

## CHILD DEATH REVIEW ARRANGEMENTS

# Multi Agency Protocol for the Management of Unexpected Childhood Deaths.

**Revised November 2014**



## **CONTENTS**

### **1.0 GENERAL**

- 1.1 Introduction
- 1.2 Aims
- 1.3 Processes
- 1.4 Statutory Implications
- 1.5 Definitions

### **2.0 RESPONSIBILITIES**

- 2.1 Joint Responsibilities
- 2.2 Evidence of Criminality
- 2.3 Notifications to Coroners
- 2.4 Record Keeping
- 2.5 Coordination of response
- 2.6 Individual Agency Responsibility
- 2.7 Adjoining Counties

### **3.0 RESPONDING TO THE UNEXPECTED DEATH OF A CHILD**

- 3.1 General Principles
- 3.2 First Response – Ambulance staff, GP, Fire & Rescue
- 3.3 Hospital Staff in Accident and Emergency Departments
- 3.4 Assessment and Investigation following admission to A & E
- 3.5 Family Support
- 3.6 Role of Health Professionals
- 3.7 Role of Police
- 3.8 Role of Coroner's Officers
- 3.9 Role of Coroner and Pathologist
- 3.10 Role of Local Authority

### **4.0 MULTI AGENCY RESPONSE**

- 4.1 General
- 4.2 Informing Co-ordinator for Child Death Overview Panel (CDOP)  
Arrangements
- 4.3 Plan and undertaking the initial scene of death visit
- 4.4 Plan of scene of death visit
- 4.5 Initial Case Management Discussion
- 4.6 Second Case Management Discussion

4.7 Third Case Management Discussion

**5.0 GOVERNANCE**

5.1 LSCB Audit Responsibilities

5.2 Accountability

**References**

**APPENDICES**

- A Protocol for Deceased Children Presenting to the Emergency Department - Cambridgeshire
- B Protocol for Deceased Children Presenting to the Emergency Department - Peterborough
- C Contact List (including bereavement organisations)
- D List of forms for child death process
- E Child Death Process Flowchart
- F Scene of Death Visits

## **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 'Protocol and Terms of Reference for the Child Death Overview Panel for Cambridgeshire and Peterborough LSCB' details how information about all child deaths in Cambridgeshire and Peterborough are collated and analysed by the Child Death Overview Panel. All professionals in conjunction with any relevant policies, procedures or protocols of their own agency, should follow the protocol.

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, potential safeguarding concerns and an understanding of the cause of death.

### **1.2    Aims**

Professionals work together in a coordinated way to;

- 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
- Identify potential safeguarding concerns

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.

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 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 NHS Trusts and Clinical Commissioning Groups 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 5 of Working Together to Safeguard Children: March 2013. 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.

---

<sup>1</sup> Office for National Statistics. Vital Statistics: Population and Health Reference Tables. 2012.  
[www.ons.gov.uk/ons/rel/vsob1/vital-statistics--population-and-health-reference-tables/index.html](http://www.ons.gov.uk/ons/rel/vsob1/vital-statistics--population-and-health-reference-tables/index.html)

<sup>2</sup> NPSA website: [www.npsa.nhs.uk](http://www.npsa.nhs.uk) and for core standard on patient safety see <http://www.cqc.org.uk/>

## **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.

### **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:

---

<sup>3</sup> Working Together 2013 Para 5.12

- 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
- 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 apprised of results of enquiries.
- On occasion, it might be appropriate to seek consent to examine family members' medical notes.
- Cooperate with an investigation by the Prisons and Probation Ombudsman if the child died in custody (or by the Independent Police Complaints Commission in the case of police custody)

## 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.

If a criminal act is suspected, immediate consideration must be given to whether or not there are other children e.g. siblings who may require safeguarding and a referral made to children's social care.

## **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 an Emergency Department in accordance with this protocol.

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 D) 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, underpinning decision making 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.

---

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



- ◆ 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 CDOP 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 CDOP Coordinator 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 would normally exclude unexpected deaths resulting from road traffic accidents and unexpected deaths in the community resulting from accidents where no safeguarding concerns or modifiable causes are identified and a home visit to the scene is not deemed appropriate.
- ◆ 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 or 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.
- ◆ The protocol is applicable for 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.
- ◆ If a death is anticipated due to a known illness, it should only be subject to this protocol **if there are reasons to be concerned about the circumstances of their death.**
- ◆ If abuse or neglect is suspected as a cause of death or as a contributory factor, immediate consideration must be given to the safety of siblings.

### **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 inappropriate to do so because resuscitation is clearly futile.

Ambulance staff should;

- ◆ Attempt resuscitation in all cases unless there is a condition unequivocally associated with death or a valid advance directive. That is, do not 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

Where resuscitation is clearly inappropriate it is usually still desirable to take the child to hospital to be examined – unless there is a clear cause of death e.g. trauma, drowning. 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 a designated department in the hospital (usually the ED but this may be the mortuary – this will be decided after discussion between police and the consultant paediatrician on call).

When there is a need to examine the body (if the cause of death is not clear) the police will contact the senior clinician on call to determine where this is done. As there may be a lack of capacity in the ED it is vital that this conversation takes place before the body is removed from the scene of death. Relevant pathology samples should be taken after death with the agreement of the Coroner and only in licensed premises in accordance with locally agreed Cambridgeshire and Peterborough protocols (See appendix A and B). If parents attend with the body an initial history must be taken by the senior clinician in conjunction with the Police. If parents do not wish to attend the medical history will be obtained by the Rapid Response Health professional as part of a joint visit with the Police usually to the home. 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.

### **3.3 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 and to support them through the process at the hospital when the child dies.
- ◆ 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.
- ◆ If there are suspicions that the child died from an unlawful act, immediate consideration should be given to the need to safeguard any remaining siblings and Social Care must be contacted immediately.

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

In all cases:

- ◆ A senior doctor should take a detailed and careful history of events leading up to and immediately prior to death. See practice note in Appendix B for details. If the Senior Investigative Officer is at the hospital, consideration should be given to a joint interview where appropriate. This should not delay the taking of a history from parents / carers.
- ◆ 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.
- ◆ A thorough examination of the body by a senior doctor must take place with the examination findings recorded on a body chart (including any post mortem changes). If the SIO is at the hospital, consideration should be given for this to take place with the SIO present. This should not delay examination of the body.
- ◆ 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;

- ◆ Additional samples as approved by the Coroner according to local protocols – See appendix A and B

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

### **3.5 Family Support**

When the child has been pronounced dead and resuscitation has discontinued;

- ◆ 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 deliberate harm 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 SIO and 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 relevant information depending on the age of the child including
  - for infants – FSID leaflet
  - for all children the CDOP leaflet “the child death review”

See Appendix C for contact details for bereavement organisations. Each hospital has its own bereavement department.

### **3.6 Role of Health professionals**

#### **3.6.1 On call Health Professional**

If a child dies unexpectedly at home or non-hospital setting, the professional confirming death should contact the Police at the earliest opportunity through calling the police control room on 01480 426001. As soon as possible, the police should follow the protocol above and make telephone contact with the health professional

named on the on-call rota. 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 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 in the ED at the earliest opportunity.

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 for phone cover is between 8am and 8pm each day including weekends and bank holidays with home visits carried out between 9am and 5pm. 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 police 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 CDOP Coordinator on 01223 725330 and send a Form A Notification to [CAPCCG.cdop@nhs.net](mailto:CAPCCG.cdop@nhs.net) 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 4.0 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 24 hours of the visit if during the working week. Form B should also be completed and sent to the CDOP Coordinator.

### **3.6.2 Designated Doctor for Child Death**

The 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 the CCG 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 D)
- ◆ Support the CDOP chair and the panel to deliver the rapid response protocols; identify training and communication needs across Cambridgeshire and Peterborough for professional staff.

**3.6.2 Senior clinician dealing with the death** (Consultant Paediatrician or ED Consultant, usually the former for children under 16 years old) has responsibility to:

- ◆ Provide clinical care.
- ◆ Examine the child's body (see appendix A and B)
- ◆ 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 Police about the death.
- ◆ Initial information sharing with relevant agencies as soon as possible:



- other health professionals e.g. GP, professional certifying death
- local authority children's services (social care)
- Child health records
- Consider a referral to Children's Social Care if there are child protection concerns

### **3.7 Role of Police**

National Guidance <sup>[a]</sup> requires an Officer of at least the rank of Detective Inspector to attend all reported cases of sudden and unexpected deaths of infants. Within Cambridgeshire Constabulary this falls to a Detective Inspector or above, who has undergone specific training to ensure they are equipped with the appropriate skills and knowledge to lead, manage and guide the Police response and investigation into the sudden unexpected death of a child. Every report of the unexpected child death received by Police will immediately be allocated to one of the specialist 'on call' Senior Investigative Officers (SIO) who has responsibility to respond to such incidents.

The specialist 'on call' SIO will be advised by the Force Control Room whenever they receive a report of a sudden unexpected child death. The SIO will attend the scene and/or the Accident and Emergency Department as circumstances require – but they will always be contactable via the Force Control Room ( 01480 426001 Duty Control Room Inspector – restricted number) in any circumstance where this protocol applies.

The SIO has responsibility for conducting a large number of 'fast track actions' in order to manage the initial stages of the investigation into understanding why the child died. 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 SIO will contact the health professional on the Rapid Response on-call rota as soon as is practicable. The purpose is to instigate the Rapid Response procedure, informing Health of the child's death and to coordinate where applicable a visit jointly performed by health and police professionals to the scene of death. If this joint visit does not occur, the rationale for this decision will be documented and reported at the

---

<sup>[a]</sup> A Guide to Investigating Child Deaths ACPO 2014

information sharing and management meeting. If further clarity is needed, the Designated Paediatrician with responsibility for the unexpected deaths in childhood process should be contacted during working hours.

### **3.8 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.

### **3.9 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 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>5</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, arrange for contact to be made with a Home Office pathologist. The Police must also be notified immediately.

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) and an exhibits officer, if relevant, to also 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 D) should be provided to the pathologist. However, the

---

<sup>5</sup> Rule 6(1) a Coroners Rules 1984

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 include a full skeletal survey for infants and the collection of samples for microbiology and metabolic investigations. This can only be done with the consent of the Coroner and must be only to ascertain the cause of death. The only exception is where the samples are taken by the Police under the Police and Criminal Evidence Act (PACE). 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 appendix A and B for details of specimens to be taken ED.

This protocol supports the Royal College of Pathologists' 'Guidelines on Autopsy Practice' (2002), which state that:<sup>6</sup>

- A provisional report (to include a preliminary cause of death where possible) should be sent out within 5 working days of the examination.
- 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, CDOP Coordinator and Designated Doctor for Child Deaths once he/she has had an opportunity to review the findings and decide on any further course of action.

### **3.10 Role of Local Authority**

---

<sup>6</sup> Royal College of Pathologists Guidelines on Autopsy Practice (2002)

### **3.10.1 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. If there are concerns about deliberate harm, Social Care must be contacted immediately in order to ensure the safety of remaining siblings.

### **3.10.2 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).

## **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 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 on 01223 725330. A Form A Notification must be sent to [CAPCCG.cdop@nhs.net](mailto:CAPCCG.cdop@nhs.net) .

From this point the Child Death Review Form B (Appendix D) should be used to collect relevant details. See LSCB Protocol 'Protocol and Terms of Reference for the Child Death Overview Panel for Cambridgeshire and Peterborough LSCB'.<sup>7</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.
- If the scene of death has been designated as a crime scene by the Police a joint visit should not automatically be precluded but should be given careful consideration.
- 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.
- It is possible for the visit to take place in two parts; if the family are not present at the scene of death and / or do not wish to return there the interview can take place in their current location and the scene of death assessed separately.
- 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 mortem is to be undertaken), the health coordinating team and the CDOP Co-ordinator. Please see appendix F for further guidance on when a home visit is indicated.
- If there has been a section 47 strategy meeting, discussion must take place within Children's Social Care about whether a scene of death visit is appropriate.

---

<sup>7</sup> [www.cambslscb.org.uk](http://www.cambslscb.org.uk) and [www.pscb.org.uk](http://www.pscb.org.uk)

#### **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 evidence that implies suspicious circumstances.
- To identify inconsistencies in history.
- 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.
- Room measurements would usually be the prerogative of the Police / SOCO. Exact measurements of room temperature will not normally need to be taken but a comment if the room is excessively hot or cold can be added to the observations.

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. Agreed actions and who is responsible for them must be recorded and forwarded to the CDOP Coordinator. Information should be shared 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 CDOP Coordinator

Where there is a criminal investigation initiated the sharing and disclosure of information remains a key element in the process of the investigation into the child's death and the meeting should still be held face to face with detailed minutes being taken. Each party at that meeting will be advised that there is a potential that any information shared could be used at a later date in a criminal court. The Police may withhold information from the meeting in order to protect the integrity of any evidence gathered as long as in doing so it does not pose a threat to the health and wellbeing of anyone or is detrimental to the decision making process relating to the safeguarding of siblings or other children.

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 shortly after the initial post mortem results become available. This may be by telephone and possibly not be needed for all unexpected deaths but should occur when the preliminary results of the post mortem are available.<sup>8</sup> The meeting will be organised by the CDOP Coordinator. 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 and any contributing factors to the death identified.

To facilitate this, the meeting will review the information and the actions of the initial discussion and gather detailed 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. 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>9</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>8</sup> Working Together 2013 Para 5.25

<sup>9</sup> Working Together 2013 Para 5.25



The minutes of this meeting will be in the completion of the Form C (see Appendix D) with the approval of all attendees then sent to the Coroner.

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 relevant LSCB Serious Case Review Panel.

## **5.0. Governance**

### **5.1 LSCB Audit Responsibilities**

The Cambridgeshire LSCB and Peterborough LSCB will:

- Observe the statutory obligations within Chapter 5 of Working Together to Safeguard Children 2013
- Monitor and review audits, to comply with DFE data collection and to demonstrate the protocol is being followed.
- Receive a report on a regular basis from CDOP

### **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
- Cambridgeshire and Peterborough Clinical Commissioning Group
- 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

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 of suggested amendments to the protocol.
- Highlighting and reconciling conflicts within their organisation arising from this protocol.
- Addressing the availability and accessibility of staff.

**Appendix A - Protocol for Deceased Children Presenting to the Emergency  
Department - Cambridgeshire**

## **Guideline**

### **Deceased children presenting to the Emergency Department**

#### **1 Scope**

Emergency Department (ED)

#### **2 Purpose**

To clarify management of deceased children in the Emergency Department in line with national and regional recommendations.

#### **3 Introduction**

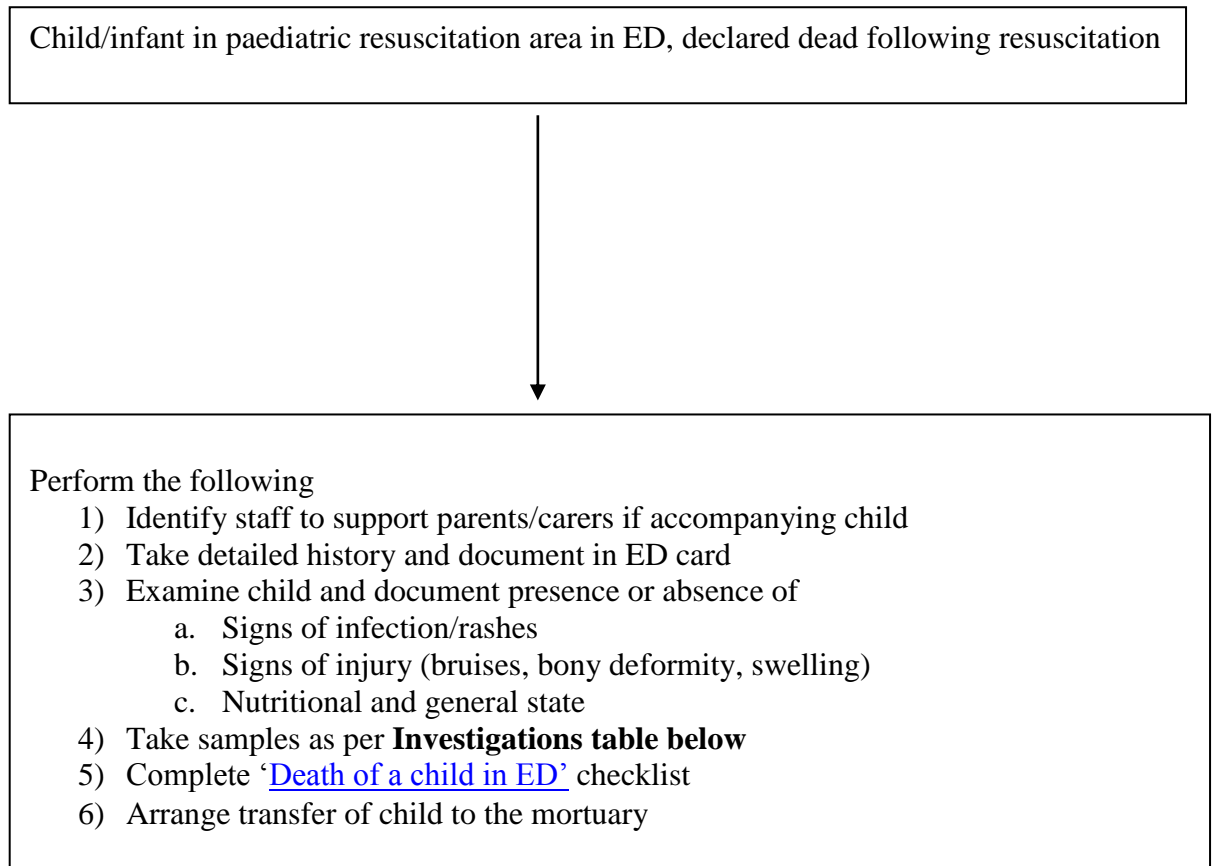
Deceased children in the Emergency department fall into two categories: children admitted as an emergency where active resuscitation is still ongoing and children where attempts at active resuscitation are clearly inappropriate or have stopped prior to arrival in ED.

Children who are **actively resuscitated** require investigations and assessment in line with national recommendations and the process is outlined below. This will almost exclusively occur in the paediatric resuscitation area of the ED.

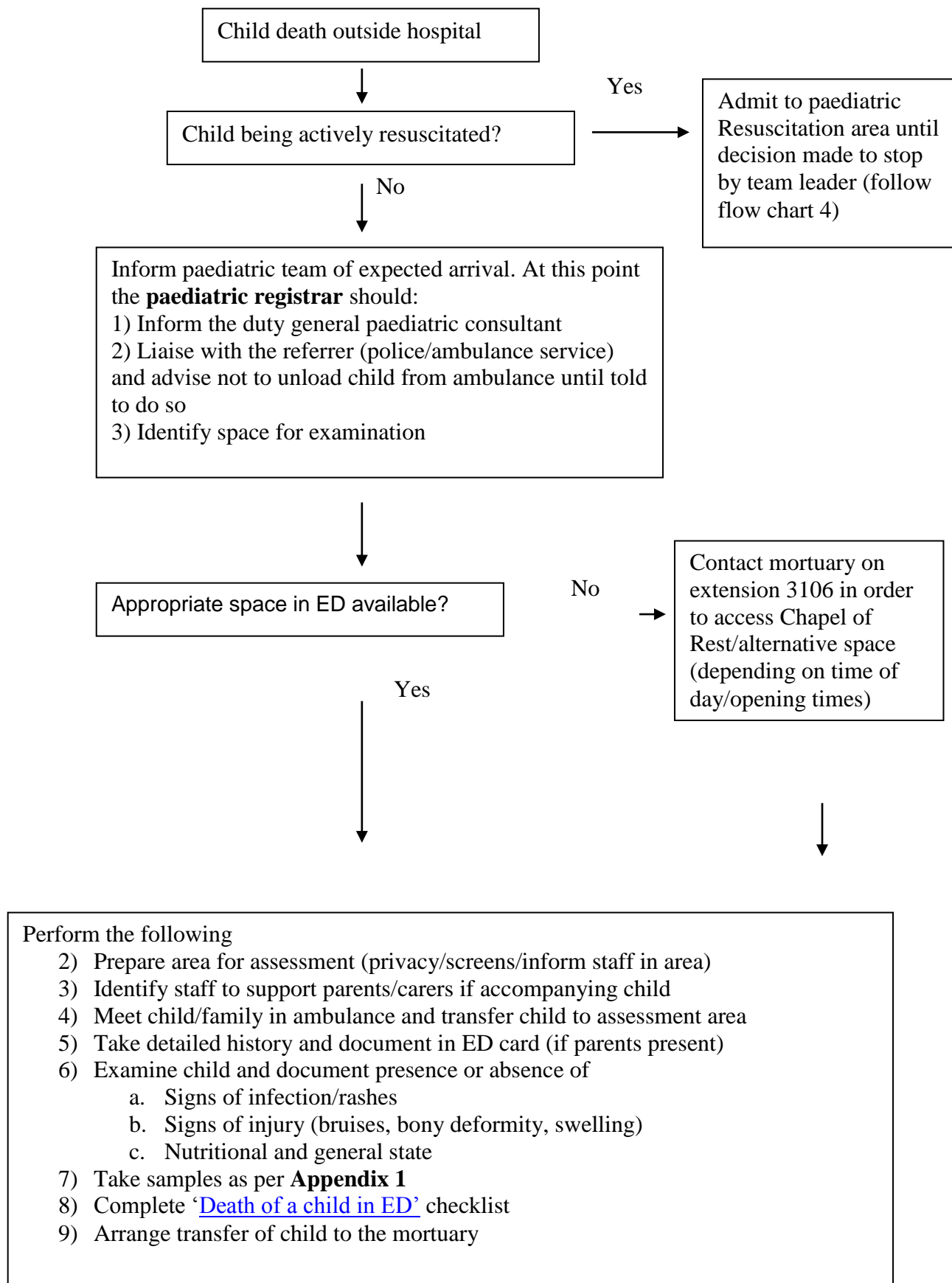
Children who are **found dead outside hospital** (excluding road traffic collisions or obvious accidental trauma) and where resuscitation either is clearly inappropriate or has stopped prior to arrival will also require assessment and investigations by a paediatrician before transfer to the mortuary. As a matter of principle this will be performed by a senior paediatrician in the ED. At times of high activity this can be challenging and an alternative location may have to be found. During office hours this could be in the mortuary and – if the child is accompanied by parents (they may choose not to accompany their child) – possibly in the chapel of rest. However, this will need prior discussion with mortuary staff/technicians.

Under no circumstances should these children be assessed (and specimens taken) anywhere outside the Emergency Department or mortuary due to the constraints posed by the Human Tissue Act licence.

#### 4 Flow chart: Management of a deceased child (active attempt at resuscitation on arrival in ED)



## 5 Flow chart: Management of a deceased child (no resuscitation on arrival to hospital)



## Investigations

Sample	Handling	Test	Purpose
<b>Blood</b> (Serum) 1ml	Clinical Chemistry Spin, store serum at -20°C	Toxicology	Identification of poisoning (intentional and non-intentional) It is particularly important that this sample is taken and labelled very clearly, and attention is given to the continuity of evidence
<b>Blood</b> Cultures	Microbiology If insufficient blood, aerobic only	Culture & Sensitivity	Identification of infection – essential to collect as soon as possible as delays may make interpretation difficult
<b>Blood</b> from syringe onto Guthrie card (only in infants)	Clinical Chemistry fill in card– <b>do not put into plastic bag</b>	Inherited metabolic diseases	Specific investigations for metabolic disorders. Also essential to retrieve initial Guthrie card as provides an ante-mortem sample for analysis
<b>CSF</b>	Microbiology – <b>CSF samples should not be taken if any suspicion of cranial trauma</b>	Microscopy, Culture & Sensitivity	Identification of infection – essential to collect as soon as possible as delays may make interpretation difficult
<b>Nasopharyngeal aspirate</b>	Virology	Viral cultures, immunofluorescence and DNA amplification techniques	Identification of viral infections
<b>Nasopharyngeal aspirate or throat swab</b>	Microbiology	Culture & Sensitivity	Identification of infection
<b>Swabs from any identifiable lesions</b>	Microbiology	Culture & Sensitivity	Identification of infection
<b>Urine</b> (if available)	Clinical Chemistry If wet nappy available, store nappy at -20°C	Toxicology, inherited metabolic diseases (infants only)	Identification of poisons and Organic acids profile indicating metabolic disorders
<b>Skin biopsy</b> (infants only)	Clinical Chemistry Take from upper, inner arm. Send to laboratory in transport medium	Fibroblast culture	Provides DNA culture for identification of specific metabolic and genetic disorders. Important to obtain early as fibroblast cultures taken after 48 hours after death will commonly not grow.
<b>X-rays</b> (infants only)	Radiology	Skeletal survey	Identifies occult fractures

**Appendix B – Protocol for Deceased Children Presenting to the Emergency  
Department - Peterborough as agreed by HM Coroner / Leicester Pathologist**

**Detailed history and Examination**

**History**

- **Presenting History:** record parents' accounts of events. Ideally, information should be recorded verbatim- use their own words as far as possible. Detailed history as for any critically ill child.
- **Basic details** of baby/child, the parents, and other family members.
- **A narrative account of the 24 hours leading up to the child's death. Unexpected death In children less than 2 yrs age**, a full description of when and how the baby slept and fed, any activity, who was with the baby at different times, the baby's health and activity levels, the final sleep and any changes to routine. Where and how the baby was sleeping, clothing, bed coverings, position; any changes in that during the course of the night; if bed sharing, who else was in the bed and their positions relative to the baby; when and by whom the baby was checked during the sleep; description of the last feed and any night time feeds; heating and ventilation.
- Where and how the baby was found, position, coverings, appearance and any unusual features; any action taken after the baby was found.
- **Past medical history**, including pregnancy and delivery, birth weight, post-natal problems, growth and development, normal routine and feeding, any illnesses, immunisations, medications, drug allergies, routine surveillance; Also details of normal routine for the baby, including feeding, sleeping patterns and practices. Check previous OPD/ hospital, A and E, HV and GP visits
- **Family medical history**, including any medical or psychiatric history of the parents and other immediate family members; infectious contacts; any history of respiratory, cardiac, neurological disorders or metabolic disorder in the family and any previous infant or other sudden deaths in the family. The **second twin MUST be examined and investigated appropriately by the Paediatrician**
- **Social history**, family structure and dynamics, housing, use of alcohol, recreational drugs, and tobacco; parents' occupations; any social services involvement in the past, including any child protection concerns.

## **Examination**

- **A detailed examination depends of the clinical presentation**
- **In unexpected deaths:** Consider the following
- Head to toe examination and front to back for bruising/injuries/ visible signs of bleeding/discharge: **use body diagrams to document the injuries (Sheet C of the UHL Standard Child Protection Paperwork)**
- **Examination:** spine, skull, chest, upper limbs, lower limbs, genitalia, anal region
- **Abdomen:** Hepatomegaly
- Signs of dehydration, Rectal temp, Wt/Length/HC, State of nutrition and cleanliness
- Petechiae in distribution of SVC
- **Eye exam:** retinal haemorrhages
- Pre-intubation mouth exam. ENT exam: frenulum/ bleeding/pink fluid from the nose. Frothy fluid, commonly bloodstained, is often present around the nose and or mouth and its presence should be documented.
- Sites of medical intervention: Example: IV lines, IO lines etc needs to be documented
- The presence of any discolouration of the skin, particularly dependent livido. Skin livido and pallor from local pressure (e.g. on the nose in a child who has been face down).



## Samples

**Initial samples to be taken immediately after sudden unexpected death in infancy/Children (SUDIC)**

- **No samples in NAI cases or suspected NAI cases.**
- Once death has been confirmed, **Please take the following samples which has Coroner's prior permission.**
- **Consent:** for post-mortem tissue samples, a fully informed consent must be obtained from the parent or carer with parental responsibility and this must be clearly documented
- **No cardiac punctures, only femoral arterial/venous punctures**
- If difficult to bleed, send samples for blood C/S only.
- **Blood samples taken DURING AND AFTER Resuscitation: send for following investigations.** Maintain strict chain of evidence for all the samples taken (chain of evidence forms-**Appendix 7**). No samples should be sent via the CHUTE.
- Please Fax a copy of this to the coroner, pathologist and the SUDIC paediatrician.
- **No supra-pubic punctures should be attempted for urine samples.**
- Urine/stool stained **nappy** should be preserved and sent for analysis

Sample	Test	Send to	Handling	Sample taken Yes or No
<b>Blood cultures aerobic 1 ml</b>	Culture and sensitivity	Microbiology	Normal	
<b>Blood (serum) 0.5 ml</b>	Urea and electrolytes	Clinical chemistry	Normal	
<b>Blood (serum) 1 ml</b>	Toxicology	Clinical chemistry	Spin, store serum at –20°C	
<b>Blood (lithium heparin) 1 ml</b>	Inherited metabolic diseases	Clinical chemistry	Spin, store plasma at –20°C	
<b>Blood EDTA 0.5 ml</b>	FBC	Haematology	Normal	
<b>Blood from syringe onto Guthrie card</b>	Inherited metabolic diseases	Clinical chemistry	Normal (fill in card—do not put into plastic bag)	
<b>Urine (if available) Wet Nappy (But No SPA)</b>	Toxicology, inherited metabolic diseases	Clinical chemistry	Spin, store supernatant at –20°C	
<b>Urine (If</b>	Microscopy,	Microbiology	Normal	

available) (No SPA)	culture and sensitivity			
Naso-pharyngeal aspirate (NPA) and Nasal Swab	Virology (Immuno-fluorescence)	Virology	Normal	

#### **Appendix C – Examination of the body following the unexpected death of a child**

#### **“Practice Note – Examination of the body following the unexpected death of a child” (11 April 2011)**

Dr Richard Brown – Named Doctor for Safeguarding Children

As soon as is practicable following the cessation of resuscitation, the baby or child should be examined by the consultant paediatrician on call (in some cases this might be together with a consultant in emergency medicine or, for some young people over 16 years of age, the consultant in emergency medicine may be more appropriate than the paediatrician). A detailed and careful history of events leading up to and following the discovery of the child’s collapse should be taken from the parents/carers. The purpose of obtaining high quality information at this stage is to understand the cause of death when appropriate and to identify anything suspicious about it. The paediatrician should carefully document the history and examination findings in the hospital notes. This should include a full account of any resuscitation and any interventions or investigations carried out. A narrative account by the carer of the events leading to death should be documented.

The examination findings, including any post-mortem changes, should be documented on a body chart. Any opinion communicated to police or children’s social care regarding such post-mortem changes should be framed within the context of the paediatrician’s experience and training.

## **Appendix C – Organisations Contact List**

### **Designated Doctor for Deaths in Childhood Cambridgeshire and Peterborough**

Elaine Lewis

Cambridgeshire Community Services  
Block 13 Ida Darwin  
Fulbourn  
CB21 5EE  
Tel: 07534980967  
[elainelewis1@nhs.net](mailto:elainelewis1@nhs.net) (secure)

### **Child Death Review Co-ordinator Cambridgeshire and Peterborough**

Kitty Paques

Cambridgeshire and Peterborough Clinical Commissioning Group  
Lockton House  
Clarendon Road  
Cambridge CB2 8FH  
Tel: 01223 725330  
Secure fax: 01223 725592

[kitty.paques@nhs.net](mailto:kitty.paques@nhs.net) (secure)

Generic CDOP inbox: [CAPCCG.cdop@nhs.net](mailto:CAPCCG.cdop@nhs.net) (secure)

### **Peterborough Safeguarding Children Board (PSCB)**

<http://www.peterboroughlscb.org.uk/>

Tel: 01733 863744

### **Cambridgeshire Safeguarding Children Board (CSCB)**

<http://www.cambslscb.org.uk/index.html>

Tel: 01480 373522

### **Cambridgeshire Social Care Contact Centre**

0345 045 0180

### **Peterborough Social Care Contact Centre**

01733 864180

### **Cambridgeshire / Peterborough Social Care Emergency Duty Team**

01733 234724

**Cambridgeshire Constabulary**

Police Headquarters  
Hinchingsbrooke Park  
Huntingdon  
PE29 6NP

Tel: 101 or 01480 456111

**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)

---

**The Lullaby Trust (previously The Foundation for the Study of Infant Deaths)**

Bereavement support

[support@lullabytrust.org.uk](mailto:support@lullabytrust.org.uk)

Helpline: 0808 802 6868

Monday – Friday	10am-5pm
Weekends and public holidays	6pm–10pm

Local contact: Julie Nicholson  
Tel: 01480 812778

---

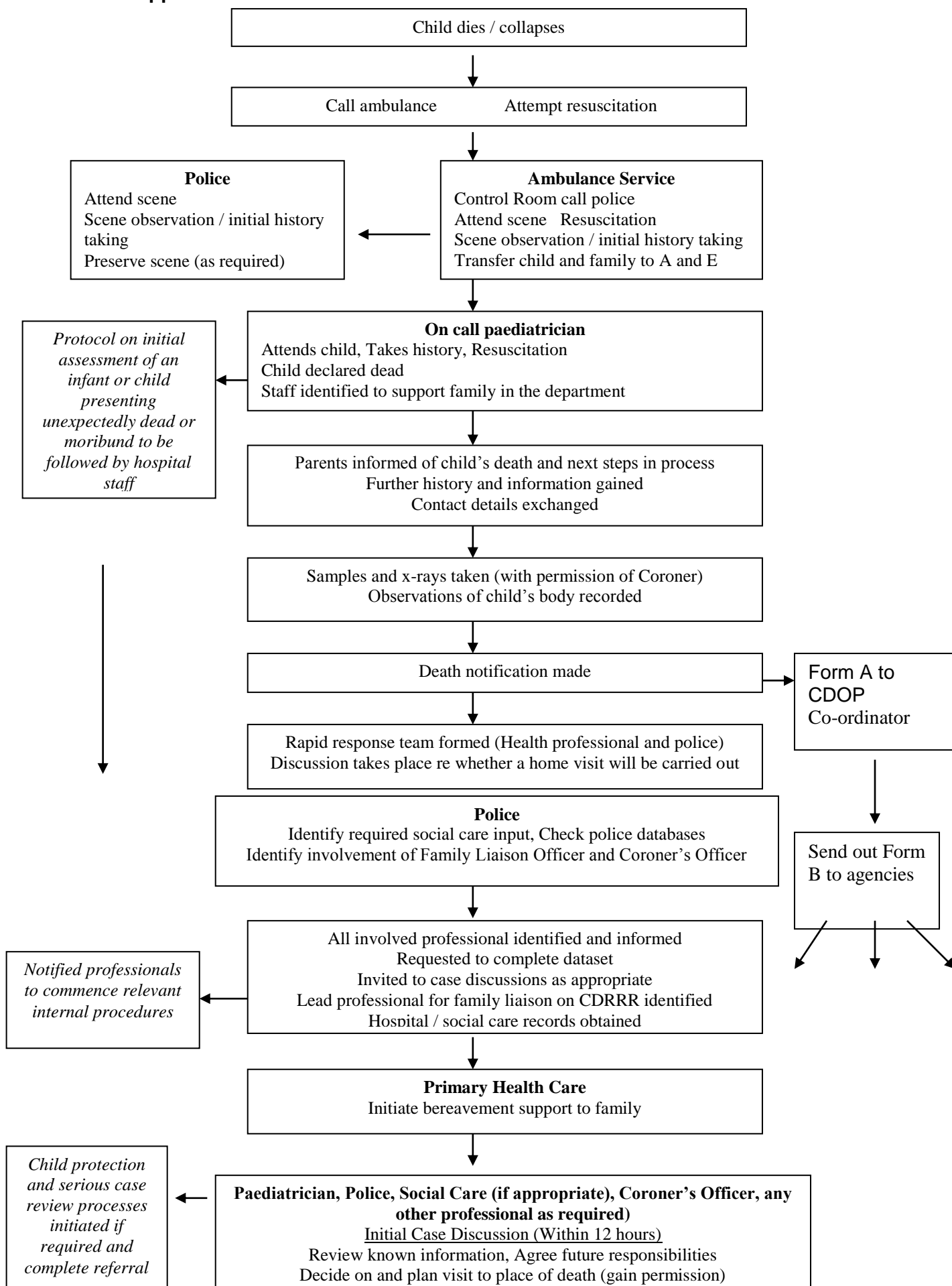
## **Appendix D**

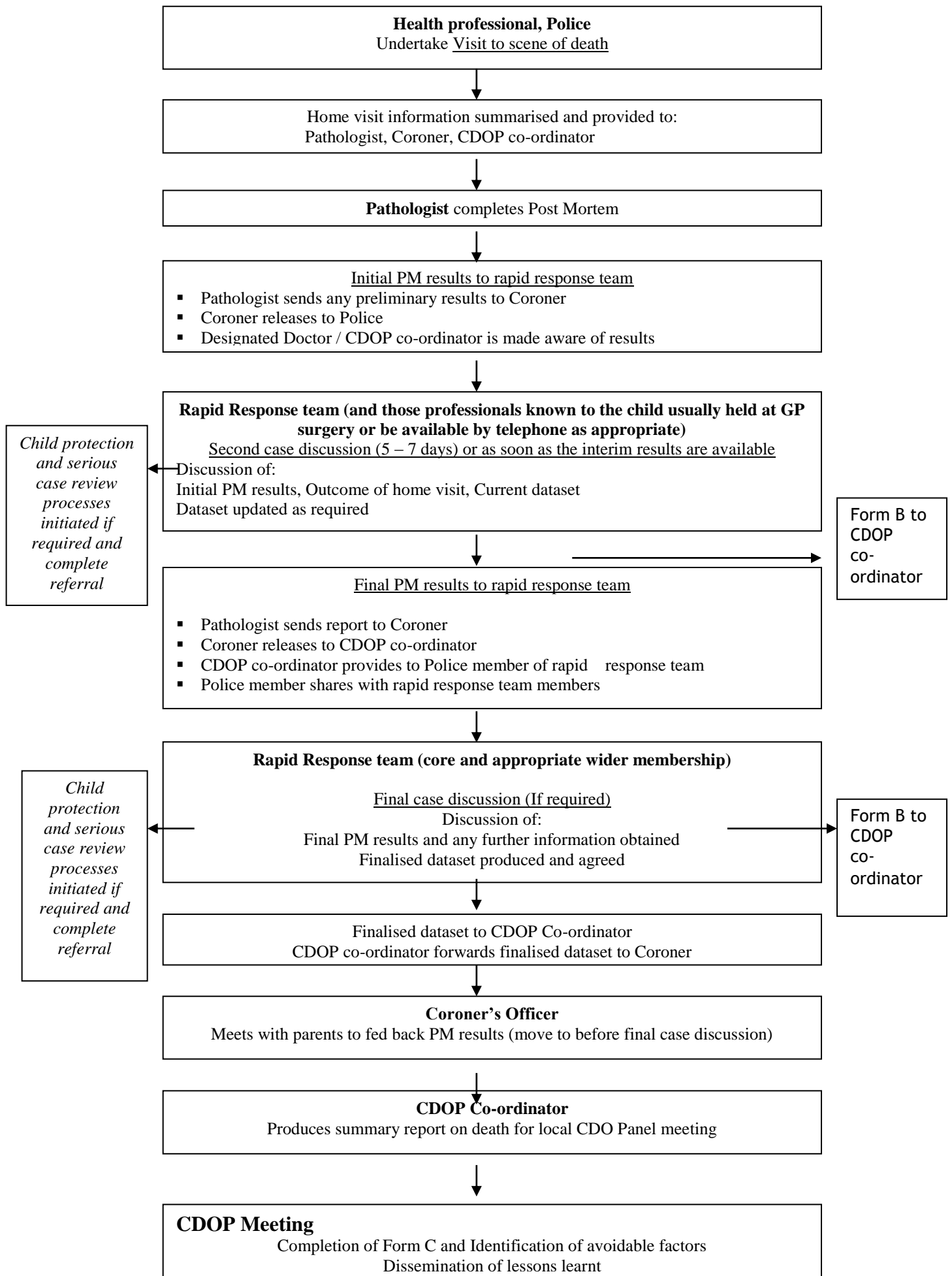
### **National templates for LSCBs to use when collecting information about child deaths**

- A Notification 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
  
- C Analysis Proforma
- D Audit Tool for Rapid response
- E Audit Tool for child death overview

These forms can be downloaded via the CSCB website or contact the CDOP co-ordinator.

## Appendix E







## **Appendix F – Scene of Death Visits**

A decision whether a visit to the place where the child died should take place when a child dies unexpectedly in a non-hospital setting must be made within 24 hours. The professionals responsible for the decision are the investigating police officer and the designated Health professional.

The circumstances for each unexpected child death will be different and the investigating police officer and designated Health professional will be expected to use their professional judgement when deciding whether a scene of death visit is appropriate.

The purpose of the home visit is to gather information which may provide immediate insight into the cause of death, or which may later prove significant to the coroner or to any criminal investigation.

In the following scenarios a joint scene of death visit would be unlikely to lead to a better understanding of the circumstances of the child's death or preceding collapse.

- A child or young person drowns in a public location such as a lake or a river. A detailed history of the child's health is unlikely to contribute to an understanding of the cause of death. However, when a child has drowned in a pond in their home garden and there are concerns regarding supervision of the child or previous concerns regarding the family a joint home visit would be appropriate.
- An unusual event / accident in a public place. A detailed history of the child's health is unlikely to contribute to an understanding of the cause of death. An unusual event / accident at home or in another private residence may be appropriate to visit.
- A child dies as the result of a road traffic accident and there are no concerns regarding the supervision of a young child.
- A young person dies as the result of a road traffic accident and there is no indication the young person has deliberately caused the accident (in which case a history from the parents focused on the young person's mental health may prove invaluable).
- Infants / children who are admitted to hospital following an acute illness and subsequently die within a short frame a visit may not take place if extensive medical information is available and there are no safeguarding concerns.

The rationale for not completing a scene of death visit must be recorded and sent to the CDOP Coordinator.