Suffolk Safeguarding Partnership

Sudden or Unexpected Collapse and Death in Infancy or Childhood (SUDIC) Protocol (children under 18 years of age)

The protocol contains general guidance about responding to unexpected collapses and deaths in infancy or childhood and information about individual agency responsibilities. It describes some of the factors that may raise concern about a death in infancy or childhood.

Joint Agency Response (JAR) should be triggered if:

- A child has died, and their death could be due to external causes (including suicide, accidental, trauma).
- A child has died, and their death is sudden and there is no immediately apparent cause.
- Deaths that occur in custody, or where the child was detained under the Mental Health Act.
- Deaths where the initial circumstances raise any suspicions that the death may not have been natural.
- Stillbirth where no healthcare professional was in attendance. Excludes all other stillbirths or planned terminations of pregnancy carried out within the law.
- Some cases of collapse or sudden death in a child with a life limiting illness where death was not expected in the preceding 24 hours.
- A child is brought to hospital near death in unexpected circumstances, when the cause of the collapse is unexplained, or who are successfully resuscitated but are expected to die in the following days.

In any of these circumstances or if in doubt, the on-call health professional (CDR Team and Consultant Paediatrician), police investigator, and duty social worker should hold a tripartite decision-making strategy discussion immediately to initiate the joint agency response.

Please scan QR code for the webpage which can be used alongside this full guideline, the information can also be found on the webpage: suffolksudic.org.uk

Policy Version History

Version	Date	Review Date	Author	comment
1	May 2016	May 2019	CDOP Subgroup	22/09/16 (LSCB PPE Group approved)
2	September 2019	September 2020	CDOP Subgroup/ Child Death Review Team	November 2019
3.	November 2020	November 2023	CDOP Subgroup/Child Death Review Team	Minor change/addition.
4.	December 2021	December 2023	Child Death Review Team	Minor amendment with updated team details.
5.	November 2022	December 2023	Designated Nurse Safeguarding Child and Child Death Reviews	Clarity over definition of SUDIC Appendices added
6.	June 2023	February 2024	Designated Nurse Safeguarding Child and Child Death Reviews	Pager number removed
7.	February 2024	February 2025	Child Death Review Team and CDOP Subgroup	Reviewed and updated
8.	May 2024	February 2025	Child Death Review Team	Appendix 2 and 3 Updated

Contents

A. Introduction and Background

This protocol represents the local operational agreement of agencies and must be read in conjunction with the Royal College of Paediatrics and Child Health Sudden unexpected death in infancy and childhood and Working Together to Safeguard Children 2023 guidance.

This protocol should also be read in conjunction with the Child Death Review Statutory and Operational Guidance (England) (2018).

Working Together to Safeguard Children 2023 Chapter 6 defines the unexpected 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 that led to the death.

The majority of sudden unexpected deaths in infancy or childhood have natural or clearly identifiable causes and are unavoidable tragedies, but in other cases this is not clear.

The principles of this protocol should also be considered for any unexplained collapse likely to lead to the death of a child and should be applied throughout the protocol and should include children up to and including their 18th birthday.

Professionals from a number of different agencies and disciplines will become involved following an unexpected death in infancy or childhood to try to establish the cause of the death and support the family. This protocol is intended to provide guidance to the professionals confronted with 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 death in infancy or childhood 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 the child died. It is as important to absolve a family from blame and to recognise medical conditions, especially hereditary disorders, as it is to identify unnatural deaths or homicides.

Please advise families that there is a guideline which staff must follow, that staff have a statutory duty to ask questions, take various samples and that this under the instruction of the coroner makes it clear it is a standardised approach for all cases, despite the fact we appreciate it is extremely stressful.

At all stages families must sensitively be told what is happening, that police and social services will be involved, and that the CDR team will be involved to support and guide them through the process.

B. Key Principles of the SUDIC Protocol

When dealing with an unexpected death in infancy or childhood, all agencies need to follow five key principles:

- Sensitive, open minded, balanced approach.
- Multi agency response
- Sharing of Information.
- Appropriate response to the particular circumstances.
- Preservation of Evidence.

These key principles are each of equal importance.

HM Coroner must be informed at the earliest opportunity of any unnatural or sudden death of unknown cause. HM Coroner has control of what happens to the child's body and decides which pathologist will complete the post-mortem examination.

Individual cases can always be discussed with a Coroner's Officer or, in an emergency, with HM Coroner directly. HM Coroner should normally be contacted via the Coroner's Office.

C. Application of the SUDIC Protocol

The protocol should be applied to all initially unexpected and/or unexplained deaths of Suffolk infants, children, and adolescents up to their 18th birthday. This includes all sudden accidental deaths, road traffic collision deaths and where sudden, unexpected collapse is expected to lead to death, or there is a reasonably high chance this may occur. This will include children and young people who are transferred to PICU or ITU. It is important that the on-call Paediatrician is aware of this, that cases up to 18 years of age may require their input and that the CDR team are also alerted as soon as possible.

The principles of the protocol will still apply to initially unexpected and/or unexplained deaths or collapse of Suffolk infants or children who die outside of Suffolk. If the death occurs in the UK, Suffolk professionals should liaise with out of county colleagues who will be following similar guidance. The principles also apply to Suffolk children whose deaths occur outside of the UK. In these circumstances, early liaison with HM Coroner will be essential to ensure optimum service provision to the affected parties.

Joint Agency Response (JAR); Joint Agency Response describes the process of communication, collaborative action and information sharing following the unexpected death of a child. A multiagency meeting (in Suffolk this is referred to SUDIC strategy meeting) will be arranged to ensure that the appropriate agencies engage and 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 enquiries/investigations that relate to the current responsibilities and actions of each organisation when a child dies unexpectedly. This includes liaising with those who have ongoing responsibilities for other family members.
- Collate information in a standard, nationally agreed manner.

- Work together appropriately post death, keeping contact with family members via an identified key worker to ensure that they are appropriately supported and informed of all information concerning their child.

Joint Agency Response (JAR) should be triggered if:

- A child has died, and their death could be due to external causes (including suicide, accidental, trauma).
- A child has died, and their death is sudden and there is no immediately apparent cause.
- Deaths that occur in custody, or where the child was detained under the Mental Health Act.
- Deaths where the initial circumstances raise any suspicions that the death may not have been natural.
- Stillbirth where no healthcare professional was in attendance. Excludes all other stillbirths or planned terminations of pregnancy carried out within the law.
- Some cases of collapse or sudden death in a child with a life limiting illness where death was not expected in the preceding 24 hours.
- A child is brought to hospital near death in unexpected circumstances, where the cause of the collapse is unexplained who is successfully resuscitated but are expected to die in the following days.

Different circumstances:

All of the above circumstance and where in doubt, the first step in this protocol is to hold an initial decision-making meeting as soon as practicable, ideally within 2 hours, with the Police SIO, EDS Operational Manager or CYPS Head of Safeguarding and Consultant Paediatrician (and CDR team in hours) by phone or Teams. This is particularly important where there is any question over whether the SUDIC protocol should be applied. There are circumstances which are described as "unusual clinical situations", and these include:

- An infant or child who was previously well, is very unwell at the time of presentation and deteriorates rapidly from sepsis or another cause, such as a known cardiac condition or known metabolic condition. If the Paediatrician can clearly identify the cause of death, there is no requirement to initiate the SUDIC process. It would be good practice to speak to other colleagues, and the case must be discussed among the CDR team and discussed with the coroner, but it is likely that a SUDIC/JAR response won't be required.
- The child with a life limiting or life-threatening condition who dies suddenly and unexpectedly. It is important that staff speak to the child's own Paediatrician, or Tertiary Centre team to discuss what has potentially led to the death e.g., a complication of the treatment. If the cause of death is clear the SUDIC investigation may not be required, but again there should still be a tripartite discussion if the death was not expected. It may be appropriate to speak to the coroner.
- Twins and multiples. When one twin dies the surviving twin must be admitted for at least 24 hrs monitoring and possible investigations. The relative risk of a second twin dying in the following days or subsequently is increased by in the region of 4 – 8-fold according to some studies.
- Newborn collapses on the neonatal unit/postnatal ward – a SUDIC/JAR should be considered when collapse is unexpected. This includes babies who are found unresponsive and die and no medical cause known.
- An **illegal** termination resulting in a live birth (who then dies).

<u>Sudden Collapse</u>

A SUDIC/JAR response should also be triggered if a child is brought to hospital near death in unexpected circumstances, where the cause of the collapse is unexplained who is successfully resuscitated but are expected to die in the following days. In these circumstances it is vital that a

conversation is held to consider whether the event should trigger a JAR or not depending on the suspected cause of the event to prevent both unnecessarily involving the police or missing the opportunity to involve the police. In such circumstances the JAR should be considered at the point of presentation and not at the moment of death, since this enables an accurate history of events to be taken and, if necessary, a 'scene of collapse' visit to occur and the taking of relevant samples whilst the child is alive.

Termination of Pregnancy (TOP)

Planned terminations of pregnancy carried out within the law are excluded from the Child Deah Review process, therefor are not included in this SUDIC protocol. This includes cases where a legal termination has resulted in a live birth.

If there are concerns around a termination of pregnancy not being legal then a multiagency discussion (Health/Police/CYP) is needed to determine if a SUDIC/JAR is needed.

Please note: The legislation on abortion does allow for the fact that someone might be at a later gestation than they think. The Abortion Act 1967 applies to England, Wales and Scotland and in certain circumstances makes lawful actions that would otherwise constitute offences in England and Wales under sections 58 and 59 of the Offences Against the Person Act 1861. For this exemption to apply, an abortion can only be performed where two registered medical practitioners are of the opinion, formed in good faith, that the pregnancy is in the first 24 weeks, and that continuing the pregnancy would involve greater risk to the physical or mental health of the pregnant woman than if the pregnancy was terminated.

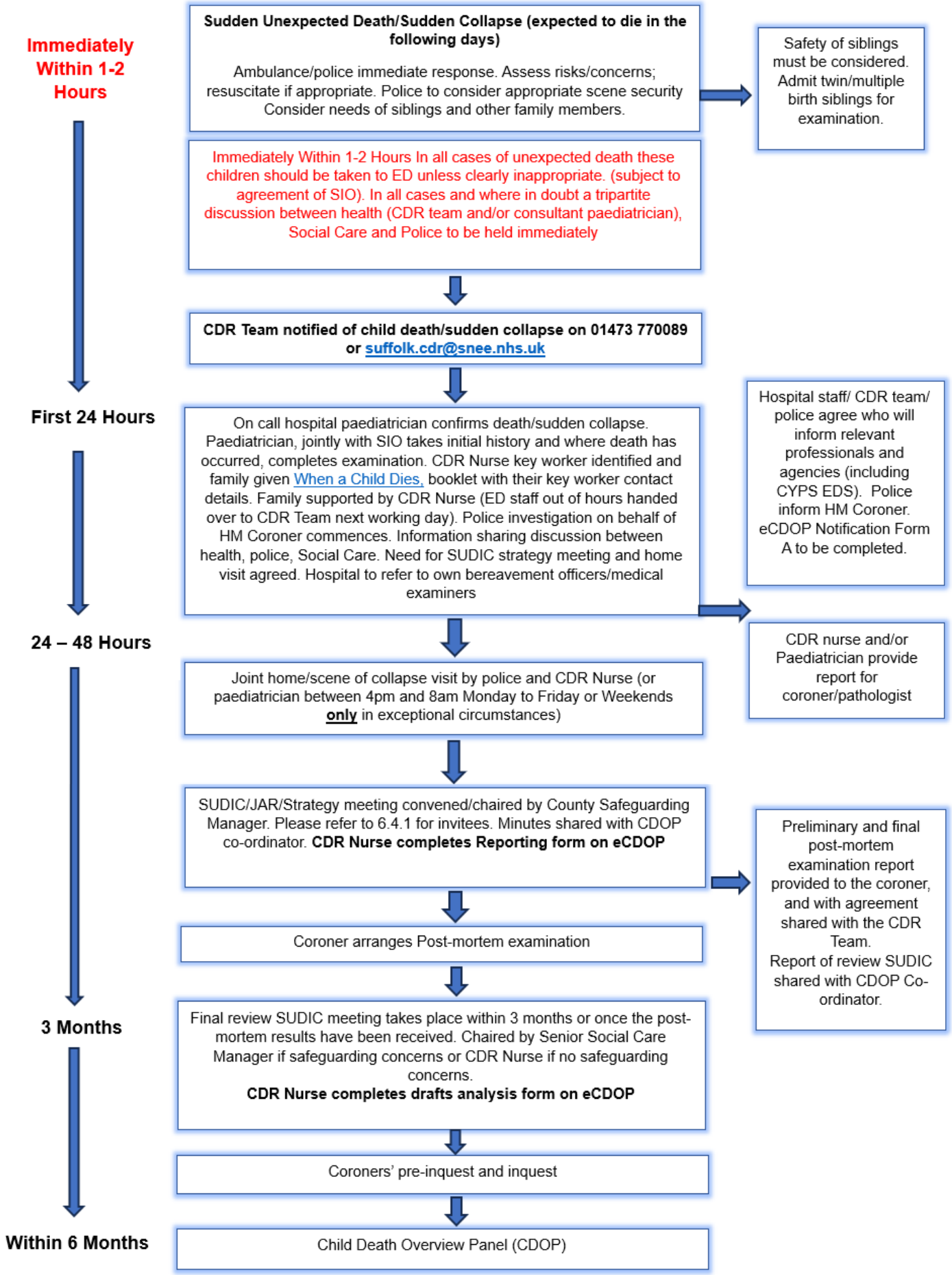
Still births

The Child Death Review process does not apply to still births in the presence of medical practitioners. If there is an unwitnessed still birth, then the SUDIC/JAR policy needs to be followed. If the still birth was a concealed pregnancy see below.

Concealed Pregnancies

The SUDIC/JAR policy should be followed in all cases where a baby is born and died following a concealed pregnancy. In the case of a concealed pregnancy resulting in a witnessed stillbirth a SUDIC/JAR meeting should still be held to consider who is best placed to assess the family regarding the circumstances that led to the pregnancy being denied/concealed. Concealed Pregnancy Guidance

D. SUDIC/JAR Pathway and Professional Responsibilities – Flowchart (children under 18 years of age)



** Every child death is reviewed following the Child Death Review Statutory and Operational Guidance (England) October 2018. Please refer to this as it includes all the necessary information regarding cases which fall outside of SUDIC process.*
*When A Child Dies Booklet

E. General Advice for Professionals when supporting the Family

This is a very difficult time for everyone. The time spent with the family may be brief, but events and words used can greatly influence how the family deals with their bereavement in the long term. It is essential to maintain a sympathetic and supportive attitude, whilst objectively and professionally seeking to identify the cause of death.

Remember that parents, family and/or carers are in the first stages of grief. They are likely to be shocked and may appear numb, withdrawn, angry or very emotional. Professionals should always consider the parents, family and/or carers views and ensure the SUDIC process is flexible and sensitive.

- The child should always be referred to and handled as if he or she were still alive and his or her name used throughout.
- Professionals need to take account of any religious and cultural beliefs that may have an impact on procedures. Such issues must be dealt with sensitively, whilst maintaining a consistent approach to the investigation.
- All professionals must record any history and background information given by parents or carers in detail. Initial accounts about circumstances, including timings, must be recorded verbatim.
- It is normal and appropriate for parents, family and/or carers to want physical contact with his or her dead child. In all but very exceptional circumstances this should be allowed with discreet observation by an appropriate professional.
- Parents, family and/or carers should always be allowed time to ask questions and be provided with information about where their child will be taken and when they are likely to be able to see him or her again.
- Parents, family and/or carers should always be made aware that HM Coroner may be involved and that a post-mortem examination will be necessary.
- Staff members from all agencies should be aware that on occasions, in suspicious circumstances, the early arrest of parents or carers may be essential in order to secure and preserve evidence and to conduct the investigation. Professionals must be prepared to provide statements of evidence promptly in these circumstances.
- A Child Death Review Nurse will be assigned to the family as the key worker and where appropriate lead health professional to support the family and coordinate health's response throughout the child death review process.

** Please refer to Managing Child Deaths in Suffolk for all deaths which occur in children who have preexisting life limiting medical or life-threatening conditions or where the death was expected*

1.0 Child Death Review (CDR) Team

1.1 In 2019 a new CDR team was set up for Suffolk. The purpose of this team is to ensure a more effective process that runs from the moment of a child's death/sudden unexpected collapse to the completion of the review by the Child Death Overview Panel (CDOP). To ensure the process is as standardised as possible the CDR Nurse will take the role of the lead health professional and key worker, being a point of contact for information sharing and effective communication for the family and professionals. The CDR Nurses will ensure that every family no matter how their child has died will be offered support throughout the Child Death Review Process.

1.2 Following the death of a child the CDR team will be notified and will attend the Emergency Department (in working hours) to meet the police and initiate support for the family.

For West and East Suffolk:

The CDR Team are available Monday to Friday, 08.00 – 16.00 (excluding bank holidays)

Contact: 01473 770089 suffolk.cdr@snee.nhs.uk

Outside of these times, all child death notifications will be picked up by the team on the next working day.

For Waveney:

The Norfolk Child Death Review Team provides cover for Waveney and is available Monday to Friday, 08.00 –18.00 (excluding bank holidays)

Contact: 01603 257160 nwicb.childdeathreviewteam@nhs.net

2.0 Ambulance Service

2.1 Following the receipt of a call to the Ambulance Operations Centre, the nearest available Emergency Response will be sent to the scene, supported by a second Emergency Response if possible.

2.2 On Emergency Response arrival, the child will be assessed (Joint Royal Colleges Ambulance Liaison Committee, 2013).

2.3 If required, Advanced or Intermediate Life Support will be commenced with immediate transport to the nearest Emergency Department, with a Hospital Pre-Alert call of expected time of arrival.

2.4 The crew attending the scene will obtain the history of events and observe the scene and position of the child on their arrival and should include these details on the Patient Report Form.

2.5 Following the assessment and all checks for signs of life, combined with the history of events, if the infant is obviously dead the crew on scene will recognise death, inform the parents or carers and liaise with Police. They will provide a Recognition of Life Extinct form to the Police (Joint Royal Colleges Ambulance Liaison Committee, 2013).

2.6 The crew will await the arrival of the Police Designated Senior Investigating Officer (SIO) and wherever possible the Operational Ambulance Duty Officer will attend.

2.7 The SIO will make the decision if the scene is a crime scene. In this case, a discussion must take place between the SIO and the Senior Ambulance Officer available as it may be appropriate for the child to be left on scene. In these circumstances the SIO or his nominee will sign the Ambulance Patient Report Form. A copy will then be kept by the SIO. The Ambulance will then clear from scene.

2.8 For all other circumstances the Ambulance Service will co-ordinate and provide support for the family. Crews are advised to transport to the nearest paediatric A&E unless exceptionally directed elsewhere by the police.

2.9 With the agreement of the SIO, the Ambulance Crew will transport the deceased child and immediate family to the nearest Emergency Department with a Hospital Pre-Alert call of expected time of arrival. For all child deaths, including 16–18-year-olds, the Paediatrician on call should be consulted for advice and/or to complete the home visit.

2.10 On receiving the Hospital Pre-Alert call, the Emergency Department should prepare a private room for parents, family and or/carers to use if required. On arrival, the parents, family and/or carers can attend resus with the infant or child or use the private room. A handover to the Emergency Department staff, Consultant Paediatrician and CDR Nurse will then be carried out.

2.11 The Ambulance crew should then be stood down from Operational Duty for a period of down time and welfare arranged by the Operational Duty Ambulance Officer.

2.12 The Ambulance crew will assist the Police in providing a witness statement as soon as practicably possible after the event and will share information with the CDR Nurse.

2.13 The Ambulance crew will make every effort to attend the SUDIC Strategy Meeting in order to assist the Joint Investigation Team in the enquiry. Where this is not appropriate or available the CDR Nurse will liaise with the crew and share their information at the SUDIC strategy.

3.0 General Practitioners

3.1 There are times when a GP is called to attend the child first. In such circumstances the GP should adhere to the same principles as the Ambulance Service (see Section 2).

3.2 It is essential for the GP to contact the Police or HM Coroner's Office if they are the first on the scene, after taking into account their primary responsibility of saving life or declaring death. Contact Police Headquarters on 101 or 01473 613500.

3.3 A GP will not issue the death certificate if the death is unexpected.

4.0 Police

4.1 Overview

4.1.1 This protocol is compliant with The National College of Policing 'Guidance on Child Abuse' (refreshed version of the ACPO 2009 Guidelines on Investigating Child Abuse and Safeguarding Children') and, where appropriate, reference should also be made to the ACPO 'Murder Manual'. Also, the 2014 NPCC 'Guide to Investigating Child Deaths'.

4.1.2 Throughout this protocol there will be references to key tasks, which officers either attending or managing the investigation will need to take into consideration.

4.1.3 It is important for police officers to remember that most unexplained child deaths have natural causes. Police actions therefore need to be a careful balance between consideration for the bereaved family, and the possibility that a crime has been committed.

4.2 Who Should Attend?

4.2.1 Initial resource deployment will be at the discretion of the Contact and Control Room and will be influenced by the location at which the apparently dead child has been reported to be. Many of these deaths will involve police attendance at Hospital Emergency Departments, where actions will be necessarily different to those where police attend other premises. Police attendance should be kept to the minimum required. For example, several police officers arriving at a private house can be distressing, especially if they are uniformed officers in marked police vehicles.

Whenever possible, consideration should be given to the initial response being from plain clothed specialist officers, but this may not be possible if an emergency response has been requested.

4.2.2 In any event, an officer of not less than the rank of Detective Inspector will be the Designated Senior Investigating Officer (SIO) in the first instance. In core hours this will be a Detective Inspector from the Safeguarding Investigation Unit (SIU). There may be variations for example a road traffic collision when specialist SIO's will come from the Serious Collision Investigation Team, or homicide (which will feature the Major Investigation Team, but they would work with the SIU who will manage the SUDIC process, as opposed to the investigation.

4.2.3 If subsequent assessment considers the death to be suspicious then the on-call Force SIO will be contacted and take the lead role in the investigation, assisted by the SIU.

4.2.4 Where the deceased child is at an Emergency Department, consideration must be given to the deployment of resources at the address from which the child came, prior to the child's attendance at the Emergency Department. Officers maintaining the integrity of any such scene should use unmarked vehicles where possible and **NOT** use cordon tape unless at the explicit instruction of the SIO.

4.3 Initial Action at the Scene

4.3.1 The first priority (as in any such case) will be the provision of medical assistance to the child.

4.3.2 Where appropriate, the Designated SIO should contact the on-call Consultant Paediatrician at the hospital and CDR Team.

4.3.3 If an ambulance is not present one must be called immediately, and consideration given to attempting to revive the child, unless it is absolutely clear that the child has been dead for some

time. (Ambulance Service Personnel will remain on scene until their release is confirmed by the Designated SIO).

4.3.4 Officers in attendance will need to show compassion and sensitivity. Careful thought needs to be given to the use of police radios and mobile telephones. Police terminology such as “scene of crime” should be avoided. Good practice is to establish and use the child’s name whenever referring to the child.

4.3.5 An officer of not less than the rank of Detective Inspector will attend as the Designated SIO (subject to the exception re road traffic collision at 3.4 above). In core hours this will be from the SIU. Amongst other considerations, he/she will:

4.3.6 Consider release of Ambulance Service Personnel and vehicle as soon as possible; ensure arrangements are made to secure all relevant documentation.

4.3.7 Arrange liaison with the County Safeguarding Manager to prompt a SUDIC Strategy Meeting. If the death occurs out of hours, notify the CYP Head of Safeguarding or their nominated deputy, normally via the CYP Emergency Duty Service (for contact details, see Section 6).

4.3.8 Ensure the Child Death Review Nurse Team has been informed and given contact details to support the family.

4.3.9 HM Coroner must be notified on the first presentation of the child or infant. **The infant or child should not be washed and NO memory making carried out without the coroner’s agreement.** Depending on when the investigation commences this may be through Coroner’s Officers. As well as the usual functions they perform, their experience in dealing with sudden deaths and bereaved family will be invaluable in explaining to the parents, family and/or carers what will happen to their child’s body and why. It may be of assistance for Coroner’s Officer to attend the scene and then liaise directly with HM Coroner as required or at the direction of the SIO. The SIO and Coroner’s Officer should continue to liaise closely throughout the investigation.

4.3.10 An explanation should be given, where appropriate, to the parents, family and/or carers that police attendance at such deaths is routine in order to try and determine how the child died.

4.3.11 An early record of events from the parents, family and/or carers is essential, including details of the child’s recent health. All comments should be recorded. Any conflicting accounts should raise suspicion, but it must not be forgotten that any bereaved person is likely to be in a state of shock and possibly confused. Repeated questioning of the parents, family and/or carers by different police officers should be avoided at this stage if at all possible.

4.4 Initial Action at the Hospital

4.4.1 The SIO or delegated officer will attend the Emergency Department (ED) as soon as practicable in order to consult with the Senior Consultant Paediatrician in order to jointly review the presenting information and to consider the appropriate course of action.

4.4.2 Child Death Review Team are notified and asked to attend the ED if between Monday to Friday 8am to 4pm or if out of hours, handed over by the receiving Consultant Paediatrician to the CDR team next working day Paediatrician in charge has discussion with police to determine appropriate setting for the body to be taken to. This will normally be the Emergency Department.

4.4.3 Issues such as handling of the deceased child will require particular care and sensitivity. This should be minimal by medical staff only until a full assessment of the situation can be made by the SIO in conjunction with the Senior Consultant Paediatrician.

4.4.4 In any event, the deceased child must not be removed from the ED until after the SIO/ Senior Consultant Paediatrician have had their joint discussion.

4.4.5 During this joint discussion consideration will be given to forensic and pathology issues which should include retention of the deceased child's clothing, nappy and contents.

4.4.6 If the child has been certified as deceased, then details of the person declaring death must be obtained as well as the relevant time. Similarly, details of any Ambulance Personnel or method of transport of the deceased child to the ED, together with what sort of medical intervention or assistance attempted, must be established for the information of the SIO.

4.4.7 Attendance at the ED should be kept to a minimum and consideration must be given to preserving any other place as a potential scene of where death occurred.

4.5 The Scene

4.5.1 The preservation of the scene and the level of investigation will be relevant and appropriate to the presenting factors.

4.5.2 Officers initially attending the scene should ensure it is preserved until such time as the SIO gives any further instruction. Any relevant items should be drawn to the attention of the SIO, who will assess the circumstances and information available. Additional resources such as photographers will be considered at this stage and the SIO will decide what items, if any, will be retained or removed from the scene. If the child has not died it is important that a robust conversation is held to determine whether the scene should be preserved or not.

4.5.3 If it is necessary to remove items, this will be done with due consideration for the parents/carers, who should be asked if they want the items returned at an appropriate time.

4.5.4 If parents, family and/or carers ask to hold the deceased child this can be permitted but should be done with the knowledge of the SIO and in the presence of a Police Officer or other professional.

4.6 Other Issues

4.6.1 In all cases HM Coroner will be kept informed of the progress of the investigation and issues for consideration will include:

- Completion of Sudden Death Pro-Forma Documentation and Report for HM Coroner.
- Identification and continuity of identification of the deceased child.
- Attendance at post-mortem examination.
- Tissue and organ retention.

4.7 Away from the Scene

4.7.1 In all but exceptional circumstances (e.g. at an obvious murder scene when police response will be in accordance with the ACPO Murder Manual) the body of the deceased child will be conveyed by Ambulance to the relevant ED.

4.7.2 If the parents, family and/or carers wish to accompany the child's body from the home to the ED, then this should be facilitated. They must be accompanied by a Police / Coroner's Officer.

4.8 Subsequent Actions

4.8.1 The SIO or his/her nominee, (in certain circumstances a Family Liaison Officer may be appointed), will continue to maintain contact with the parents, family and/or carers and keep them informed of any developments.

4.9 Joint Home Visit

4.9.1 When a child dies unexpectedly the SIO and the Child Death Review Nurse should, where appropriate, plan a joint visit to the place where the child died.

4.10 SUDIC Strategy Meeting - Ideally within 24 Hours

4.10.1 The SIO will attend in accordance with the joint agency protocol. It should be exceptional only that the SIO who initially deals with the SUDIC is not present at this critical meeting and cover arrangements should be addressed to facilitate this. Where the Serious Collision Investigation or Joint Major Investigation Teams are investigating the death, the SIO or Deputy SIO's attendance should also be arranged.

4.11 Review SUDIC Strategy Meeting

4.11.1 Within 12 weeks after death a detailed post-mortem examination report should be available, and the investigation completed. A multi-agency professionals meeting chaired by a County Safeguarding Manager should then take place. This should include those involved in the care of the child and family to include the Health Visitor, School Nurse, Police, GP, Coroner's Officer, receiving Consultant Paediatrician, Education staff either school or education safeguarding team County Safeguarding Manager and where appropriate, the Social Worker. If there are no safeguarding concerns, then this meeting may be led by the CDR team. This meeting will represent the final child death review meeting.

4.12 Retained Items

4.12.1 At the earliest opportunity after enquiries are completed, (after consultation with Coroner's Officer), any items the parents, family and/or carers wish to have returned, should be returned to them.

4.12.2 All police documentation will be removed, and the property will be returned if appropriate in new/clean wrapping/bags. If soiled articles were taken, parents, family and/or carers should be asked about their return, and if they would like them cleaned prior to return.

4.12.3 An appointment should be made with the parents, family and/or carers to return any property, remembering that this could be a significant event for them in terms of their bereavement.

5.0 Hospital Staff

5.1 Overview

Hold an initial decision-making meeting as soon as practicable ideally within 2 hours during the working week/hours, with the Police SIO, EDS Operational Manager or CYP Head of Safeguarding, Consultant Paediatrician and CDR team (in hours) by phone or Teams. This conversation is to determine whether it is possible to give a cause of death and thus a medical certificate for cause of death or not. If there is any uncertainty regarding the possible cause of death, then a SUDIC/JAR process should be initiated. Remember there will be a review of every child death by the CDR process, and that an internal hospital review process may also occur independent of the SUDIC/JAR process.

5.1.1 The child will **not** be taken straight to the mortuary unless directed to do so by the Designated SIO. Ensure that the child is taken to the appropriate area of the ED even if they appear to have been dead for some time. **The child should not be washed and NO memory making carried out without the agreement of the SIO and Coroner.**

5.1.2 Find out the identity of the people accompanying the child and their relationship to the child. Use the child's first name.

5.1.3 Notify the Child Death Review Nurse Team and a CDR Nurse will, attend the ED and be allocated to the family (in working hours).

5.1.4 Consider admission of siblings. Always consider the admission of a twin or multiple births.

5.1.5 When out of hours for the CDR team the hospital should allocate a Nurse to look after the parents, family and/or carers to keep them informed about what is happening. The Nurse should record any medical or other information they obtain. This Nurse will then handover ongoing care of the family to the CDR Nurse next working day.

5.1.6 A discreet presence of a member of staff should be at all times even when a family and/or carers wishes to be alone with their child after their death. A member of staff should keep them informed about what is happening.

5.1.7 Ensure that a copy of the Information for families following a bereavement has been given to the parents, family and/or carers.

5.1.8 Complete hospital after death care plan/checklist (this will vary between different hospitals)

5.1.9 Ensure that the County Safeguarding Manager has been notified to prompt a SUDIC Strategy Meeting. If the death occurs out of hours, notify the Head of Safeguarding or their nominated deputy, usually via the CYPS Emergency Duty Service (for contact details, see Section 5).

5.2 History and Examination (Kennedy Report, 2004 pg. 30)

5.2.1 An initial history should be taken while resuscitation is underway. A history and examination, with due consideration to the acute bereavement felt by the family members, are extremely important in the process of trying to identify the cause of death. Appendix 1 provides a proforma to be completed by the Consultant Paediatrician (as used by the Pathologist) at the home visit.

5.2.2 A full examination should be undertaken by a Consultant Paediatrician and a careful record of any findings made on a body chart. Photographs should be taken of any injuries, subject to discussion with the Designated SIO.

- Any attempts at intravenous lines, intraosseous lines, Endotracheal tube insertion should be documented. The coroner needs to give permission for tubes/lines to be removed. If there is any doubt about the ETT position, its location should be documented, and if it is not correctly located it needs to remain in situ.
- Examination of the eyes of infants should be attempted as per the joint Royal College Statement (Jan 2022), with the understanding that this may not be possible and that the lack of identification of retinal haemorrhages does not mean these are not present. If identified retinal haemorrhages may inform next steps of an investigation process.
- Take the samples as per Appendix 2, there is a check list called the Kennedy samples and it is important that this is completed and sent to the coroner. In addition, consider others as per clinical presentation e.g. Ammonia, PCRs.
- If there is any doubt about cause of death take as many samples as possible.
- If unsure contact a Colleague, and /or Lead Dr/Paediatrician for Child Deaths or the CDR Team. (CDR Landline Number 01473 770089)
- Complete the eCDOP notification NorfolkSuffolk eCDOP
- Dictate your Medical report as soon as possible so this can be sent to the Coroner's Office.
- Contact the Coroner's office with results when they become available.

5.3 Medical Examiners

Medical examiners provide independent scrutiny of non-coronial deaths in England and Wales, including those of children and neonates, using the same principles of scrutiny as they do for other deaths. Good working relationships and processes between medical examiners and paediatric and neonatal services, along with obstetricians and midwives, will help ensure an accurate cause of death is documented on the MCCD and that learning is disseminated, and may reduce unnecessary coroner referrals.

There has been an agreement by the Suffolk coroners service that the medical examiners in Suffolk will still carry out this independent scrutiny for coronial deaths and will share their findings with the coroner. Therefore, when applicable, medical examiners will be invited to the initial SUDIC/JAR strategy meeting to enable sharing of information. Medical examiners and the Child Death Review team will work closely together to ensure all the correct information is captured.

Please see National Medical Examiners Good Practice series No.6; Medical examiners and Child Deaths for further details Good-Practice-Series-Child-Deaths.pdf (rcpath.org)

5.4 Emergency Department

5.4.1 During the process of resuscitation various investigations will be initiated, samples will be taken as appropriate (see Appendix 2), and child weighed, and weight recorded in the medical record.

5.5 HM Coroner

5.5.1 Once the attending Consultant Paediatrician has confirmed death, HM Coroner assumes immediate lawful jurisdiction of the body.

5.5.2 HM Coroner has given consent in Suffolk to an agreed set of samples to be taken in SUDIC circumstances, without the need for hospital staff to seek prior approval from the parent/s or HM Coroner's Office in each case (see Appendix 2). The range of samples taken will depend on the circumstances of the child's death. The original Kennedy samples were designed to identify a possible cause of death in babies with sudden unexpected death not for a traffic accident or inflicted self-harm for instance. It is important to consider what samples may be helpful to identify a cause of death.

5.5.3 The Consultant Paediatrician should send the Pathologist details of the child's recent and past medical history, resuscitation attempts at home and hospital including needle sites, any physical findings, and any investigations, via HM Coroner's Office.

5.6 Recommended Information to be collected by the Consultant Paediatrician and/or Child Death Review Nurse at the First Interview and the Home Visit (Appendix 1)

5.6.1 When the child is pronounced dead, the Consultant Paediatrician should break the news to the parents, family and/or carers and review all the information. The Consultant Paediatrician should explain that investigations will be done into possible medical causes of the death; that the Police and HM Coroner also have to investigate the death; and that HM Coroner will order a post-mortem examination by a Pathologist with special expertise.

5.6.2 Parents/carers should be able to hold and spend time with their child after agreement with the Consultant Paediatrician and Designated SIO. If resuscitation is attempted, intravenous and intra-arterial lines and endotracheal tube should be removed (checking that the tube had been correctly placed). **Professional presence must be discreet during parents, family and/or carers time with their child.**

5.6.3 Inform parents, family and/or carers that a Child Death Review Nurse and Police Officer will visit them at home in the next 1-2 days to talk more about what has happened. Parents, family and/or carers should be given contact details for the Child Death Review Nurse Team and Police Officer.

5.6.4 The Emergency Department will discuss how the parents, family and/or carers are getting home and will inform all relevant professionals and agencies about the death (i.e. GP, Health Visitor, Records Departments, etc.) using the Death Notification Form and discuss contacting friends, family, employers, etc.

5.7 Post-Mortem Examination Results

5.7.1 HM Coroner's Office will issue or disclose post-mortem examination results to relevant parties.

5.7.2 The Consultant Paediatrician will offer to meet the parents, family and/or carers again to discuss the post-mortem examination findings and any other questions.

6.0 CYPS and Emergency Duty Service (EDS)

6.1 Out of hours

6.1.1 In the case of a SUDIC out of hours, the on-call EDS Social Worker will be notified by Police or Hospital Staff.

6.1.2 The EDS Social Worker will inform the Out of Hours Duty Manager and they will be responsible for liaising with the Head of Safeguarding or their nominated deputy.

6.1.3 An initial strategy discussion will be held as soon as practicable with the Police SIO, EDS Operational Manager or CYP Head of Safeguarding and Consultant Paediatrician. The next working day, the County Safeguarding Manager will co-ordinate any subsequent SUDIC strategy Meeting during office hours.

6.1.4 The contact telephone number for the EDS is 0808 800 4005.

6.2 SUDIC/JAR Strategy Meeting

6.2.1 When the death/sudden collapse is unexplained a multi-agency Strategy Meeting will be chaired by a County Safeguarding Manager within 24 hours of the child's death to share information relevant to the investigation of the death, and support of the parents, family and/or carers.

6.3 The purpose of the SUDIC/JAR Strategy Meeting

6.3.1 For each agency to share information from current or previous case notes or other records which may shed light on the circumstances leading up to the child's death. This includes previous and current medical and family history to help exclude a possible underlying medical condition, child protection issues, previous unexplained or unusual deaths in the family, parental substance misuse, violence etc.

6.3.2 To ensure that a coordinated bereavement care plan is in place to support the parents, family and/or carers. This should include information about the Child Death Review process.

6.3.3 To ensure a co-ordinated plan for peers/school support as appropriate. The relevant school should be involved as soon as possible to enable them to put strategies in place for supporting other students, parents and staff that may be affected. Communication with schools is possible and should be encouraged during school holidays.

6.3.4 To enable consideration of any child protection risks to siblings or other children in the household and referral under child protection procedures.

6.3.5 To nominate a named professional to share Post-Mortem results with the parents, family and/or carers.

6.3.6 To set the date for the Review SUDIC Strategy Meeting within 12 weeks of the death.

6.3.7 To consider, where appropriate, referral to the LSCB Serious Case Review Panel.

6.3.8 To ensure, where appropriate, notification to OFSTED takes place in the case of a death of a looked after child or child subject to a Child Protection Plan.

6.3.9 To liaise, where appropriate, with the Coroner's Office to ensure that a CYPS representative can attend the Inquest in the case of a death of a child who has received a CYPS service around the time of their death.

6.4 Contributors to the SUDIC/JAR Strategy Meeting may include:

6.4.1 Child Death Review Team who will facilitate the setting up of this meeting and establish correct Health representatives are present.

- Health – Health information gathering will be coordinated by the Child Death review Team. Information from the Doctor who declared the death, family Health Visitor, School Nurse, Named Nurses, GP, receiving Consultant Paediatrician, the Emergency Department and Ambulance Service. reference for flow chart.
- Children's Social Care
- Police Child Abuse Investigation Unit
- Representative of HM Coroner's Office
- Designated Doctor/Nurse for Safeguarding and Child Deaths
- Education staff if the child and/or siblings attended school or other education provision

- In the event of a death on public grounds or property, the Borough Council Safeguarding Lead.

A MARF needs to be submitted for all sudden unexpected deaths so that the MASH can review the referral and complete multiagency checks. MASH assessments need to be shared with the Child Death Review Team and complex Strat admin as soon as possible so that the information can be considered.

7.0 Review SUDIC/JAR Strategy Meeting

7.1 Overview

7.1.1 Within 12 weeks after death a detailed post-mortem examination report should be available, and the investigation completed. A multi-agency professionals meeting chaired by a County Safeguarding Manager should then take place. This should include those involved in the care of the child and family to include the Health Visitor, School Nurse, Police, GP, Coroner's Officer, receiving Consultant Paediatrician, Education staff either school or education safeguarding team County Safeguarding Manager and where appropriate, the Social Worker. If there are no safeguarding concerns, then this meeting may be led by the CDR team. This meeting will represent the final child death review meeting.

7.2 The purpose of the Review SUDIC/JAR Strategy Meeting

7.2.1 To share and review the outcome of the investigation.

7.2.2 To close the investigation if possible.

7.2.3 To address outstanding questions about cause, implications for family and ongoing support.

7.2.4 At this meeting all of the relevant information concerning the death, the child's history, family history and subsequent investigation should be reviewed. A report of the Review SUDIC Strategy Meeting should be forwarded to the Coroner and the LSCB Designated Person (Child Death Overview Panel Co-ordinator).

8.0 Post-Mortem, Pathologist and HM Coroner

8.1 If there are no suspicious circumstances, after an evaluation of initial information (from the Ambulance Service, Hospital and previous records, Primary Care, Police and Children's Social Care records), the post-mortem examination should be conducted by a Pathologist with special expertise in Paediatric Pathology. The post-mortem examination should be completed as soon as practicable after the infant's death. If during the post-mortem examination the Pathologist becomes at all concerned that there may be suspicious circumstances, they must halt the examination and inform the Police.

8.2 If HM Coroner has any concerns, having been made aware of all the facts, that the death may be of suspicious nature, then a Home Office 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.

8.3 Both HM 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 Consultant Paediatrician, any relevant background information concerning the child and the family, and any concerns raised by any agency. The SIO is responsible for ensuring that this is done. Pro-forma is available for the

Consultant Paediatrician. Consideration should be given to provision of medical notes to the Pathologist via the Coroner's Officer.

8.4 Coroner's Officer should inform all relevant professionals of the time and place of the postmortem examination, including the SIO and Consultant Paediatrician. The family should also be informed.

8.5 The SIO will attend the post-mortem examination only if there are suspicious circumstances. If this is not possible, then he/she must send a representative who is aware of all of the facts of the case. A full Crime Scene Investigation (CSI) team, including a photographer, must attend all post-mortems conducted by a Home Office Pathologist.

8.6 A number of investigations will be arranged by the Pathologist at the post-mortem examination. If the Consultant Paediatrician has arranged any medical investigations before death, the Pathologist and HM Coroner must be informed, and the results forwarded.

8.7 All professionals must endeavour to conclude their investigations expeditiously. This should include the post-mortem examination results such as histology. The funeral of the dead child must not be delayed unnecessarily.

8.8 The interim or final findings of the post-mortem should be provided immediately after the postmortem examination is completed. The interim result may well be "awaiting histology/virology/toxicology" etc.

8.9 The final result must be notified in writing to HM Coroner as soon as it is known. The final report should then be sent to HM Coroner within 7 to 14 days of the final result being known.

8.10 When a Home Office Pathologist has been used, the Pathologist should provide an interim report within fourteen working days of the post-mortem examination, either verbally or in proforma. A full written report should be provided as soon as possible to the SIO normally via HM Coroner.

F. References and Resources

References

Sudden Unexpected Death in Infancy and Childhood (2016): Multi-agency guidelines for care and investigation

Child Death Review Statutory and Operational Guidance (England) October 2018

Working Together to Safeguard Children (2023) 'A guide to inter-agency working to safeguard and promote the welfare of children'.

Joint Royal Colleges Ambulance Liaison Committee, (2016): UK Ambulance Services Clinical Practice Guidelines 2016.

Managing Child Deaths in Suffolk

Resources – Information for families following a child death

When a child dies

Lullaby Trust (formerly FSID) Booklet 'When a baby or young child dies suddenly and unexpectedly'

Guide to Coroner Services

Victims Voice Booklet on Sudden Death and the Coroner

G. Appendices

Appendix 1: SUDIC information to be collected by the Paediatrician at the first Interview and Child Death Review Nurse at the Home Visit

Appendix 2: Samples to be taken immediately after Sudden Unexpected Deaths in Infancy or Childhood

Appendix 3: Skin Fibroblast Sampling

Appendix 4: Examples of cases that fall under the SUDIC protocol

Appendix 5: NCMD Suicide JAR Response Checklist

SUDIC Appendix 1: SUDIC Information to be collected by the Paediatrician at the first interview and the Child Death Review Nurse at the home visit

Introduction

The importance of the history being taken by an experienced Paediatrician or Child Death Review Nurse, with knowledge and understanding of the care of children and sensitivity to the needs of the family, cannot be over-emphasised. This list is meant as a guide. It cannot be comprehensive, as additional specific questions may arise as a consequence of information given by the parents.

Encouraging the parents to talk spontaneously, with prompts about specific information, is likely to be better than trying to collect a structured history in the more usual way. In recording parents' accounts of events, it is important to use their own words as far as possible. Ideally, information should be recorded *verbatim*.

Much of the information is very sensitive. Parents may feel very vulnerable when asked about their sleeping arrangements, alcohol intake or drug use, so great skill is needed in asking the questions in a non-threatening way, with no implication of value judgment or criticism. Parents may ask directly if their alcohol intake has contributed to the child's death; it is very important that the interviewer does not jump to conclusions about such questions, whilst not being dishonest when asked direct questions.

The Child

- First name and family name (plus any other names by which the child may be known).
- If possible, obtain the NHS number as this may facilitate access to other records.
- Date of birth and place of birth.

The Mother

- Full name (plus any other names by which the mother may be known).
- Full address, including post code.
- NHS number if possible.
- Date of birth.
- Phone number (home number and mobile number) and phone number of any available close relative or friend (to facilitate making contact again).
- Address to which mother will be returning when she leaves the hospital, plus phone number there and the name of the person with whom mother will be staying.

The Mother's Partner and/or Father of the Child

- Full name (including any other names by which he may be known).
- Full address, including postcode.
- Date of birth.
- Phone number (home number and mobile number) and phone number of any available close relative or friend (to facilitate making contact again).
- Address to which father/partner will be returning when he leaves the hospital, plus phone number there and the name of the person with whom he will be staying.

Other members of the household (present and in the recent past)

- Names.
- Dates of birth.
- Relationship to the child who has died.

Family medical history

- A detailed account of past medical and social history of all members of immediate family and household.
- Particular note and detailed information (name, date of birth, place of birth) of any previous children.
- Also detailed information on any deaths in infancy or childhood of any offspring, siblings or other close relatives of any member of the current household (to include as much information as possible concerning date of birth, age at death, place of death, cause of death and any other known information).

Social and family history

- A detailed account of the social structure of the family and of the household, including detailed information on alcohol, tobacco and other drug use, together with information on any prescription or non-prescription medications that may have been present or in use in the household.
- Information on recent changes in composition of the household (e.g. who has come and who has gone, and for what reasons).

Detailed medical history of the Mother

- Details of past medical and social history of the mother, including any significant past illnesses or injuries.
- Detailed past obstetric history, including detailed information on the pregnancy leading to the birth of the child who has died.

Detailed medical and developmental history of the Child who has died To include:

- Gestation.
- Birth weight.
- Perinatal or neonatal problems.
- Type of feeding (and date and reason for changing type of feeding).
- Growth, development and past assessments (e.g. Health Visitor or GP routine, well child checks).
- Immunisations.
- Any known contact with infection.
- Medication (either prescribed or over the counter).
- If possible, obtain the parent-held child health record to copy (return this to the parents after copying it); plot the weight record onto a centile chart.

A detailed narrative account of the child's feeding, sleeping, activity and health over the two-week period prior to the death This should include information on:

- Changes in feeding or sleeping patterns.
- Changes in place of sleep.

- Any social, family or health related changes in routine practices over the past two weeks.
- Any illness, accident or other major event affecting other family members in the past two weeks.

A detailed (hour-by-hour) narrative account of events within the 48 hours prior to the child being found dead A detailed description of:

- Precisely where the child was placed for sleep.
- Duration of sleeping period.
- Position at the end of the sleeping periods.
- Any changes in routine care or routine activity levels.
- Any disruptions to normal patterns.
- Information on the activity and location of all significant members of the household.
- Information on alcohol intake and recreational drug use by members of the household during this period.

The final sleep

A very careful description of when and where the child was placed to sleep, including:

- The nature of the surface.
- Clothing.
- Bedding.
- Arrangement of bedding.
- Precise sleeping position.
- Who was sharing the surface on which child was sleeping (e.g. bed or sofa).
- How often the child was checked.
- When he or she was seen or heard.
- The times at which the child awoke for feeds.
- Whether feeds were given.
- Whether they were taken well.
- Who else was in the room at each stage.
- What were the activities of others in the room.
- Were they awake.
- Where, when and by whom was the child found.
- What was the appearance of the child when found.
- What was the position of the child when found.
- Where was the bedding.
- Were there any covers over the child.
- Had the covers and the position of the covers moved.
- Were there other objects in the cot or bed adjacent or close to the child (e.g. teddies, dolls, pillows).
- Was the heating on.
- What type of heating was there.
- Were the windows and/or doors open.

Action after the Child was found

A detailed narrative account of events that followed the discovery of the child collapsed or apparently dead, to include details of:

- When, how and by whom the emergency services were called.
- Who was with the child at each stage.
- Was resuscitation attempted and if so by whom.
- Were any responses obtained from the child.
- How long did it take for the emergency services to arrive.

Further specific questions

In addition to the information outlined above, information should be collected on the parents' perception of:

- Whether the child was feeding as well as, or less well than, usual in the past 24–48 hours.
- Any vomiting.
- Any respiratory difficulty, noisy breathing, in-drawing of the ribs, wheezing or stridor.
- Excessive sweating.
- Unusual activity.
- Unusual behaviour.
- Level of alertness.
- Difficulty sleeping and/or difficulty waking the child.
- Passage of stool and urine (how often and how much).
- Were any healthcare professionals consulted within the past two weeks, the past 48 hours or the past 24 hours.
- If so, who was contacted, what was the problem described to the healthcare professionals and what advice was given.
- Was the child seen and assessed by any healthcare professional during the past two weeks.

Whilst most of the medical and social history will be obtained during the initial discussion with the parents in the Emergency Department, a very careful and detailed account of the final 24–48 hours will almost always be considerably supplemented by information collected at the time of the initial home visit and close examination of the circumstances of death.

The home interview and visit to the place where the child died can be very difficult but may also be of great value in understanding the sequence of events leading to the death. Parents commonly find this home interview, whilst stressful and sometimes painful, very helpful – the fact that the Child Death Review Nurse is willing to spend this time with them, helping to understand what has happened to their child may in itself be very important to the family and many questions commonly arise out of this visit (in particularly in relation to the factors that may have contributed to the death).

Time will also be needed for the Child Death Review Nurse to help the parents deal with the very powerful emotions that are commonly brought out by this discussion. If conducted sensitively and with awareness of the parents' needs, this interview can have a therapeutic

‘debriefing’ value for the family – commonly allowing them to talk about some of their feelings for the first time. Parents have commonly reported that this home visit has been an extremely important and very positive aspect of their care.

SUDIC Appendix 2: Samples to be taken immediately after Sudden Unexpected Deaths in Infancy or Childhood (Royal College of Pathologists and Royal College of Paediatrics and Child Health Report 'Sudden Unexpected death in Infancy', 2004). *The range of samples taken will depend on the circumstances of the child's death. The original Kennedy samples were designed to identify a possible cause of death in babies with sudden unexpected death not for a traffic accident or inflicted self-harm for instance. Consider which samples may be helpful to identify a cause of death. Add additional ones as appropriate.*

Name of Child: **Dob:** **Dod:**

Name of Doctor: **Date samples taken:**

Tick the samples have been taken and record any needle sites on this form or a body map to aid pathologist.

	Routine Minimum Samples	Send to	Handling	Test
	Blood serum: 1– 2 ml **Blood** EDTA and Clotting **Blood gas**	Clinical Chemistry Clinical Haematology	Straight to lab And any spare Spin, store serum at 20° C **process immediately**	UE, LFTs, CRP Possible Toxicology Haematology Blood gas
	Blood cultures (aerobic and anaerobic): 1 ml	Microbiology	If insufficient blood, aerobic only	Culture & Sensitivity
	Blood from Guthrie card	Clinical Chemistry	Normal (fill in card; do not put into plastic bag)	Inherited Metabolic Diseases
	Blood (Lithium Heparin): 1-2 ml	Cytogenetics	Normal - keep unseparated	Genetics
	Cerebrospinal fluid (CSF): a few drops	Microbiology	Normal	Microscopy, Culture & Sensitivity
	Nasopharyngeal Aspirate	Virology	Normal	Virology, immunofluorescence, and DNA amplification techniques*
	Nasopharyngeal Aspirate	Microbiology	Normal	Culture & Sensitivity
	Swabs, urine and stool samples from any identifiable lesions	Microbiology And Virology	Normal	Culture & Sensitivity
	Additional Urine if available Consider Suprapubic aspirate	Clinical Chemistry	Spin, store supernatant -20° C	Toxicology & Inherited Metabolic Diseases
	Additional Samples			

	Skin biopsy for fibroblast culture if post-mortem to be delayed by more than 12 hours. NB. This could be taken in the local mortuary by a Pathologist, but the Paediatrician will have to request this.	Local arrangements agreed between IH, WSH, Addenbrooke's Hospital, JPUH & NNUH. Record where sample sent and copy this record for local database. HM Coroner's investigation powers allow these samples to be taken in Suffolk without requiring explicit additional permission from parents, but they must be informed, and a record must be kept.
	Muscle biopsy if history suggestive of mitochondrial disorder.	As Above

Samples must be sent to an appropriate virological laboratory

SUDIC Appendix 3: Guidance on Skin Fibroblast Sampling for Ipswich and West Suffolk Hospital (James Paget please referrer to your Norfolk policy).

Skin biopsy for fibroblast culture is recommended within the Kennedy Sampling Guidelines in cases of sudden unexpected child death where an underlying chromosomal anomaly, a genetic cause or metabolic disorder may be a possibility.

Fibroblasts from skin biopsy are used to extract DNA which can be stored indefinitely. This allows future further DNA extraction and metabolic testing. The RCPCH recommend it should be considered at the time of the initial blood, CSF, urine and stool samples.

The best time to take the sample is up to approximately 48 hrs of death and to process the sample and send it to the Genetics lab as soon as possible.

If the sample is taken out of hours or at the weekend it should be kept in the fridge and sent the next working day.

The decision to take a skin biopsy must be by the Consultant Paediatrician. Have a low threshold to take the sample, which will be saved for possible use later.

Examples include:

- Sudden death in babies and children
- Suspicion/ possibility of or family history metabolic disorders in any SUDIC
- Children with complex medical/developmental needs without clear unifying diagnosis

Consent

Skin biopsies obtained in cases of unexpected neonatal or child death should be conducted in liaison with the coroner.

If the death is suspicious, discussion with police and coroner must take place before any investigations are carried out, including the skin biopsy. The coroner can be contacted out of hours, if required, via the Police.

Document the discussion with the family, including both the process itself and the need for DNA and skin fibroblast storage to enable future genetic or metabolic investigation should this be needed.

Use the Rare and inherited Disease referral form.
https://www.eastgenomics.nhs.uk/for-healthcare-professionals/genomic-tests/referral-formsindex/rare-disease-tests-non-wgs/

NB If the samples is to be detained long term separate consent will be required in the future.

Taking the skin biopsy for fibroblast culture

Taking the skin biopsy for fibroblast culture

Use the prepared skin biopsy kit OR a scalpel - see below.

Clean the front of the thigh with an alcohol wipe, or chlorhexidine solution. Rinse with sterile water and allow to dry.

1. Use the punch biopsy device. The punch biopsy instrument is held vertically over the skin and rotated downward using a twirling motion created by the first two fingers on the dominant hand. Once the instrument has penetrated the dermis into the subcutaneous fat, or once the instrument reaches the hub, it is removed.

2. Press out/guide the punch biopsy with the forceps into the sample pot into normal saline (approx. 10ml) or Tissue Transport Medium (TTM) if available. (For ipswich hospital use normal saline, for WSH, TTM can be collected in hours from histology lab and out of hours use saline and sterile pot).

3. **OR**: Use the scalpel and take a skin biopsy. The skin surrounding the biopsy site is stretched with the thumb and index finger of the non-dominant hand. The skin is stretched perpendicular to the lines of least skin tension. Cut out an elliptical-shaped sample (approximately 5 mm X 2 mm) with a scalpel in the same direction as the lines of least skin tension. Transfer the ellipse skin biopsy into the sample pot into normal saline (approx. 10ml) or TTM if available.

4. Use a suture or steristrips if there is some bleeding (likely to be absent or minimal) and cover with a dry dressing.

5. Label the pot and complete the Genetics form with the relevant details, indicating SUDIC/ possible underlying chromosomal or metabolic condition and as much details as you can. https://www.eastgenomics.nhs.uk/for-healthcare-professionals/genomic-tests/referral-formsindex/rare-disease-tests-non-wgs/

6. Send to the pathology lab to store in the fridge until the sample can be sent to the Addenbrooke's' genetics lab in office hours. Ring lab staff to ensure they will do this. **Remind them - Do not freeze**. (For Ipswich hospital cases send with the child to the mortuary and the mortuary will ensure sample is sent to Addenbrookes.)

7. Remind Local lab staff that **the sample should be sent to Addenbrooke's Genetics Lab the next workday**. (It is the paediatric consultant's responsibility to make sure this sample gets to the lab and that it is sent to Addenbrookes on the next working day).

Please call the Addenbrookes cytogenomics Lab 01223 348 706 to let them know to expect a sample. Check with your pathology lab that they have sent it off.

SUDIC Appendix 4

Examples of cases that fall under the SUDIC protocol
Death or collapse leading to death.

- Is or could be due to external causes
  - Suicide or fatal self-harm
  - Road traffic accident
  - Choking
  - Death due to trauma from accident or inflicted trauma such a stabbing.

- Is sudden and there is no immediately apparent cause
  - Child is brought to hospital with no underlying illness/pre-existing condition and dies and death certificate cannot be issued.
  - Child has an underlying illness/pre-existing condition, but the death does not appear to be connected and death certificate cannot be issued.

- Occurs in custody, or where the child was detained under the Mental Health Act

- Where the initial circumstances raise any suspicions that the death may not have been natural

- In the case of a stillbirth where no healthcare professional was in attendance. Excludes all other stillbirths, miscarriage or termination carried out within the law.

Appendix 5: NCMD Suicide JAR Response Checklist

NCMD
National Child Mortality Database

JOINT AGENCY RESPONSE CHECKLIST FOR SUSPECTED SUICIDE IN CHILDREN AND YOUNG PEOPLE (CYP)

Who is this document for?

- Any professional who may be part of a joint agency response in cases of suspected suicide

Purpose of the document

- To provide a prompt to professionals on questions to ask when speaking with families after a child or young person has died and suicide is suspected
- To ensure as much detail as possible is collected for inclusion in the report to the coroner. This will enable good postvention support to the family and others who knew the child following death. It will also enable quick escalation of any concerns to a national level to support fast action e.g. removal of content from social media platforms

How to use this document

- This document can be added to local SUDIC protocols and printed out if needed.

Checklist

Events surrounding death	☐ Who found the CYP, where when and how? ☐ What was the appearance of the CYP when found? ☐ Who called emergency services? ☐ When was the CYP last seen alive and by whom/where? ☐ Details of any resuscitation at home, by ambulance crew, and in hospital ☐ Details of circumstances around the death including any witnesses ☐ Are the details of the circumstances of death in accordance with the developmental stage of the CYP? Could the CYP have managed to do this unaided? (This is particularly relevant for CYP with disabilities) Indicators of intent to die by suicide ☐ Was there a suicide note? (Written or electronic) ☐ Had the CYP made any statements to others that they intended to take their own life? ☐ What was the method of suicide?
Detailed narrative account of last 24-48 hours	☐ Give a detailed account of the last 24-48 hours including all activities, social contact and routines as known by the family. ☐ Were there any particularly stressful events? ☐ How was the CYP mood and behaviour?
Health history and risks	**Mental health and physical health history** ☐ What, if any, physical or mental health conditions did the CYP have? (previous/current)

	☐ Give details of any current or previous contact with Child and Young People's Mental Health Services (CYPMHS)[1] or substance misuse services including if referred and on waiting list. ☐ If the CYP was under the care of a mental health trust or provider, please include the name of the trust or provider. ☐ Was the CYP under the care of their GP or private counsellor/therapist for assessment or treatment of mental health needs? (previous / current or awaiting) ☐ Has the CYP ever been admitted to a CYPMH inpatient bed or detained under the MHA? ☐ Did the CYP have a diagnosis of autism spectrum disorder (ASD) and/or attention deficit hyperactivity disorder (ADHD) or other neuro-developmental condition or Learning Disability. **Vulnerabilities and risk-taking behaviours:** ☐ Has the CYP previously self-harmed (including self-poisoning), experienced suicidal ideation or attempted suicide? If yes, please describe when and how many instances ☐ Have there been any other suspected or confirmed suicides in the CYP's education/social circles? ☐ Did the CYP take any alcohol or drugs (including prescription drugs)? If yes, give details of what was taken and how regularly ☐ Were any drugs or alcohol consumed in the 48 hours before death? If yes, please give details ☐ Did the CYP access any social media platforms, chatrooms or websites with suicide related content? ☐ Did the CYP experience any bullying or cyber-bullying? If yes, please give details of any social media involvement including what (known) social media platforms were used and whether there were any concerning interactions/content on there. ☐ Had the CYP ever been subject to school suspension or exclusion / or truanted from school or college. ☐ Did the CYP experience any difficulties because of their gender identity / sexual identity ☐ Had the CYP experienced any significant relationship losses e.g. due to bereavement, relationship break down etc ☐ Had the CYP had any contact with social care services? (previous/current) Or been adopted/fostered/looked after? This should include kinship and guardian carers. ☐ Had the CYP ever runaway or been reported missing? ☐ Had the CYP ever been in contact with the law/criminal justice system? ☐ Did the CYP have support from any other service (including voluntary or 3rd sector services) or were they a member of any other network/community e.g. faith or LGBTQ communities etc.
Family and social history of the CYP	☐ What is the household composition? ☐ Did the CYP regularly spend time in more than one household? ☐ Did any family members or carers have any previous or current physical or mental health conditions? If yes, did any of these things impact on the child's relationship with their parent or their role as carer ☐ Did any family members or carers have alcohol or substance misuse problems?

[1] Previously known as CAMHS (Child & Adolescent Mental Health Service)

	☐ Was there conflict in family relationships or concerns about household functioning including domestic violence? ☐ Are there any concerns the CYP experienced abuse or neglect (emotional, psychological, physical or sexual) of any kind? ☐ Were there any issues with the CYP's immigration status? ☐ Was the CYP an asylum seeker? Where they accompanied or unaccompanied?