point while in the A&E department. They should also be offered mementoes eg a lock of hair or a photo.
10. As soon as possible after arrival, the child should be examined by a consultant paediatrician and a careful history should be taken from the parents.
11. A standard set of investigative samples should be taken.

12. When the child is pronounced dead, the paediatrician should break the news to the parents/carers, and explain police and Coroner involvement and the need for a post-mortem examination, including that tissue blocks and slides will be taken and retained permanently as part of the pathology medical record. The paediatrician should also give the parents the opportunity to donate tissues or organs. This requires the Coroner's permission.
13. As soon as death has been confirmed, notification should be given to the Coroner (via the coroner's officer), the police and the primary care team.

INITIAL STRATEGY DISCUSSION

14. An initial strategy discussion should be held between the lead professionals (the paediatrician, the senior investigating officer in consultation with the CAIU DI and the duty team at Children's Social Care). This is usually done by telephone
 - To agree their approach
 - To ensure continuing close collaboration
 - To ascertain whether any agency has any relevant information about the child, other close family members and members of the household
15. Further notification of the child's death (as per the "Communicating the Death of a Child in Hospital" protocol) should be completed.
16. In most cases a formal strategy meeting will be convened urgently by Children's Social Care. There will be situations where the circumstances of the death are straightforward and this is not required.
17. If the death is suspicious or significant concerns are raised at any stage about the possibility of abuse or neglect, a decision will be taken for the police to become the lead agency, and take primacy in the investigation. In this case the police must inform a Senior Investigating Officer (SIO) from Major Crime, who will take responsibility for investigating the child's death. In these circumstances consultation must take place with the police, to ensure no compromise of information to the parents/carers or those close to them, who may be responsible for or contributed to the cause of death.
18. Otherwise Health remains the lead agency.

INITIAL ACTION

19. In the case of Sudden Unexplained Infant Death (Cot Death) the police are responsible for investigating the circumstances of the death, and may have to secure the death scene. There will be a visit to the scene of

the death (preferably within 24 hours). Consideration should be given to making this joint visit by Police (ideally CAIU) and Health (ideally SUDI Health Visitor), however there may be reasons for this to take place separately. The SUDI health visitor should discuss his/her findings with the paediatrician to pass on to the pathologist and should compile a written report for the case discussion. The Police are responsible for providing the Coroner with a report from the scene visit and subsequent investigation into the death.

20. The involved paediatrician should compile a report for the coroner and the pathologist, based upon the clinical circumstances of the death, the history obtained in hospital and at the home visit and a review of all relevant medical and social records.

SUBSEQUENT ACTION

21. The coroner will order a post-mortem examination to be carried out as soon as possible, preferably within 48 hours, by the most appropriate pathologist. In most cases, this should be a paediatric pathologist, following a recommended protocol, but if significant concerns have been raised about the possibility of homicide, abuse or neglect, a Home Office approved paediatric pathologist should take the lead. If the post-mortem examination reveals no sufficient identifiable cause of death, whether or not any concerns have been raised during the post-mortem examination or previously about the possibility of abuse or neglect, the pathologist should categorise the death as “unexplained pending further investigations” and the coroner should in every case hold an inquest.
21. If the post mortem indicates death from abuse or neglect.
 - The police will commence a criminal investigation
 - Action will be taken to safeguard other children in the household
 - The MKSCB should be notified, via the MKSCB Business Manager on 01908 254373
22. The paediatrician should discuss the results of the post-mortem examination with the parents at the earliest opportunity, unless there is an outstanding police investigation.

FINAL CASE DISCUSSION

23. A case discussion meeting should be held once the results of the main post mortem tests are available, approximately 8-12 weeks after death. This meeting should involve those who knew the child well and those who investigated the death: GP, health visitor and involved paediatrician as core and, (where appropriate) midwife, SUDI health visitor, other paediatrician if caring for the child, SIO,CAIU, and social worker. All relevant information concerning the circumstances of the death, the

child's history, family history and subsequent investigations should be reviewed.

The main purpose of the meeting is:

- To share information
 - To agree the cause of death
 - To identify factors that contributed to the death and plan future care of the family, including the format of the meeting with/letter to the parents
 - To hold an explicit discussion of the possibility of abuse or neglect and, if no evidence is identified to suggest maltreatment, to document this as part of the report of the meeting
 - To send a report to the Coroner, who will take the case discussion information into consideration when evaluating the evidence at the inquest, assisting the Coroner in deciding whether the cause of death is ascertainable or unascertainable and in arriving at a verdict and notifying the Registrar of Births and Deaths
25. The paediatrician (or other person involved if more appropriate) should arrange to meet with the parents to give information concerning the cause of the child's death, answer their questions, and offer future care and support. If the parents do not wish direct contact this should be done by letter.
26. All information and the standard dataset will be forwarded to the Child Death Overview Panel.
27. In the case of SUDI it should be noted that any subsequent infants in the family will be offered a referral to the CONI programme (Care of Next Infant) at booking.

ABBREVIATIONS & ACRONYMS

A&E	Accident and Emergency
BCU	Basic Command Unit
CAIU	Child Abuse Investigation Unit
CONI	Care of Next Infant
CSC	Children's Social Care
DI	Detective Inspector
GP	General Practitioner
LSCB	Local Safeguarding Children Board
SID	Sudden Infant Death
SIO	Senior Investigating Officer (Police)
SUDI	Sudden Unexpected Death of an Infant