Chapter Eighteen

Investigation After Sudden Unexpected Death of an Infant or Child

18.1 This Procedure provides the agreed framework for the inter-agency information-sharing and joint assessment when an infant or young child (up to the age of two years) dies suddenly and unexpectedly.

18.2 Sudden, unexpected deaths in infancy and early childhood should always prompt **a co-ordinated and consistently applied inter-agency response which:**

- approaches the investigation with an open mind, in the knowledge that the majority of sudden unexpected deaths in infancy are natural tragedies
- recognises the duty of care by all agencies to the parents, to the child who has died and to other surviving children
- establishes consistent and well-co-ordinated patterns of responding within and between agencies, which combine effective assessment and consistency in response to the family
- aims to establish, wherever possible, the cause of death both for agencies and for parents
- identifies those situations where the death is suspicious of child abuse

Initial Assessment of the Infant Presenting Unexpectedly Dead or Moribund

18.3 Infants found collapsed or dead will be brought immediately to an Accident and Emergency Department where resuscitation will be instituted or continued. Nothing in this procedure should interfere with the absolute priority of effective resuscitation if this is possible. As the first agency to see the child, the Ambulance Service has a key role to observe and later record the “scene” as this may be crucial to the process of making sense subsequently of the circumstances of the death.

18.4 On occasions it is apparent to the attending doctor or ambulance staff that an infant found collapsed out of hospital has been dead for some time and attempted resuscitation is inappropriate. These infants must also be transferred to the Accident and Emergency Department, as this may assist in preserving the ‘scene’ as well as ensuring that medical and social support is available for the family. The only exception is where the child is dead and has obviously been the subject of violent assault, in which case the police should be called.

18.5 The infant should be carefully and thoroughly examined by a consultant in paediatrics or emergency medicine immediately after resuscitation has ceased. Consideration should be given to asking for a police photographer to photograph any skin discolouration as soon as possible, as it may help in estimating the time of death, as well as the position in which the child was lying.

18.6 During the process of resuscitation, various investigations will be initiated. Further samples are directed by the coroner as laid down in the UHL internal policy. Consent from those with parental responsibility for the child is required for tissue to be retained beyond the period required by the Coroner, for example, for use in research or for possible future review.

Note:

- no samples in NAI cases or suspected NAI cases
- no cardiac punctures, only femoral arterial/venous punctures
- if difficult to bleed, send blood samples for blood C/S only
- maintain strict chain of evidence for all the samples taken, all the samples should be handed over to the biochemistry /microbiology staff No samples should be sent via the CHUTE
- please fax a copy of this to the coroner, pathologist and the SUDI paediatrician
- urine/stool stained nappy should be preserved and sent for analysis

Patient's details: Name, sex, DOB, Address/ patient's label

Name and designation of doctor completing the form:

Sample	Test	Send to	Handling	Sample taken Yes or No
Blood (serum) 0.5 ml	Urea and electrolytes	Clinical chemistry	Normal	
Blood (serum) 1 ml	Toxicology	Clinical chemistry	Spin, store serum at -20°C	
Blood (lithium heparin) 1 ml	Inherited metabolic diseases	Clinical chemistry	Spin, store plasma at -20°C	
Blood EDTA 0.5 ml	FBC	Haematology	Normal	
Blood cultures aerobic 1 ml	Culture and sensitivity	Microbiology	Normal	
Blood from syringe onto Guthrie card	Inherited metabolic diseases	Clinical chemistry	Normal (fill in card-do not put into plastic bag)	
CSF	Microscopy, culture and sensitivity	Microbiology	Normal	
Urine (if available)	Toxicology, inherited metabolic diseases	Clinical chemistry	Spin, store supernatant at -20°C	
Urine (few drops, if above sample taken)	Microscopy, culture and sensitivity	Microbiology	Normal	
Naso-pharyngeal aspirate (NPA)	Virology (Immuno-fluorescence)	Virology	Normal	

18.7 If resuscitation is not instituted, such investigations should be taken as soon as possible after the arrival of the infant according to the UHL internal policy. Once life has been declared to be extinct by the attending paediatrician or accident and emergency doctor, the coroner assumes responsibility for the body. From this point onwards the police have responsibility to keep the coroner fully informed of the inter-agency information sharing and analysis of the situation, which forms the core of the subsequent processes in this chapter.

Care of the Parents

18.8 On arrival at hospital, parents are always allocated a specific member of staff to provide support, advice and care. Any relevant information must be recorded in writing. Continuing pastoral care is normally the responsibility of the SUDI paediatrician.

18.9 The paediatrician on call should, as part of the initial assessment, take a detailed and careful history of events leading up to and following the discovery of the infant's collapse. It is important that, as far as possible the parents or carer's account of events should be recorded verbatim. It is also important that details are obtained of all other children and adults in the immediate family.

18.10 The senior detective will work alongside a supervisor from the police Child Abuse Investigation Unit (CAIU).

18.11 Before the family leave the relevant hospital ward the consultant paediatrician who has been dealing with them should introduce the SUDI paediatrician and senior detective designated to lead the investigation to the parents / carers. The joint investigation into the circumstances surrounding the death of the infant should then begin. The two lead professionals should explain their role and the procedure that is routinely followed in all cases of SUDI. Detailed family history and background information should be obtained but this can either take place at the hospital or when back at the family home when visiting the place where the child died. Where there is any concern about the circumstances surrounding the child's death then consideration should be given to speaking with the parents / carers separately so that their accounts can be compared and verified.

18.12 The consultant paediatrician is now responsible to:

- advise the family thoroughly and sensitively of the inter-agency process routinely followed when a child suffers a sudden unexpected death where the cause of death cannot immediately be established
- request a check of the child protection register for the child or siblings
- contact the police and make arrangements for the senior detective designated to lead the investigation into the death to attend and talk to the parents
- contact the SUDI paediatrician with special responsibility for investigation of unexpected deaths in childhood

- contact the duty social worker so that further records are checked relating to the child and all immediate family members

18.13 The parents should, if they wish, be given the opportunity for the police to interview them separately from the paediatrician, but in virtually all instances they are likely to prefer to talk to both together. This joint interview will be conducted with care and sensitivity but must include a thorough exploration of the circumstances of the death, relevant events and previous history.

Sudden Unexpected Death Strategy Discussions

18.14 The sequence of procedures is set out in Figure 1.

18.15 Before the family leave the hospital, the consultant paediatrician and the senior detective (together with the SUDI paediatrician) should briefly review the history and circumstances of the death (including consulting with the ambulance crew who attended and the member of staff initially allocated to provide support to the parents). The paediatricians and the senior detective should consider any issues that raise questions of abuse or neglect and review any relevant social care information on the telephone with the duty social worker. As soon as possible the GP and health visitor should be informed and any further information gained from any other source.

18.16 Arrangements should also be made at this stage for a visit to the scene of death by the SUDI paediatrician and senior detective as soon as possible. Parents must be informed that such a visit is routine and that the police have to thoroughly investigate the circumstances of all unexpected deaths of children.

Initial Home Visit (or visit to the scene of death if this is not the home)

18.17 As soon as possible after the infant's death, and before the scene is disturbed, the SUDI paediatrician and senior detective should visit the scene of death to carry out a very careful and systematic examination of the site, again emphasising the routine nature of the visit and the purpose of the investigation as trying to find out the cause of the death. Where the parents would find it supportive the GP and/or health visitor should be encouraged to attend. The purpose is to talk through in great detail the events leading up to the infant's death.

18.18 Provided effective arrangements have been made for the incident scene to remain undisturbed, this visit should not usually take place in the middle of the night. As part of this visit, the SUDI paediatrician, together with the general practitioner or health visitor, will provide information, care and support to the family and make arrangements for further contact and communication with them.

18.19 The SUDI paediatrician will also, at this stage, make appropriate arrangements to see the family again with the initial results of the post mortem examination which should usually be available within a few days. The senior detective may also wish to attend this subsequent meeting to inform the family about police and coroner's procedures.

Post Mortem Examination

18.20 The post mortem examination will be ordered by the Coroner and should be carried out by a paediatric pathologist within 48 hours of the child's death, or as soon as reasonably practical thereafter. If there is anything to suggest that the circumstances of the death are suspicious or of an unnatural cause, the post mortem examination should also involve a Home Office Forensic Pathologist.

18.21 Prior to the post mortem examination, the pathologists should be fully briefed on the history and physical findings at presentation, by the consultant paediatrician involved, and the findings of the death scene investigation by the SUDI paediatrician and senior detective. This includes viewing any photographs and videos of the death scene or child.

18.22 The pathologists should discuss the preliminary results of the post mortem examination with the SUDI paediatrician and senior detective as soon as possible (usually within 48 hours of the initial post mortem examination) and the coroner should be immediately informed of the initial results.

18.23 If the initial post mortem findings suggest evidence of neglect or abuse as a cause of the child's death, the procedures for commencing a criminal investigation and where appropriate child protection enquiries in relation to other relevant children, should be instigated.

18.24 If the initial post mortem findings suggest natural causes of death, then no further police investigation is likely to be necessary at this stage and the SUDI paediatrician will assume the role of lead professional in communicating information to the primary care team and the family. This will almost always involve a further meeting with the family and GP two or three days after the post mortem to pass on this preliminary information. It is helpful for the senior detective to also attend this meeting, to ensure (s)he is fully informed, and to answer any relevant questions from the family.

18.25 In all cases the SUDI paediatrician should convene and chair a further multi-agency meeting involving children's social care, police and healthcare professionals after the initial post mortem results are available.

18.26 There should be an explicit discussion of the possibility of abuse or neglect either causing or contributing to the death, and if no evidence is identified to suggest maltreatment this should be documented as part of the minutes of the meeting.

Concerns Develop that the Death may be Suspicious

18.27 At any stage significant concerns may be raised from family members, or from any of the involved agencies, that neglect or abuse may be a cause of the child's death. If this happens, the decision may be made that there is sufficient evidence to suspect that a crime has been committed against the child. The police will then take the lead role and instigate a criminal investigation. Their role changes from that of acting as agents of the

coroner within which they seek the cause of an unexpected death, to that of leading an investigation into a possible serious crime.

18.28 This decision has implications in terms of how the police can discuss matters with the family, as there are duties to ensure that a suspect's rights are protected, and legal restrictions which apply in terms of how the person can be spoken to and by whom when conducting a criminal investigation.

18.29 If there are other children in the household, or children who have significant contact with this family and suspicion develops at any stage that the death may be caused by neglect or abuse, child protection enquiries must also be instigated. Children's social care must be fully involved and take the lead in considering whether the other children in the household need immediate protection. In the event that a child protection conference is convened in relation to other children, the SUDI paediatrician will attend the conference and provide the medical assessment. However, in most instances there will not be immediate reason to suspect abuse or neglect.

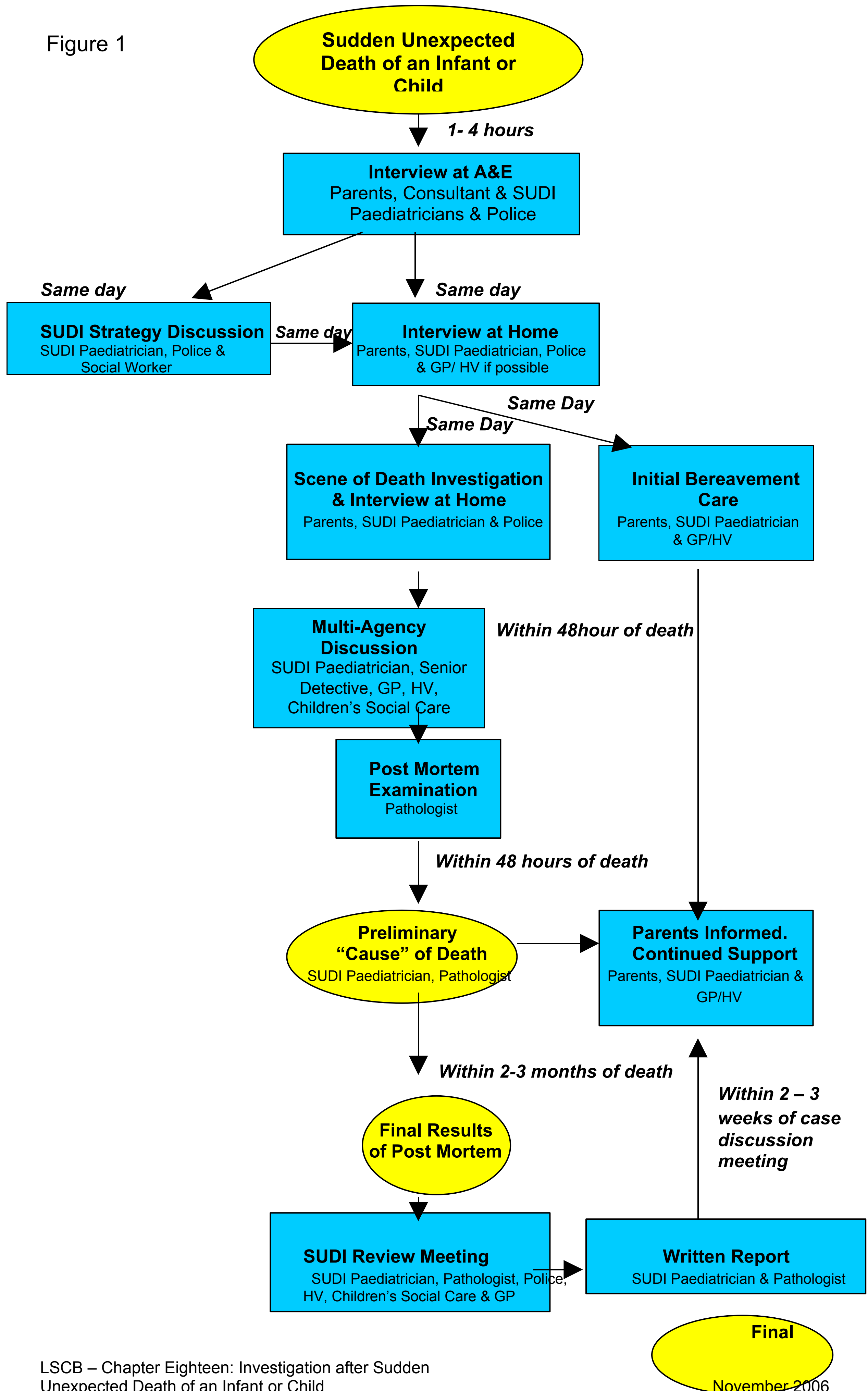
Sudden Unexpected Death Review Meeting

18.30 As soon as the final post mortem result is known, the SUDI paediatrician should convene and chair a case discussion meeting. This meeting should involve the general practitioner, the health visitor, paediatrician(s), pathologist, senior detective and social worker. At this review meeting all relevant information concerning the circumstances of the death, the child's history, family history and subsequent investigations should be reviewed. The coroner or coroner's officer may choose to be present at the meeting. The main purpose of the meeting is for information sharing and for future care planning for the family.

18.31 During the course of this case discussion meeting, it is important that there is an explicit discussion of the possibility of neglect or abuse as a contributory factor to the child's death. If no evidence is identified to suggest neglect or abuse as contributory factors, this should be documented as part of the report of this meeting. This will be of great importance in assessing the possibility of risk to surviving and future children in the family. A copy of the report of the meeting should be sent by the SUDI paediatrician to each of the agencies involved.

18.32 The results of the local SUDI review meeting should be communicated to the coroner by the SUDI paediatrician and further information concerning the cause of the child's death (particularly the identification of metabolic or other medical causes) should be notified to the Office for National Statistics to ensure correct registration of the cause of death. Where the coroner has decided to hold an inquest, information gained from the process of information sharing and reviewing should be made available to the coroner.

Figure 1



Classification
Pathologist