Children that are covered by the guidance

An unexpected death is defined as the death of a child which was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death. This guidance applies to the unexpected death of all children up to the age of 18, excluding babies who are stillborn.

Introduction

From April 2008 each Safeguarding Board must have arrangements for enquiring into all unexpected deaths of children in their area¹. The SSCB (Surrey Safeguarding Children Board) also has in place a Child Death Overview Panel to evaluate data in respect of all child deaths in Surrey.

The majority of sudden and unexpected child deaths are an unavoidable tragedy for any family.

Professionals from a number of different agencies and disciplines will become involved following an unexpected child death to try to establish the cause of the death and support the family. This document is intended to provide guidance to the professionals working with one of these tragic events.

It is acknowledged that each death has unique circumstances and each professional has their own experience and expertise to draw on in their handling of individual cases. There are, however, common aspects to the management of unexpected child deaths and it is important to achieve good practice and a consistent approach.

All professionals need to strike a balance between managing the sensitivities of a bereaved family and identifying and preserving anything that may help to explain why a child has died. It is as important to identify medical conditions and hereditary disorders, and to absolve a family from blame, as to identify unnatural deaths or homicides.
Any professional becoming aware of the death of a child, other than stillborn babies, should notify the Surrey Safeguarding children Board Child Death Coordinator on the notification form (Appendix1). All unexpected child deaths should be telephoned to the Coordinator on 01372 833319 and followed up in writing on the notification form.

Principles

All Professionals and agencies should adhere to the following principles

- An open minded approach, sensitivity, discretion and respect;
- A balance between forensic and medical requirements and the family’s need for support;
- Consideration of the welfare of any other children within the household
- A multi-disciplinary and interagency approach;
- Appropriate and timely sharing of information;
- A planned response to the circumstances;
- Recognition of cultural need;
- Preservation of evidence;
- Detailed record keeping;
- Working to a protocol agreed with the local coronial service;
- Conclusion of any enquiries or investigations expeditiously in order that the funeral is not delayed unnecessarily.

These principles are of equal importance.

The unexpected death of a child is an extremely difficult and emotionally charged time for all concerned. Staff in all agencies should bear in mind that in most cases the deaths are the result of natural causes and represent an unavoidable tragedy for the family.

In all cases, it is imperative that there is a sensitive balance between the care and support of the family and gaining an understanding of the cause of death. There should be a balanced, open-minded approach by all the agencies and effective sharing of information. Enquiries should address the possible needs of other children in the household.

A minority of unexpected deaths will be the consequence of abuse or neglect, or be found to have abuse or neglect as an associated factor. If it is thought at any time that the criteria for a Serious Case Review might apply, the Manager of the SSCB should be contacted and the serious case review procedures followed.
**Inter-agency working**

This guidance applies whenever there is an unexpected death regardless of where the death occurred and may run alongside other processes, such as the Serious Untoward Incident Protocol within a health setting. The child may have been in the care of a parent, carer, residential establishment, children’s home, boarding school, day care provider, hospital (including psychiatric care) youth offending or any other provider at the time of death and this protocol applies equally to all settings and situations. Children with a known medical condition and disabled children should be responded to in the same manner as other children.

A multi-professional approach is required to ensure collaboration among all involved, including: ambulance staff, accident and emergency department staff, coroners’ officers, police, general practitioners, health visitors, school nurses, midwives, pediatricians, mental health professionals, hospital bereavement staff, voluntary agencies, coroners, pathologists, forensic medical examiners, children’s services, probation, schools and any others who may find themselves with a contribution to make in individual cases, for example, fire and rescue or faith leaders.

**Immediate response to an unexpected death in the community**

If the first professionals on the scene are not medical professionals, they must obtain urgent medical assistance as the first priority.

The ambulance service or GP / doctor or other medical personnel should not assume death. They must:

- Initiate immediate resuscitation unless clearly inappropriate.
- Resuscitation once commenced should be continued according to UK Resuscitation Guidelines until an experienced doctor (usually the consultant paediatrician on call) has made a decision that it is appropriate to stop;
- Notify the police if they are not already present;
- Arrange for the child to go to an accident and emergency department by ambulance, unless the circumstances of the death require the body to remain at the scene for forensic examination;
- Prior to arrival at the accident and emergency department, provide relevant information and history to accident and emergency staff.
- In the majority of cases the child should go to the accident and emergency department and the body should only go direct to the mortuary when the
death has been certified at the scene and circumstances are such that it is clearly inappropriate for the body to go to accident and emergency, for example the child have clearly been dead for some considerable time. The coroner has jurisdiction of the body and will decide on when it is appropriate for the body to be moved.

- Where a child is not taken immediately to accident and emergency, the professional confirming the fact of the death should inform the designated paediatrician with responsibility for unexpected deaths in childhood at the same time as the coroner is informed.

**Ambulance Service Response**

The ambulance service communication centre will immediately notify the Police control room when there is a call to the scene of an unexpected child death and the recording of the initial call to the ambulance service should be retained in case it is required for evidential purposes.

Ambulance staff should follow the Joint Royal Colleges Ambulance Liaison Committee Guidelines:

- Do not automatically assume that death has occurred, clear the airway and if in any doubt about death apply full cardiopulmonary resuscitation
- Transport the child to an accident and emergency department
- Inform the accident and emergency department giving estimated time of arrival and patient’s condition
- Take note of how the body was found - including the position of the child (e.g. prone) clothing worn and the reported circumstances
- Note any comments made by those caring for the child, any background information given, any evidence of possible substance misuse and the conditions of the living accommodation
- Pass on all relevant information, on the data form, to the accident and emergency department receiving doctor and to the police on arrival.
- Attend the post death planning meeting.

**General Practitioners Response**

There are times when a GP is called to the child first. In such circumstances the GP should adhere to the guidance above for responding to an unexpected death in the community.

- The GP should immediately contact the police if they are the first on the scene, after taking into account their primary responsibility of saving life.
• A GP may not issue the death certificate in these circumstances.
• Children who have died unexpectedly should in most circumstances be seen in the Accident & Emergency Department by a paediatrician as this enables the clinical history, examination and any initial investigations to be completed and information given to parents.

• The doctor confirming the death should inform the paediatrician for unexpected deaths in childhood and child death co-ordinator of the death so that the Rapid Response Team can be convened.
• The body should not be sent directly to the mortuary unless it is clearly inappropriate for the body to go to accident and emergency, for example, they have clearly been dead for some considerable time.
• The coroner has jurisdiction over the body and will decide when the body should be moved in such circumstances.
• Attend the post death planning meeting.

**Hospital Staff Response**

• Ensure that the child is taken to the appropriate area of the Accident & Emergency Department even if they appear to have been dead for some time.
• Call the duty paediatrician and the resuscitation team.
• Establish the identity of those present and their relationship to the child
• Ensure that the parents are allocated a supporter and kept informed
• Whilst resuscitating, undertake a full general examination, reporting on injuries, rashes and observations about the child’s physical condition;
• Check that the police have been notified if the child is dead on arrival or subsequently dies;
• Check if any of the children in the family are subject to a child protection plan.
• Only in exceptional circumstances should the child be taken straight to the mortuary

**Paediatrician or Doctor in Emergency Medicine**

• The consultant paediatrician on call should examine the child. (In some cases this might be together with a consultant in emergency medicine, or for some young people over 16 years the consultant in emergency medicine may be more appropriate than a paediatrician) and record any findings made on a body chart (see Appendix 2 for findings to be recorded)
• Inform the police immediately if injuries are noted or suspicions raised.
The paediatrician should ensure that a detailed verbatim history of events leading up to and following the discovery of the child’s collapse is taken including:

- Past and recent symptoms, any resuscitation attempts at home
- Family history of childhood deaths or serious illness.
- Full medical and family history, including siblings, history of other child deaths and medical concerns;
- The consultant paediatrician on duty must ensure that all hospital records of the child and siblings are reviewed and arrange for the records to be secured and available for the police as appropriate.
- When the child is pronounced dead, the paediatrician should inform the parents, having first reviewed all the available information.
- Explain future police and coroner involvement including the latter’s authority to order a post mortem examination. This may involve the taking of tissue blocks and slides to ascertain the cause of death.

The paediatrician or consultant in emergency medicine confirming the death should inform the paediatrician for unexpected deaths in childhood and SSCB Child Death Co-ordinator of the death so that the Rapid Response Team can be convened. The paediatrician should fill in the data set form to begin the process of collecting the agreed data set. The paediatrician should attend the post death planning meeting.

### Medical investigations

During attempted resuscitation, various investigations may be initiated including urea and electrolytes, full blood count, blood sugar, blood culture and gases, blood, and in young children urine for metabolic studies.

Where the causes of death or factors contributing to it are uncertain, investigative samples should be taken immediately upon arrival and after the death is confirmed and should include the standards set for Sudden Unexplained Death in Infancy (Royal College of Pathologists and Royal College of Paediatrics and Child Health 2004) as identified in the Warwick list.

Consideration should always be given to undertaking a full skeletal survey and, when appropriate, it should be made before the post mortem is commenced as this may significantly alter the required investigations.

If there is particular concern that the death of a child may have unnatural causes, an early full skeletal survey, and an urgent opinion from a specialist radiologist may be appropriate. Abnormal findings may affect the management of any siblings.
If there is definite external evidence of injury early samples should only be taken after discussion with the Coroner/Coroner’s officer, as this could interfere with the interpretation of injuries at post mortem.

However, the only opportunity to identify or exclude some medical conditions is by taking samples at or shortly after death and this should not be missed.

Routine minimum samples to be taken immediately after Sudden Unexpected Deaths in children under 2 years as outlined in 2004 National Working Party Recommendations.

In children over the age of 2 years, the Paediatrician should consider which medical investigations are indicated on the basis of the medical history and findings.

N.B. The following guidance about medical investigations following the death of an older child has been given by the Departments of Histopathology Great Ormond Street Children’s Hospital and of Paediatric Metabolic Medicine Guy’s Hospital 2006.

1. Where there is any possibility of infection, the taking of samples shortly after death may improve the chances of growing the organism responsible. In these circumstances, blood cultures, throat and nose swabs should be taken routinely in A/E. CSF should be collected if the clinical information suggests that meningitis is a possibility.

2. Unless the death is clearly unnatural, full metabolic investigations, as described in the protocol above, are indicated.

3. Always consider sending blood for toxicology

4. If the post mortem is to take place within 24 hours of death, arrangements can be made by the paediatrician for samples to be taken by the pathologist.

**Mementos**

Mementos should be offered sensitively and can be taken at the time in Accident and Emergency or at any time up to the funeral through the coroner’s office. If there are marks on the child’s body, which might be masked by taking mementos, these areas must be avoided. Details of mementos taken must be sent to the pathologist.
Care of the family and follow up

- A dedicated support nurse should be allocated to the family.
- The nurse should keep the parents informed about what is happening.
- Discussions with the family should be in the privacy of a quiet, appropriate room.
- If English is not the parents’ first language, arrangements should be made for an interpreter to be involved.
- Parents should be informed that sometimes there is a delay of several days before the post mortem and that their child may need to be transferred to another hospital for this. They should be told that the Coroner’s Officer is the Coroner’s representative and will keep them informed. Parents should be given a copy of the Department of Health leaflet on post-mortems.
- It is normal and appropriate for parents to want physical contact with their child. In all but the most exceptional circumstances, such as when crucial forensic evidence may be lost, they should be allowed to hold their child for as long as they need to with the support and care of the support nurse or other professional.
- It is important to provide support, empathy and a caring environment to the bereaved parents and any other family members who are at the hospital, no matter what the circumstances of the death.

Police response

Most unexpected child deaths have natural causes and represent an unavoidable tragedy for the family. In all cases, it is imperative that there is a sensitive balance between the care and support of the family and gaining an understanding of the cause of death and the possibility that a crime has been committed.

The police will begin an investigation into the unexpected death of a child on behalf of the coroner. They will carry this out in accordance with relevant Association of Chief Police Officers guidelines. Where the body is taken directly to a hospital the Senior Investigating Officer should attend and liaise with the paediatrician on call and the Designated Paediatrician for Unexpected Deaths in Childhood.

The police will secure the scene of the death, in a discreet and sensitive manner, until the Designated Paediatrician for Unexpected Deaths in Childhood or other health care professional and the police have visited, as appropriate.
Police attendance should be kept to the minimum required. Several officers arriving at the house can be distressing. Whenever possible consideration should be given to the initial response being from plain clothed specialist officers.

If the police are the first on the scene they must obtain urgent medical assistance as the first priority. There needs to be some link to the following section.

- Initiate immediate resuscitation unless clearly inappropriate.
- Call an ambulance.
- Arrange for the body to go to an accident and emergency department by ambulance, unless the circumstances of the death require the body to remain at the scene for forensic examination;
- Ensure that the Senior Investigating Officer is informed of any resuscitation attempts in order that they can inform the paediatrician.
- Make a visual check of the child and his/her surroundings, noting any obvious signs of injury.
- Handle the child as if he or she were alive and ascertain and use the child’s name whenever referring to the child.
- Ensure that the appropriate specialist officers are contacted and attend.
- Secure the scene of death, in a discreet and sensitive manner, so that nothing is disturbed before the home visit by the designated paediatrician for child deaths and senior investigating officer, if appropriate.
- Consider the need for seizure of exhibits and any photography or video recording.
- Officers should at all times be sensitive in the use of personal radios and mobile phones. Whenever possible, whilst remaining contactable, such equipment should be turned off.
- Avoid the use of jargon or phrases like “crime scene” and “scenes of crime officer” within the hearing of parents or carers.
- Ensure the attendance of an appropriate police officer at the post mortem to fully brief the pathologist.

A detective sergeant from the relevant Public Protection Investigation Team, or If unavailable, a detective constable from the PPIU should attend. They will:
- Act as a source of advice on child protection matters to the Senior Investigating Officer.
- Consider any apparent child protection issues at the scene.
- Consider the needs of any siblings.
- Undertake enquiries at the direction of the SIO.
- Inform the Coroner’s Officer (see below)
- Liaise with Paediatrician for Unexpected Deaths in Childhood and the child death response team
- Request and retain the relevant personal child health record from the parents
- Attend the post mortem examination if necessary.
- Liaise with pathologist and ensure family, paediatrician and GP are updated as appropriate.
- Obtain reports and statements for inquest, if relevant
- Attend the post death planning meeting.

Retained items

- Any articles taken from the scene that the family wish to retain should be returned to them at the earliest opportunity unless they are required to be retained for any inquest,
- Ensure that all police documentation is removed, and that the property is returned in new and appropriate bags If soiled articles were taken, ask the parents about their return, and if they would like them cleaned. If so, arrange for any items to be cleaned before their return.
- Always make an appointment with the parents to return any property, as this could be a significant event for them.

Children’s Social Care

The duty manager at the Surrey County Council Contact Centre must check records on notification of an unexpected child death.

If the child and/or family are known to Children’s Services (open or closed case) other than merely through school attendance at a local or other school or registered day care provider and there is cause to be concerned about possible neglect or abuse, the manager must inform the Safeguarding Children Manager who should arrange to:

- Secure the file and inform the appropriate Service Manager, Head of Children’s Service and the Director of Children’s Services.
The responsible team manager or their assistant team manager should liaise with the Designated Paediatrician for Unexpected Deaths in Childhood and attend the child death planning meeting.

Any Section 47 Enquiry planned by the Strategy Meeting/Discussion must be conducted within the child protection procedures framework as set out in the SSCB Manual.

Whenever and wherever an unexpected death of a child has occurred

The professional confirming the fact of death should inform the Designated Paediatrician for Unexpected Deaths in Childhood. Including details of the Senior Investigating Officer if known.

The professional confirming the fact of death should also ensure that the SSCB Child Death Co-ordinator is notified who, in liaison with the Designated Paediatrician will then be responsible for arranging a planning meeting and who will ensure that relevant professionals (i.e. police, school and children’s services) are informed of the death. The coordinator will obtain the details of the Senior Investigating Officer and pass details to the Designated Paediatrician if these have not already been notified.

The Coordinator will inform the designated nurse and doctor for child protection and they will contact the relevant GP, health visitor, school nurse or other relevant health professionals as a matter of routine practice in order that relevant information can be shared.

The Designated Paediatrician for Unexpected Deaths in Childhood should agree the members of each child death response team and who should be invited to the post death planning meeting which as a minimum will include police, social care, hospital staff and ambulance staff were appropriate.

Urgent contact must be made with any other agencies that know or are involved with the child in order to inform them of the child's death and to obtain information on the history of the child, the family and other members of the household. If a young person is under the supervision of a Youth Offending Team they should also be approached.

**Child Death Response Team**

A multi-agency child death response team is the group of professionals who come together in response to the unexpected death of a child. They will work together to:

- Respond quickly to the unexpected death of a child.
• Make immediate enquiries into and evaluate the reasons for and circumstances of the death, in agreement with the coroner.
• Undertake the type of enquiries/investigations that relate to the current responsibilities of their organization.
• Collect information in a standard manner.
• Follow the death through and maintain contact with family members and other professionals to ensure they are kept informed.

The Designated Paediatrician for Unexpected Deaths in Childhood in discussion with the Child Death Coordinator will initiate an immediate information sharing and planning discussion/meeting between the lead agencies (i.e. health, police, children’s services) to decide what should happen next and who will do what.

This will also include the coroner’s officer and consultant paediatrician on call and any others who are involved (e.g. the GP if called out by family, or for older children the professional certifying the fact of death if they have already been involved in the child’s care / death).

The Designated Paediatrician for Unexpected Deaths in Childhood, the Senior Investigating Police Officer, Children’s Service and other representatives should review the circumstances of the child’s death and undertake their responsibilities as outlined above. Agencies should collaborate closely and communicate as often as necessary, often by telephone. The Designated Paediatric will chair the post death planning meeting.

All meetings or discuss should explicitly consider the needs of the family and how this will be provided and ensure parents are aware of available support.

The Designated Paediatrician for Unexpected Deaths in Childhood should collate the information collected by those involved in responding to the child’s death and send it to the pathologist conducting the post mortem in agreement with the paediatrician on call.

Visit to the home

When a child dies unexpectedly in a non-hospital setting, the Senior Investigating Officer and the Designated Paediatrician for Unexpected Deaths in Childhood should make a decision about whether a visit to the place where the child died should be undertaken.
This should almost always take place for infants who die unexpectedly; the visit should take place as quickly as possible normally within 24 hours.

In most cases, a joint home visit is preferable but if separate visits are arranged, the Designated Pediatrician, and the police officer should confer as soon as possible after the visit to share their findings and to discuss their interpretations.

The home visit is an opportunity to gather background information about the events that led up to the death and to interview parents in the environment where the collapse or death occurred.

A detailed narrative account of events leading up to the death should be taken including places, people, and activities. A full account of events of the last few weeks and any changes from usual practice should be gathered. Medical and family history must be taken and details of alcohol consumption and smoking in the household noted as well as recent exposure to infections.

If there are concerns about other children in the household, the SSCB Child Protection, Managing Individual Cases, procedures should be followed.

If there are grounds for considering initiating a serious case review, the SSCB Serious Case Review process should be followed.

The designated paediatrician should complete a report based on the history taken in accident and emergency, their home visit and a scrutiny of all available records, usually within 72 hours and prior to the post mortem.

**Post Mortem, Pathologist and Coroner**

The Coroner must be informed of all unexpected deaths and the Coroner has control of the body. If there are no suspicious circumstances, after an evaluation of the initial information from the ambulance service, hospital and previous records, primary care, police and social care records, the post-mortem should be conducted by a pathologist with special expertise in paediatric pathology. If possible the post-mortem should be completed within 48 hours of the child’s death. If during the post-mortem the pathologist becomes at all concerned that there may be suspicious circumstances, they must halt the post-mortem and inform the Coroner.

If the Coroner has any concerns, having been made aware of all the facts, that the death may be of suspicious nature, then a forensic pathologist will be used in conjunction with a paediatric pathologist. Where a pathologist is qualified both as a forensic and paediatric pathologist they may complete the post-mortem on their own.

Both the Coroner and the pathologist must be provided with a full history at
the earliest possible stage. This will include a full medical history from the paediatrician, any relevant background information concerning the child and the family and any concerns raised by any agency. The Senior Investigating Officer is responsible for ensuring that this is done. The medical notes will also usually be sent or taken to the pathologist by the police officer attending the post-mortem.

The Coroner’s Officer should inform all relevant professionals of the time and place of the post-mortem, including the Senior Investigating Police Officer and Consultant Paediatrician. The family should also be informed.

The Investigating Officer should attend the post-mortem. If this is not possible, then a representative who is aware of all of the facts of the case must attend. A full Scenes of Crime Officer team, including a photographer, must attend all postmortem examinations conducted by a forensic pathologist.

If the paediatrician has arranged any medical investigations before or after death, the pathologist and Coroner must be informed and the results forwarded. The funeral must not be delayed unnecessarily, and can take place before all postmortem examinations have been completed as long as the pathologist and the Coroner are fully satisfied that there is no evidence of abuse or neglect.

The interim or final findings of the post-mortem should be provided immediately after the post-mortem examination is completed.

The final result must be notified in writing to the Coroner as soon as it is known. The final report should then be sent to the Coroner within seven to fourteen days of the final result being known.

The Coroner’s Officer will arrange the release of a copy of the report to the Designated Paediatrician for Unexpected Child Deaths who will share the findings with the child death response team and consider with the Coroner’s Officer how the family will be informed. A full written report should be provided to the Senior Investigating Officer.

In cases where an inquest is to be held, the Coroner may not be prepared to release a copy of the report until the Inquest is concluded.

The Senior Investigating Officer should ensure that a copy is forwarded to the PPIU for inclusion on file for future reference. The report must not be shared with other agencies without the permission of the Coroner.
**Child Death Overview Panel**

The Child Death Overview Panel has the responsibility on behalf of the Surrey Safeguarding Children Board to review all deaths of children under eighteen whether expected or unexpected. The panel will review information and data on all deaths and will be provided with a report from the Designated Paediatrician for Unexpected Deaths on all unexpected deaths.

The panel will have a permanent core membership drawn from the key organisations represented on the Board although not all core members will necessarily be involved in discussing all cases. It should include a professional from public health as well as child health.

Other members may be co-opted to contribute to the discussion of certain types of death when they occur (for example, fire and rescue for house fires).

The functions of the Child Death Overview Panel include:

- Implementing, in consultation with the local Coroner, local procedures and protocols which are in line with this guidance on enquiring into unexpected deaths and evaluating these together with information about all deaths in childhood;
- Collecting and collating an agreed data set and where relevant seeking information from professionals and family members;
- Evaluate the routinely collected data and identifying lessons to be learnt with a particular focus on effective interagency working;
- Evaluating specific cases in depth, where necessary;
- Monitoring the appropriateness of the response of professionals to an unexpected death of a child;
- Reviewing the reports produced by the rapid response team on each unexpected death of a child;
- Where there is an ongoing criminal investigation, CPS must be consulted as to what it is appropriate for the Panel to be considering and what actions it might take in order not to prejudice any criminal proceedings;
- Referring to the Chair of the SSCB any deaths where, on evaluation of available information, the Panel considers there may be grounds for further enquiries, investigations or a [Serious Case Review] and explore why this had not previously been recognised;
- Informing the Chair of the SSCB where specific new information should be passed to the Coroner or other appropriate authorities;
- Providing relevant information to those professionals involved with the child’s family, so that they in turn can convey this information to the family;
- Monitoring the support and assessment services offered to families;
- Monitoring and advising the SSCB on the resources and training required to ensure an effective inter-agency response to child deaths;
• Organising and monitoring the collection of data for the nationally agreed data set
• Identifying any public health issues
• Co-operating with regional and national initiatives e.g. the Confidential Enquiry into Maternal and Child Health (CEMACH)

The Child Death Overview Panel work plan will be approved by the SSCB. The will prepare an annual report for the SSCB, which will have responsibility for publishing relevant, anonymised information.

1 “Working Together To Safeguarding Children: A guide to interagency working to safeguard and promote the welfare of children “

NB This protocol should be read in conjunction with the SSCB Procedures Manual available at www.surreycc.gov.uk/safeguarding .

Appendix 1
Notification of Child Death form
## Notification of Child Death

Notification to be reported to CDOP Coordinator at:
- **Email**: lindaanne.king@surreycc.gov.uk
- **Tel**: 01372 833319
- **Fax**: 01372 833355

The security of any system for transferring the information on these forms must be clarified and agreed with the Caldicott guardian.

If there are a number of agencies involved, liaison should take place to agree which agency will submit the Notification.

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</table>
Details of Agency Contacts

Please note that is the notifying agency’s responsibility to clarify these details.

<table>
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<tr>
<th>Agency</th>
<th>Name, Address &amp; Tel No.</th>
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<td>(date)</td>
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<tr>
<td>GP</td>
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<tr>
<td>Midwife/Health Visitor/School nurse</td>
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<td>Paediatrician</td>
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<tr>
<td>Police</td>
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<tr>
<td>Children’s Social Care</td>
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<tr>
<td>School/nursery etc</td>
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<tr>
<td>Others (list all agencies known to be involved)</td>
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</table>

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## Management

<table>
<thead>
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<th>Death expected or unexpected?</th>
<th>□ Expected</th>
<th>□ Unexpected</th>
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<tr>
<td>Reported to</td>
<td>□ Yes</td>
<td>Date: / /</td>
</tr>
<tr>
<td>Coroner</td>
<td>□ No</td>
<td>Name:</td>
</tr>
<tr>
<td>Reported to Registrar</td>
<td>□ Yes</td>
<td>Date: / /</td>
</tr>
<tr>
<td>Post mortem examination:</td>
<td>□ Yes</td>
<td>Date: / /</td>
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<tr>
<td></td>
<td>□ No</td>
<td>Venue:</td>
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<tr>
<td>Level of review</td>
<td>□ Notification only</td>
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<td>□ General review</td>
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<td></td>
<td>□ In depth review</td>
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<td>□ Serious Case Review</td>
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<tr>
<td>Date of local case discussion</td>
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<td></td>
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<tr>
<td>Date discussed at panel</td>
<td>/ /</td>
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</tbody>
</table>
Appendix 2

To be noted on examination by pediatrician:

- The child’s general appearance, cleanliness, any blood or secretions around nose or on clothes
- Marks on skin, bruises, abrasions, other injuries, skin conditions
- Marks from invasive procedures or resuscitation attempts such as venepuncture, cardiac puncture or cardiac massage and record the site and route of any intervention in resuscitation
- Lesions inside the mouth including frenulum and possible effects of intubation
- Appearance of retinae, although these may not be clearly seen
- Any signs of injury to the genitalia or anus
- Ensuring that specimens are collected according to protocol (as agreed with the Coroner) and use body maps in detailing injuries / marks
- Taking specimens of blood and urine for metabolic toxicology investigations, and to exclude infection (after death is declared consent is not necessary for blood and urine specimens to be taken). The nature of any tests must be accurately recorded for the pathologist.
- Ensure that personal mementos, clothing or bedding are not removed prior to consultation with the coroner and police.
- For all children keep all clothing removed from the child in labeled specimen bags and give to the senior police officer. The clothing may assist the pathologist and occasionally be required for forensic examination. Clothing may not be returned to the parents until the Coroner agrees.
- The child’s body should not be washed or “cleaned up” as this may interfere with the pathologist’s investigation. How well the baby has been cared for and the presence of secretions or substances on the face may be important.
- Inform the police immediately if injuries are noted or suspicions raised.
The foundation for the study of infant deaths

The Foundation for the Study of Infant Deaths has a 24 hour helpline offering support and information to anyone who has suffered the sudden death of an infant. The helpline is also available for family and friends and those professionals involved with the death. The telephone advisors personally answer the telephone every day of the year. The Foundation has a wide range of leaflets and information for bereaved families and professionals. It also has a network of befrienders who are previously bereaved parents. Arrangements can be made for a befriender to contact the bereaved family to offer additional support.

Artillery House
11-19 Artillery Row
London SW1P 1RT
Helpline: 0870 787 0554
General: 0870 787 0885
Fax 0870 787 0725
E-mail: fsid@sids.org.uk
www.sids.org.uk/fsid