Essential Kennedy 2016 – Need to know (Full details see source document 'Sudden unexpected death in infancy and childhood – Multi-agency guidelines for care and investigation' 2nd Edition November 2016.

(Note: Page Numbers. If hard copy printed page numbering may vary due to page size – page numbers given are as in digital and original hard copy version)

Section/Page	Topic	Key Point(s)	Comment
Preface P3	Preface	Multi-professional, multi-agency working norm New rules New guidance - More research Guidelines input from all professional groups Best current International research	Ongoing project – stimulate discussion and further research
P4	Overview	Kennedy 2004 – first edition Starting point Vast majority of cases where babies die nothing unlawful has taken place 4 times as likely to die in first year of life from both natural and unnatural causes than at any other time Family's right to have death properly investigated Families desperately want to know what happened, how occurred, cause of death and could it have been prevented	 Majority nothing unlawful Family's right plus support Families want to know
P5		Kennedy 2016 A statutory duty to undertake an investigation of any death in childhood now introduced Review and improved Kennedy 2004 Terminology used Chief Coroner recommends use of unascertained – unascertained (SIDS)	 Statutory duty – link WT2018 and CDR SAOG England 2018 Preferred terminology by Coroner
P6		Innocent parents experience child taken and prosecuted when natural cause = nightmare Small percentage something unlawful has taken place Child protection responsibility of all as youngest have no voice Justice for parents v safeguarding young	Not wrongly accuse Unlawful deaths small percentage Ensure hear the voice of the child Balanced investigation

P8	Introduction	Every infant dies respect and care including right in unexpected death Fully and sensitively investigated Try and identify cause of death and learn preventative lessons Sensitive = supportive approach to parents Statutory requirements met Family members, community and all professionals supported through the process Statutory processes WT 2015 in England BUT also applied in other areas in which other systems are in place Focus on SUDI Principles in guidelines broadly relate to all unexpected deaths in children from birth (excluding still births) to age 18 Includes unexpected deaths: • Early neonatal period (1st 28 days life) • No natural cause immediately apparent • Deaths external causes including accidents, suicides, possible homicides (multi agency process consistent with police investigative priorities) The principles recognise that the exact process followed may require modification according to the age of the child and specific circumstances Lullaby Trust - family overwhelming need find out why their child has died and they would like the investigation to be as thorough as possible	Rights of the child Investigation include All involved supported WT2015 updated WT2018 Still births - www.nhs.uk Born dead after completed 24 weeks of pregnancy Before 24 weeks – miscarriage/late foetal loss (PM consent parents) Still birth registered (E&W) 42 days of birth, Scotland 21 days, N Ireland within a year [Macerated still birth - death before onset of labour – skin and soft tissue changes. Prepartum – before delivery e.g. macerated Intra Partum – more recently 'fresh'] Modification process according to age Family – Why and Thorough investigation

P9		Lullaby Trust support detailed comprehensive history, meticulous PM with all appropriate ancillary tests and careful discussion between professionals Recognise police involvement appropriate but sensitive manner At all stages family updated on what happened, found, happen next Support and care for bereaved family from outset core component of JAR and carries on throughout the process Respect family wishes and beliefs	Detailed history, PM, tests and discussion between professionals. Police involvement but sensitive Family regularly updated Support for family Respect family wishes and beliefs
P9	i)Age range covered by document	Focus 0-24 months Most principles applied to all children up to 18 – modifications for deaths of older children Terminology infant = baby, infant or child	Age range Modifications for older children over 24 months
P10	ii)Terminology	Designated paediatrician statutory role Family including extended Lead Health professional – coordinate Health response to the death Senior attending paediatrician before designated paediatrician takes over Specialist nurse – supported by designated paediatrician with adequate case supervision Post mortem - autopsy	Terminology CDR SAOG England 2018 p7
P11		SUDI/SUDC definition 'all cases where there is death (or collapse leading to death) of a child, which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent' Undetermined pending further investigation SUDI up to 24 months SUDC above 24 months	SIDS = SUDI under 12 months, with onset of lethal episode apparently occurring during normal sleep, which remains unexplained after a thorough examination including PM, review of circumstances of death and clinical history.
P12		SIDS (Sudden Infant Death Syndrome) as per definition on page 12 SUDI/SUDC unexplained – e.g. high likelihood of asphyxia but positive evidence lacking Unascertained – legal term – medical cause of death not determined to legal standard e.g. balance of probabilities	

P13	iii)Unusual clinical situations	1. Possible sepsis 2. Infant successfully resuscitated from out of hospital arrest but subsequently dies – home visit prior to death 3. Child life limiting condition dies suddenly unexpectedly	If not clear if need for JAR discussion with coroner, designated paediatrician and other JAR professionals – resolved by Coroner if required [If in doubt initiate JAR]
P14		4. Twins and multiples – surviving twin admitted to inpatient paediatric unit for close monitoring 24 hours 5. New-born infant suddenly collapses and dies on neonatal unit consider a JAR but most not appropriate	
P15	iv)Levels of evidence	Classification on levels of evidence basis for guidance	Research evidence base for K2016
P17	**The Guidelines**		
P18	**1.Introduction**	1.1 Tragedy family and all involved – death result of unrecognised medical conditions, unintentional incidents. However significant proportion SUDI remain unexplained. Significant number associated with adverse environmental conditions (sleeping/smoking/drinking/substance misuse). Rare cases abuse or neglect may have contributed/caused death. 1.2 Bereaved family and deceased infant treated with sensitivity and respect 1.3 guidelines framework for up to 24 months, many of principles applied to unexpected deaths in older children 1.4 The aims of the response (JAR) a) establish cause of death b) identify potential contributory or modifiable factors c) provide ongoing support family d) ensure all statutory obligations met e) learn lessons in order to reduce risks future deaths 1.5 Unexpected death suitably explained that attending Dr can issue a medical certificate of the cause of death (MCCD) may not require JAR	Causes of death but some unexplained **Aims of JAR** Dr can issue MCCD and may not require a JAR

P19		1.5 All professionals have responsibility to work with coroner to determine cause of death and statutory registration requirements are met. 1.6 No action in relation to deceased without permission of coroner Standard response agreed in advance and standard set of investigations including mementos. Any doubt on course of action coroner consulted and if abuse neglect police initiate investigations 1.7 JAR essential components – manner may vary in accordance with local priorities, needs and resources BUT no response should be considered complete without these CORE COMPONENTS **a) Careful multi-agency planning of the response** **b) Ongoing consideration of the psychological and emotional needs of the family, including referral for bereavement support** **c) Initial assessment and management,** including • careful history • examination of infant • preliminary medical and forensic investigations • immediate care of the family, including siblings **d) An assessment of the environment and circumstances of the death**	Responsibility of all professionals. Permission Coroner required Standard response agreed in advance **Core components of JAR** a) p21 b) p25 c) p29 (Appendix 4 Examination – p80) (Appendix 5 Proforma – p86) d) p38
P20		**e) A standardised and thorough post mortem examination** **f) A final multi-professional case discussion meeting** 1.8. **Figure 1 JAR sequence of procedures from WT 2015**	(p40 - The initial case discussion) e) p41 (Appendix 6 PM – p93) f) p45 JAR Flow chart also in CDR SAOG England 2018

P21	**2 Multi-agency planning**	2.1. Multi-agency approach key – keep each other informed, share relevant information, work collaboratively [communication] 2.2. Infants collapsed or dead taken to nearest Emergency Dept with facilities for paediatric resuscitation – lead health professional assigned e.g. on call consultant paediatrician, designated paediatrician, specialist nurse – ensure health responses implemented and ongoing liaison with police and other agencies. Process still applied if not brought to emergency department 2.3. No out of hours specialist provision on call paediatrician take role of lead health professional until handed over and others notified 2.4 police contacted asap – lead police investigator attends – should be experienced in abuse/death investigations	Communication Lead Health Professional Lead Police Investigator
P22		2.4 contd.If not available handed over asap and prior to any multi-agency meeting Knowledge of and adhere to 5 national policing principles for dealing with child death • Balanced approach sensitivity - investigative mindset • Multi-agency response • Sharing of information • Appropriate response to the circumstances • Preservation of evidence 2.5. Local Children's social care services – contacted check records relevant information promptly shared police and paediatrician 2.6 Police may appoint a FLO if neglect, non-accidental harm, unusual circumstances – if appointed clear and accurate information on their role 2.7 If certain factors in history or examination give rise to concerns important information documented and shared with relevant professionals	Appendix 1 p62 - outlines principles of police investigation Local Children's Social Care Police may appoint FLO
P23		2.7 continued. All injuries recorded and photographed List of factors in Appendix 2	Appendix 2 Factors that suggest a death may be suspicious – p73

P23		2.8. An initial information sharing and planning discussion should take place before family leave emergency department. Should include lead paediatrician and police investigator and where possible children's social care and ambulance crew – preferably face to face if not by telephone. Clear records and access to ambulance crew if not present facilitated by ambulance trust 2.9 This initial discussion should review history, circumstances, immediate background information (police, health, social services). and any concerns arising. Particular consideration to well being and safety of other children in household. 2.10. If at any stage concerns that neglect/abuse contributed to death, or significant child protection concerns an initial multi-agency strategy discussion/meeting convened by children's social care. In these circumstances the Police will normally take the lead in investigating the death and the JAR adapted to take account of forensic requirements.	**Initial** Information Sharing and Planning Meeting discussion @ hospital, before family leave, lead paediatrician and police investigator, where possible CSC and ambulance crew. Aims S47 concerns – police lead investigating death JAR adapted
P24		2.11 Lead health professional and police investigator review and plan ongoing approach to information gathering and assessment include outstanding medical investigations, notification appropriate agencies, PM, plans for home/scene visit 2.12 Lead health professional make contact asap with family GP, health visitor/midwife. Consideration initial and subsequent meetings with family to include member of primary care team to provide ongoing care and support to the family 2.13 ASAP after death ANOTHER further information sharing and planning meeting should be held. Key action within JAR, normally in office hours to ensure all relevant professionals attend face to face including lead health professional, police investigator, primary care team, children's social care and other relevant professionals who know the family. Coroner's officer invited to attend. A copy of minutes sent to coroner, pathologist, all agencies involved in the meeting and CDOP coordinator.	Primary care = day to day first contact Secondary care = specialist Tertiary care = specialist high level/intensive e.g. GOSH FURTHER Information Sharing and Planning meeting Attendees CDOP co-ordinator

P24 P25		2.14. Meeting review all information available at that stage and identify further investigations required including ongoing support to family 2.15 **FOLLOWING home visit, results from PM known** – further discussion between lead health professional, police investigator and coroner's officer to review information, discuss what is known about **COD**, **contributory factors**, determine **further investigations** needed, **confirm what information can be provided to family**, **how and by whom.** These and any further discussions required may be by telephone or multi-agency meetings if complex circumstances or many professionals involved.	Information Sharing Planning Meeting FURTHER discussion and actions
P25	**3 Family Support**	3.1 Family allocated member of staff to care for them (KEY WORKER) what happening, facilities contact family, friends and cultural religious support 3.2. Attempts at resuscitation – fully informed, option to be present with medical approval, supported throughout including explanation of what going on 3.3 Family hold, spend time with infant when death confirmed – even if concerns but discreet professional presence 3.4 Consideration as to capacity to engage in process – language, health, mental capacity, faith, culture 3.5 English not first language – provide translation/interpreting service including out of hours e.g. Language Line. Family members especially children not act as interpreters for their parents	Key Worker CDR SAOG England 2018 p7 plus Appendix 5 p63,64 Resus Family access to child Capacity to engage in process
P26		3.6 Clear liaison regarding care and support shared and should be coordinated – lead health professional, police investigator, coroners officer 3.7 Family sensitively informed at early stage that because death unexpected coroner be informed and a police investigation – but routine for all unexpected infant deaths 3.8 JAR purpose and process explained to family i.e. that all professionals working together to try and understand why died and to support them	Information for family

P26		3.9 Informed as part of process information shared with primary care team, social services and other relevant professionals. 3.10 Unless COD immediately apparent Information regarding need for PM, arrangements, movement of body, tissue retention provided in sensitive manner. 3.11 Time scales explained to family e.g. several weeks for PM results and for coroner to make determinations. Family provided with regular updates on progress including if further delays.	Information for family
P27 P28		3.12 Written information provided to family e.g. Lullaby Trust booklets, NHS leaflet re process including child death review by CDOP. Provided also with external bereavement support organisations (Appendix 3). Support factored in as part of multi-agency response. 3.13 Family provided with contact details for lead professionals – updated and introduced to new professionals involved 3.14 Family advised of whom to contact with any questions or concerns in working hours and out of hours. 3.15 If persons suspected of possible crime PACE 1984 applies e.g. how spoken to and by whom. Mentions specifically s.1(2)(b) CYPA 1933 – offence suffocation whilst sleeping with adult under influence of drink/prohibited drug in bed (furniture or surface being used for sleeping)	Appendix 3 National bereavement support organisations p77 Possible overlaying offence
P28		3.16 Explanation of PM include tissue retention include HTA 2004 and family decision regarding retention after coroner's investigation. 3.17 In SUDI as COD not known all organs need to be examined so option of organ donation if raised by family sensitively informed not an option. 3.18 Child resuscitated after cardiac arrest and stabilised on ICU but decision to withdraw support may be options for organ donation if COD known. Organ/tissue donation discussed with family and coroner at an early stage. 3.19 Consideration practical support needs of family – supressing breast milk, housing, employment, anxiety, sleep disturbance – mainly by primary care team who should be kept updated on progress of JAR.	Further information for family PM Tissue retention HTA 2004 Organ donation Practical family support

P29 P30	**4 Initial Assessment and Management**	4.1. 999 call infant unexpectedly collapsed – call centre despatch ambulance crew/first responder Police notified and officer despatched to the scene – ideally an appropriately qualified investigator and in plain clothes. 4.2 On arrival first responder/ambulance crew immediate appraisal of circumstances. **UNLESS** clear indications that the infant has been dead for some time appropriate resuscitation started and continued until infant brought to hospital 4.3 Paramedic/ambulance inform emergency department of hospital that infant unexpectedly collapsed or dead and to have resus team on standby 4.4 First responder/ambulance crew – elicit brief initial account of circumstances, any infant medical issues, relevant past medical history, current medication for child. Impressions of environment, concerns regarding care. Copy of ambulance crew's record provided to lead health professional and police investigator. 4.5 **Unless exceptional reasons not to** – infant immediately to emergency department with paediatric care – resuscitation continued on route to hospital. Default position to always attend emergency department **BUT** with older children where cause of death more apparent (stabbing, train injuries) decision may be to go to mortuary or remain in situ at crime scene to allow forensic recovery under guidance of SIO. Must be ensured bereavement support is in place.	Ambulance and Police first responders actions/considerations Responsibilities identified with JAR **First responder/ambulance crew** • Appraisal circumstances • Appropriate resuscitation • Initial account • Medical issues – past current • Medication • Environment • Concerns re care • Record • Supply copy Default taken to A&E resus contd. Older children COD apparent mortuary or in situ? Bereavement support
P30		4.6 Arrangements family attend emergency department in ambulance with infant or separately. Consideration to care and welfare of other children in home – attending police officer could assist with these arrangements. 4.7 Attending police investigators initial appraisal of environment where child found, brief questioning of family but priorities are infant with family to emergency department, safety of others including children in home and to MAINTAIN INTEGRITY of ENVIRONMENT. Police should assist ambulance crew in these arrangements.	Family to A&E – ambulance Care others including children **Police actions** • Care of others at home • Integrity of environment • Appraisal environment • Briefly question family • Assist ambulance crew

P30 P31		4.8 If infant clearly dead and has been for some time e.g. rigor mortis, dependent livido – resuscitation not appropriate. Discussed with family. Most circumstances still be appropriate for child and family to emergency department with paediatric facilities where JAR initiated, infant examined, appropriate immediate medical investigations carried out. 4.9 Infant remaining at home address very rare occurrence and not routinely offered to family – exceptional circumstances – in liaison with coroner, paediatric team at hospital. GP, certified ambulance staff, FME may confirm infant died. Consideration must be given to how an examination of the child and appropriate immediate medical investigations will be carried out. Hospital is best place and family encouraged for infant being moved to the hospital. ALL OTHER ASPECTS OF THE JAR SHOULD PROCEED ALONG THE SAME LINES AS FOR ANY OTHER INFANT. Removal of samples from body must take place on HTA licensed premises.	**Infant dead/resus not appropriate still to A&E** • JAR initiated • Infant examined • Appropriate immediate medical examinations • Samples from body HTA premises If certified dead? JAR carries on
P31		4.10 Immediate indications abuse, neglect, assault contributed to death, police lead in management. If infant clearly dead may not be appropriate to move the infant and scene secured as a potential crime scene. 4.11 Resuscitation or not, care of family and investigation into cause of death follow similar course. 4.12 Decision to stop resuscitation made by senior medical practitioner after discussion with resuscitation team and family 4.13 Infant successfully resuscitated – stabilised moved to PICU Discussions re intensive care or withdrawal of care should involve PICU team, family and police investigator. Consideration to timing of withdrawal of intensive care, support of family, appropriate timing and process of JAR, including home visit.	**Abuse, neglect or assault contributed to death** Potential crime scene Decision stop resuscitation **Successful resuscitation** • PICU • Withdrawal of care, discussions, timing • JAR including home visit

P32		4.14 Decision made to stop resuscitation – qualified medical practitioner confirm dead. Fact of and time of death recorded in infant's notes. 4.15 When infant pronounced dead, lead health professional, having reviewed all available information inform family. Interview in appropriate room. 'Key worker' supporting family also present. 4.16 Death confirmed. On call consultant paediatrician or designated SUDI paediatrician examine the infant with the police investigator present. <u>Note made of:</u> • Marks, abrasions, rashes, dehydration, identifiable injuries, with detailed general examination • Presence of discolouration of skin, dependent livido accurately documented • Other PM changes frothy blood stained fluid from airways and rigor mortis. • Where possible eyes examined by direct fundoscopy for presence of retinal haemorrhages • Findings carefully documented in notes and body chart • Infant weighed/measured (length/head) [plotted on centile chart. • Re-examined where practicable to note any external marks not present or visible on initial examination, particularly if trauma being considered. More details in Appendix 4 (p80)	**Decision to stop resuscitation** **Confirmation of death** **Informing family/support** Examine child with lead police investigator Examination include: **Appendix 4 – Examination of the child who has died suddenly and unexpectedly – p80**

P33		4.17 Resuscitation attempted Intra(within)venous(veins)arterial (artery) osseous (bone) lines inserted for purpose only removed following discussion with police or coroner All medical interventions, including sites of attempted vascular (vessel) access noted on body chart If intra (within)vascular (vessel) cannula (tube) been inserted and thought may have contributed to failed resuscitation e.g. causing a pneumothorax (collapsed lung – thorax – chest) should not be removed. 4.18 If endotracheal (placed within trachea (windpipe)) tube has been inserted, may be removed after correct placement confirmed by direct laryngoscopy (look in throat voice box and glottis) by other person than the person who inserted it – and discussed with police or coroner. Size and position of tube documented. 4.19 Infant examined – findings recorded – police and/or medical photographs where indicated and sampling taken – infant can be cleaned/dressed and family hold if wish unless suspicious findings which preclude this. Family option cleaning dressing infant in an appropriate setting – v important for some cultures. 4.20 Option of mementos – handprint, footprints, lock hair and photographs in emergency department. If suspicious circumstances taking of mementos discussed with investigating officer and may be more appropriate to delay until after the PM 4.21 All emergency department staff follow general principles of family support outlined above.	**Removal and retention of medical equipment** Nasogastric tube (nose throat stomach) And retained/examined e.g. Lego figure **Family contact with child** **Mementos** – if suspicious circumstances after PM **Family support**

P34		4.22 Senior medical practitioner initiate JAR by contacting designated paediatrician or specialist nurse. Initiating information sharing and planning discussion with police investigator and children's social care 4.23 Lead health professional (consultant paediatrician on call, designated paediatrician, specialist nurse) detailed history from family. Where possible with police investigator to avoid repeat questioning. 4.24 Where suspicious circumstances may be necessary for police to interview the parents/carers separately. Still important to obtain a full and careful medical history. Coordinated plan of who talks to the family and when agreed between senior police investigator and lead health professional. In some cases police investigator may request voluntary blood and/or urine samples from family members if they think alcohol or drugs may be a contributory factor. 4.25 History careful review of past medical history – pregnancy, birth, growth, development, relevant social family history, events leading up to and following discovery of infant's collapse. **Checklist Appendix 5** IT IS IMPORTANT THAT AS FAR AS POSSIBLE THE FAMILY'S ACCOUNT OF EVENTS SHOULD BE RECORDED VERBATIM **Red book** – **Personal Child Health Record** important source of information including family history, birth details, immunisation status, growth trajectory, outcome from routine reviews and other information about infant.	As above 2.8. p23 **History Taking** – Appendix 5 Proforma for history, examination of the infant and scene examination – p86 **Voluntary blood and urine samples from parents** Appendix 5 p.86 **Recording family accounts** Body Worn Video/recorder? Red Book
P35		Information obtained from all these sources including ambulance record (4.4) recorded on standard SUDI proforma – commenced in hospital and taken to home visit.	Use of proforma Link Home Visit

p.35		4.26 History taking ongoing process – all details carefully recorded and shared with the lead professionals – gaps covered in subsequent meetings with family. 4.27 During resuscitation medical investigations may be initiated including blood samples – if not taken should be obtained post mortem, along with blood for metabolic investigations, according to **Table 1 p.37 Routine suggested samples**. Samples PM must be on HTA licensed premises and are property of the coroner. 4.28 Single attempt at femoral (main artery blood lower body groin area and back leg) or cardiac aspiration (withdrawing fluid through a needle) – repeated attempts compromise integrity of cardiac anatomy. Blood ideally taken from venous or arterial site (femoral vein), rather than cardiac puncture – avoided in forensic cases. 4.29 Single attempt at urethral catheterisation (direct drainage bladder) or supra-pubic aspiration (needle in skin just above pubic bone into bladder) for urine – microscopy and culture, metabolic investigations and toxicology – according to Table 1 p.37 4.30 Single attempt at lumbar puncture for cerebrospinal fluid sent for microscopy and culture. If sufficient frozen for future metabolic investigation.	History taking **Samples taken during resuscitation** – identified and arrangements for retention e.g. for pathologist Kennedy/SUDI samples p37 in **Table 1. Routine suggested samples to be taken immediately after SUDI/C** 'In unexpected deaths in older children, the appropriate clinical samples will be guided by the circumstances of the death and the clinical findings.' **Single attempts blood/urine and CSF** [If suspected AHT delay CSF lumbar puncture at PM? Remove suggestion of false +ve]
P36		4.31 Stool/urine passed by infant plus any gastric (stomach) or nasopharyngeal (tube nostril to sit behind tongue) aspirate obtained labelled frozen after samples sent for bacterial culture and virology (viruses?) Nappy wet/soiled – removed, labelled,frozen 4.32 Lead health professional arrange full radiological skeletal survey/appropriate imaging. Performed and reported on by paediatric radiologist prior to PM. **Children over 24 months** – need discussed with designated paediatrician.Imaging investigations reported on asap to rule in/out bony injuries as may change focus of investigation.	**Other possible samples**: • Stool/urine • Gastric/nasopharyngeal aspirate • Nappy **Skeletal survey - +CT/MRI?** • Reported by paediatric radiologist prior to PM • Discussion re older children over 24 months

P36		4.33 Details recommended samples and purposes in Table 1 p.37 Samples for metabolic tests obtained asap after death. Link with PM samples Appendix 6 p 93 4.34 Lead health professional ensure relevant professionals and organisations are informed of the death, including coroner, GP, health visitor/midwife, child health computer system and local CDOP. 4.35 Recorded in infant's notes: careful account resuscitation (methods used, duration and personnel involved), History and examination findings carefully documented, all actions taken following the death, details of information shared with family and other professionals.	Appendix 6 p.93 Post-mortem examination protocol for SUDI (nonsuspicious) **Information recorded and shared**
P 37	Table 1. Routine suggested samples to be taken immediately after SUDI and childhood	Samples in table taken in all SUDI In unexpected deaths of older children, the appropriate clinical samples will be guided by the circumstances of the death and the clinical findings.	**Kennedy/SUDI samples**
P 38	**5 Assessment of the environment and circumstances of the death**	5.1 Home/death site visit – asap lead health professional (designated paediatrician, specialist nurse or on call paediatrician), police investigator, accompanied by family GP or health visitor if possible should visit the family at home or at site of death/collapse. 5.2 Purpose of visit – further more detailed information about circumstances and environment – provide family with information/support 5.3 Normally within daylight hours. If delay in arranging joint home visit police investigator consider whether police undertake initial visit to review environment/ forensic requirements?/ record what is found. Unless clear forensic reasons environment should be left undisturbed so fully assessed on joint visit in presence of family. 5.4 Lead Health professional with police investigator inform family of nature/purpose of home visit. Family go at own pace. Allowance for other family members/friends to be present to support the parents.	**Home visit – asap** **If delay Police undertake an initial visit – unless forensic reasons environment left undisturbed for joint assessment** **Explain purpose – allow family and others support parents if appropriate**

P38 P39		5.5 Lead health professional with police investigator review key elements of history – family elaborate/clarify/add – observations by family in days leading up to death – photographs/video clips on a mobile phone may be useful. 5.6 Family ready lead health professional and police investigator review environment where infant died. Useful family describe in detail final events – how infant put to sleep and how found 5.7 Consideration to reconstruction of sleeping environment using prop – help clarify account – not distress family further 5.8 Police investigator consider CSI photos/video, items seized for forensic testing, other relevant recordings e.g. temperature detailed in police APP. Rarely necessary to seize bedding or clothing but may be occasions where cot/sleeping environment needs to be taken for further examination. Only taken after joint visit so items first seen in situ. May need to take feeding bottle, feeds or medications for further analysis. 5.9 After reviewing the information the lead health professional and police investigator discuss findings with family, careful if concerns re possible abuse/neglect. Family informed of further investigations required including PM and how/when they will be informed of the results.	**Review Key elements of history** **Mobile phones may assist** **Review environment where child died** **Reconstruction of sleeping environment** **Attendance of CSI** **Seizing items – necessity/reason?** **Last feed, medications?** **After reviewing information appropriate discussions with family and additional information provided to them re JAR e.g. PM and results timing**
P40		5.10 Information given to family in general terms at this stage around possible causes of death, not possible give definitive cause at this stage until all investigations complete and ultimately decision on COD rests with coroner. 5.11 Family clear information who contact for support/advice including contact details for bereavement support – Appendix 3 National bereavement support organisations p77	Further information to be provided to family COD coroner decision Appendix 3 – national bereavement support organisations p77

P40	**6 Initial Case Discussion**	6.1 Following Home Visit – lead health professional and police investigator review information to date. May be through an initial case discussion within a multi-agency meeting – especially if complex circumstances 6.2 Following this review – Lead health professional prepare a report of initial findings – history, initial examination, home visit, medical investigations/procedures carried out. Can use Appendix 5 Proforma for history, examination of infant and scene examination p 86 and updated as investigation progresses. 6.3 Report available to pathologist, coroner, police investigator asap and before PM	Link - Information sharing planning meeting Following review lead health professional prepares a report. England – E CDOP forms Notification form A Supplementary reporting forms B NCMD for England from 1.4.2019
P41	**7 The post-mortem examination**	7.1 Aim establish as far as possible COD. Investigation consider family history, past events and circumstances in addition to infant. Sensitivity, discretion and respect for infant who has died and family. All staff open mind - some deaths result of neglect/abuse but majority natural tragedies. PM ordered by coroner carried out by paediatric pathologist – if concerns abuse/neglect joint post mortem examination protocol (Appendix 6 p 93 - PM examination protocol for SUDI (non-suspicious) BUT Scope of Recommendations 1 p 93 - paediatric pathologist with HO forensic pathologist). If paediatric pathologist concerned at any stage abuse/neglect and forensic pathologist not present the procedure must be stopped and reconvened with joint procedure in presence lead police investigator or other designated police representative.	Establish COD Paediatric pathologist – if concerns with forensic HO pathologist
P42		7.2 Families right to be represented at PM by medical practitioner of their choice provided notified coroner of their wishes. 7.3 Prior to examination pathologist fully briefed – history, physical findings at presentation and death scene investigation by lead health professional or police investigator. Other photographs – presentation or emergency department should be made available. 7.4 PM must include a full radiological skeletal survey or other appropriate imaging, reported by paediatric radiologist.	Family can be represented at PM Briefing for pathologist Skeletal survey reported by paediatric radiologist

P42		7.5 Standard protocol (Appendix 6) – tissue samples, specimens, frozen samples and others deemed necessary by pathologist to ascertain COD. 7.6 Organs not routinely retained but when necessary coroner and family informed – dealt with according to wishes of family e.g. returned to body, donated for future use specifying purpose they can be used for and with appropriate consent. 7.7 Coroner immediately informed of initial results, and with their permission, discussed with lead health professional and lead police investigator.	PM standard protocol Organs not routinely retained Dealt with according to wishes of family Coroner informed of results – with their permission shared
P43 P44		7.8 If initial PM findings suggest evidence neglect/abuse police investigation team and Children's Social Care immediately informed and further investigations set in process. 7.9 When initial PM findings known, with coroner's permission, lead health professional and police investigator meet family to discuss preliminary findings – at that stage not possible to draw conclusions about COD. 7.10 Procedure when initial results PM known: a) complete sufficient COD found must be given as COD at this stage b) no clear or insufficient COD pathologist give coroner initial medical COD as 'undetermined pending further investigation' Coroner open an investigation, issue coroner's interim certificate of the fact of death, allow funeral to proceed unless valid reasons to delay c) Initial PM findings suggest neglect/abuse police and coroner informed, coroner open and adjourn an inquest, still able issue interim certificate of the COD and release body for funeral as soon as practicable, Police initiate criminal investigation compliance PACE 1984	Neglect/abuse suspected Initial findings discussed with family Dependent on findings • COD known • Undetermined pending further investigation • Neglect or abuse suspected
P44		7.11 Whatever interim COD important to pursue other aspects of JAR, including support for family	JAR continues including support for family

P44		7.12 As part of explanation about PM to family lead health professional or coroner's officer explain that according to Coroners (Investigation) Regulations 2013 fate of tissues samples taken, will after coroner's investigation, be determined by family according to HTA 2004 guidelines. Lullaby Trust advise that majority families accept approach that whilst waiting for confirmation of precise COD providing kept informed and can proceed with funeral arrangements.	Tissue retention – HTA procedures Family informed of progress
P45 P46	**8 The final case discussion**	8.1 ASAP relevant results of investigations known a multi-disciplinary local case discussion meeting held. • Review information – likely cause death/contributory factors • Identify lessons – prevent future deaths • Consider ongoing support to family including children/subsequent children • Supportive environment for professionals to reflect on case and their involvement 8.2. Local case discussion meeting take place before inquest and CDOP review. A report go to Coroner and CDOP 8.3 Responsibility convening/chairing meeting agreed in advance by lead health professional and lead police investigator 8.4 All relevant professionals involved with infant/family at time of death or previously invited, should include • Lead health professional - designated paediatrician/specialist nurse • Primary care staff – GP, health visitor, midwife • Emergency dept staff • Ambulance crew • Police investigator • Coroner's officer • Pathologist • Children's social care	Local case discussion meeting Before Inquest and CDOP Responsibility convening/chairing List relevant professionals

P46 P47		8.5 Family informed of meeting – opportunity to contribute information/questions – only attend in rare circumstances 8.6 During meeting explicit discussion of possibility of neglect or abuse contributing factor to death – no evidence identified noted accordingly Quality medical/social care given discussed, identify shortcomings and measures to improve future care 8.7 Concerns child protection nature other medical experts may be utilised – consideration Criminal Procedure Rules, experts meeting, other parallel procedures, Family Court procedures and information sharing 8.8 Arrangements most appropriate professionals to meet with family after the meeting to give feedback ASAP. Lead health professional/police/primary care team Letter or report of summary of findings – meeting agree information and by whom agreed with Coroner Final conclusion on COD responsibility of coroner at inquest	Further information to family Parallel proceedings Experts meeting Disclosure of Information in Cases of Alleged Child Abuse and Linked Criminal and Care Directions Hearings 2013 Agreed feedback to family
P47		8.9 Unless ongoing concerns conclusions of meeting shared with family but decision on final registered cause of death coroner – informed by but not bound by findings of multi-agency investigation. If not already done ascertain wishes of family regarding organs tissue retained during PM investigation.	Conclusions of meeting shared with family Registered COD - Coroner
P47 P48	**9.The inquest and role of the coroner**	9.1 Coroners independent judicial office holders – statutory duties to investigate deaths 9.2 Coroners vital role in SUDI/C as most will come under their jurisdiction 9.3 Coroners investigate deaths reported to them by medical practitioners and sometimes by Registrar of births and deaths. At present no statutory criteria for doctors reporting deaths to coroners (referrals) but advised in notes to the Medical Certificate of Cause of Death to use the criteria the Registrars must use	 Chief Coroners Guidance No 23 Report of Death to Coroner

P48		9.4 Coroners and Justice Act 2009 – when senior coroner made aware body of deceased within their area must conduct an investigation ASAP if reason to suspect death violent, unnatural, COD unknown, deceased died in custody or state detention. 9.5 Most SUDI/C reported to Coroner by Drs. Coroner take initial legal possession of body and open investigation into the death 9.6 Body will pass to the legal custody of the coroner within public or hospital mortuary. Coroner assisted by coroner's officers and professionals. Potentially distressing for families so needs to be sensitively explained to them, followed up by Corner's officer 9.7 Coroner order PM, when suspicious in conjunction with police 9.8 Following PM usually released promptly to family for funeral arrangements	Role of Coroner
		9.9 Once jurisdiction of coroner engaged – coroner's officer main point of contact with family – timely, regular, sensitive – weekly updates if protracted – meet family's needs.	Coroner's officer
P49		Specifically, family informed early on of coroner's involvement, need for/timing of PM including their right to be represented there, if investigation/inquest opened, dates of reviews, inquest, delays but inquest ASAP	Information for family
P49		9.10 Family asked if any concerns in relation to the death of their child e.g. treatment/care	Family express concerns
		9.11 Family informed that inquests are public hearings – attended by press and public	Inquests public hearings
		9.12 Family formally designated as 'interested persons' for purpose of coroner's investigation and entitled to appropriate disclosure from coroner, make submissions, ask relevant questions during inquest and make submissions on law	Family – 'Interested persons'

P49 P50		9.13 Purpose of inquest laid down in statute. Investigative not adversarial, determine who died, how, when and where died, medical COD, certain personal particulars required for registering the death. If argued state may not have appropriately upheld a person's right to life the remit is extended to include the circumstances in which death occurred. Coroner call/examine evidence, usually without a jury, record answers to questions above on a public document – 'Record of Inquest'. Family central party in an inquest. 9.14 Not all deaths reported to Coroner proceed to inquest although most SUDI/C do. Preliminary enquiries may conclude death from natural causes in which case coroner may sign the case off to local registrar of births and deaths as natural causes – • Form 100 A – without PM, • Form 100 B – with PM	Purpose of Inquest
P50		9.15 If coroner's duty to investigate death triggered coroner will open a formal investigation, usually lead to an inquest. Following inquest coroner complete Record of Inquest, public document, refer findings/conclusions to Registrar on Form Rev 99. 9.16 Once coroner opened investigation/inquest will issue Interim Certificate of the Cause of Death. If COD known be recorded on certificate. Usually not the case so COD recorded as 'the precise COD is not known'. 9.17 Coroner legal duty to make a finding as to the medical cause of death. If known following inquest, recorded on Record of Inquest and Form Rev 99 and passed to Registrar. 9.18 Medical COD not ascertained recorded as 'Unascertained' on Record of Inquest and Form Rev 99, if sufficient to describe death as SIDS then may enter 'Unascertained (SIDS)'.	
P51		9.19 Coroners enquiry assisted by many other agencies who may be designated as 'Interested Persons' e.g. police, treating physician. Coroner must inform LSCB if open investigation/order a PM of person under 18.	Interested persons

P51 P52		9.20 All agencies/persons with pertinent information under a duty to disclose this to the coroner in fully unredacted format. Coroner common law and statutory powers to enforce disclosure. 9.21 Agencies /individuals may be Interested Persons so entitled to relevant and appropriate disclosure from the coroner. Coroner statutory duty to disclose information, PM reports to LSCB's. 9.22 Agency/Individual may request information redacted before passed to Interested Person – coroner may accede to this if not relevant to coroner's enquiry or release compromise future criminal proceedings 9.23 Children die abroad brought back to E and W and unnatural/unknown COD coroners duties will apply but not if buried or cremated abroad. Usually coroner for area where body brought for funeral arrangements. Deaths abroad assisted by F and CO – Coroner no power to summon evidence or witnesses outside E and W.	Duty of disclosure and right to disclosure Children die abroad
P52		9.24 Following inquest Interested Persons may request recording of proceedings 9.25 If during inquest coroner identifies matters that, if changed, may prevent future deaths have a duty to report these matters to agencies or individuals who they believe may have power to take such action.	Coroner report matters to agencies to prevent future deaths
P52	10. Child Death Overview Panels	10.1 Statutory basis from WT to gather data on child deaths, identify remediable factors, learn lessons, reduce risk of future child deaths. 10.2 CDOP manager notified under local protocol when ever child dies, for SUDI/C usually lead health professional. 10.3 Conclusion JAR – copy of report from final case discussion sent to CDOP manager and other relevant documentation. 10.4 CDOP multi-agency panel meets on regular basis to review all child deaths. SUDI/C scheduled for discussion after conclusion of JAR including coroner's inquiry.	'modifiable factors'

P53		10.5 CDOP review all relevant information, consider contributory factors (intrinsic to child, parenting capacity, family, environment and service delivery) form opinion as to relevance of factors, cause/category of child's death and whether death preventable according to definition in WT. CDOP consider learning and appropriate recommendations. 10.6 Coroner duty to notify LSCB when investigate child death and share information with LSCB. 10.7 Parents informed by JAR team of role and purpose of CDOP, given opportunity to submit information to CDOP. 10.8 CDOP statutory duty to review deaths of ALL children resident in their area, irrespective of place of death including abroad. Coroner assist CDOP with advice when child dies abroad and agencies abroad.	Role CDOP Parents contribute
P53 P54	**11 Commissioning arrangements**	11.1 2008 CDOP statutorily established in England under LSCB for children under 18 11.2 DfE commissioned Woods review, published 2016 – responsibility for CDOPs transferred to Department for Health 11.3 LSCB Regulations 2006 – LSCB's responsible for reviewing deaths of all children under 18 in their area and putting in place procedures to ensure a coordinated response by authority, Board partners and other relevant persons. 11.4 All registered healthcare providers duty to notify Care Quality Commission of the death of a service user – NHS providers can discharge duty by notifying NHS England. 11.5 These guidelines a framework for multi-professional identification, reporting and investigating SUDI/C; LSCB statutory responsibility developing, implementing a coordinated response to these deaths as per agreed protocols. Responsibility to commission resources required for development of required services and regularly audit and monitor the optimal functioning of SUDI/C procedures in their population.	
P55 - 60	**References**		

P61	**Appendices**		
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