

Unexplained Child Deaths

Protocol 2003

The majority of unexplained child deaths have natural causes and are unavoidable tragedies. The incidence of unexplained child deaths is highest in infancy. About 1 in 1600 children die unexpectedly in infancy. The likelihood of two infant deaths in the same family is small.

A series of professionals from a number of different agencies and disciplines will become involved following an unexplained child death 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 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 unexplained child deaths and it is important to achieve good practice and a consistent approach.

This protocol aims to provide information about the responsibilities and priorities of the professionals involved following an unexplained child death and to promote mutual understanding of each agency's role. 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 to identify unnatural deaths or homicides.

What is in the protocol?

The protocol contains general advice about responding to unexplained child deaths and information about individual agency responsibilities. It describes some of the factors that may raise concern about the death. It does not however go into great detail about the care of the bereaved family, information that is well covered by the Foundation for the Study of Infant Deaths leaflets and other sources.

Age of children to whom the protocol should be applied

The protocol should be applied to children up to the age of 12 years and applied with discretion to children up to 17 years.

Principles

When dealing with an unexplained child death all agencies need to follow five principles:

- sensitive, open minded balanced approach
- inter-agency response
- sharing of information
- appropriate response to the particular circumstances
- preservation of evidence

These are of equal importance.

General advice for professionals when dealing with 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 alongside professional roles and responsibilities investigating a death.

Remember that people in the first stages of grief are likely to be shocked and may appear numb, withdrawn, angry or very emotional.

The child should always be referred to 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 but cannot prevent 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 a parent or carer to want physical contact with his or her dead child. In all but very exceptional circumstances this should be allowed albeit with observation by an appropriate professional.

Parents/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 should always be made aware that Her Majesty's Coroner will be involved and that a post-mortem will be necessary.

Staff from all agencies need to 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 conduct to the investigation. Professionals must be prepared to provide statements of evidence promptly in these circumstances.

Inter-agency working

All unexplained child deaths must be treated as a multi-agency child protection investigation. Surviving siblings may be subjects of enquiry under section 47 of the Children Act 1989.

Strategy Discussion

Early strategy discussion

A multi-agency strategy discussion will be convened by the police officer leading the investigation within 72 hours of the child's death to share information relevant to the investigation of the death and support of the parents.

The purpose of this discussion is:

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 information to help exclude a possible underlying medical condition, child protection issues, previous unexplained or unusual deaths in the family, parental substance misuse, violence etc.

To ensure a co-ordinated bereavement care plan for the family.

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

Contributors to the strategy discussion will include:

Health - Information from the doctor who declared the death, family Health Visitor, GP, Duty Consultant Paediatrician.

Social services duty team.

Police child protection team.

Other relevant contributors including the A&E department/Ambulance Service.

Relevant information will need to be shared with the pathologist and Coroner.

Early joint home visit for unexpected deaths of young children

The Police are responsible for arranging this with either the duty Consultant Paediatrician or an alternative Consultant Paediatrician identified by the duty Paediatrician.

Aims: a) to complete and jointly review the medical history at an early stage including identifying any possible medical or child protection factors contributing to the death.

b) to provide an overview and continuity for family on medical questions and bereavement support.

Late multi-agency meeting

6 weeks after death a detailed post-mortem report should be available and the investigation completed. A multi-agency meeting should then be organised by the police, ideally at the GP's surgery and include the Health Visitor, Police, GP, Paediatrician and other relevant agencies.

Aims:

To share and review the outcome of the investigation

to close investigation if possible

to address outstanding questions about cause, implications for family, future support.

Factors which arouse suspicion

Some factors in the history or examination of the child may give rise to concern about the circumstances surrounding the death. If any of these are identified it is important that the information is documented and shared with senior colleagues and relevant professionals in other key agencies involved in the investigation. The following list is not exhaustive and is intended only as a guide.

Previous child deaths in the family.

Two or more unexplained child deaths occurring within the same family is unusual and should raise questions both about an underlying medical or genetic condition as well as possible unnatural events.

Previous child protection concerns within the family.

Inappropriate delays in seeking help.

Inconsistent explanations

The account given by the parents or carers of the circumstances of the child's death should be documented verbatim. Any inconsistencies in the story given on different occasions or to different professionals should arouse suspicion, although it is important to be aware that inconsistencies may occur as a result of the shock and trauma of the death.

Evidence of drug, alcohol or substance misuse particularly if the parents are still intoxicated or sedated.

Evidence of parental mental health problems.

Unexplained injury

Unexplained bruising, burns, bite marks on the dead child or a previous history of these injuries should cause serious concern. A child may have no external evidence of trauma but have serious internal injuries.

Neglect

Observations about the condition of the accommodation, general hygiene, cleanliness, adequacy of clothing, bedding and the temperature of the environment in which the child is found are important. A history of previous concerns about neglect may be relevant.

Individual Agency Response

Police (being revised by Sgnt Eddie Hick)

Ambulance Service

The ambulance service Communication Centre will immediately notify the police when there is a call to the scene of an unexplained child death. The Emergency Patient Communication Centre will contact the police control room. 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 and the Sussex Ambulance Service Child Protection Procedures.

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 the carers, any background information given, any evidence of possible substance misuse and the conditions of the living accommodation.

Pass on all relevant information to the accident and emergency department receiving doctor and to the police.

Any suspicion should be reported directly to the police and the receiving doctor at the hospital as soon as possible.

General Practitioners

There are times when a GP is called to the child first. In such circumstances the GP should adhere to the same general principles as the ambulance staff (see above).

It is essential for the GP to contact the police or Coroner's officer if they are the first on the scene, after taking into account the primary responsibility of saving life or declaring death. The best route is the Police Control Room.

A GP may not issue the death certificate.

Children who have died without explanation should be seen in the Accident and Emergency department by a Paediatrician and not sent directly to the mortuary. This enables clinical history and examination and any initial investigations to be gathered and information given to parents about procedures.

Additional guidance for GPs and health visitors in relation to the longer term care for the family can be obtained from two FSID publications:

“Guidelines for GPs when cot death occurs.”

“Guidelines for Health Visitors when cot death occurs”

Whilst these booklets are written about cot deaths, many of the principles apply to other child deaths.

Hospital Staff

Also see section 5-general advice for professionals

Ensure that the child is taken to the appropriate area of the Accident and Emergency department even if they appear to have been dead for some time. The child should not be taken straight to the mortuary.

Call the Duty Paediatrician and the resuscitation team. Find out the identity of the people with the child and their relationship to the child. Use the child's first name.

Allocate a nurse to look after the family to keep them informed about what is happening. The nurse should record any medical or other history they obtain.

A detailed history and examination are essential in the process of trying to identify the cause of death. The medical history is one of the most important 'investigations'.

A paediatrician should take a detailed medical history -including events preceding admission, past and recent symptoms, any resuscitation attempts at home and any family history of childhood deaths or serious illness.

Examination

A full examination should be done by a paediatrician and a careful record of any findings made on a body chart. Features to be recorded should include:
the child's general appearance, state of nutrition and cleanliness, weight without clothes or equipment and position on centile chart.
marks on skin, including bruises, abrasions and other skin conditions.
marks from invasive procedures or resuscitation attempts such as venepuncture, cardiac puncture or cardiac massage.
lesions inside the mouth including frenulum and possible effects of intubation
appearance of retinae if possible
any signs of injury to the genitalia or anus.

Recommended medical investigations

Early investigations are important particularly to identify infection.

Where there is definite external evidence of injury it is best not to do any additional initial investigations as these could interfere with the recognition of injuries at post mortem.

Where the possibility of an asphyxial death is present, there should be discussion with the Coroner's officer/Coroner before taking samples.

Early medical investigations should otherwise be completed routinely including when there is evidence of possible neglect etc.

Specimens should be taken by an experienced paediatrician. If blood/CSF specimens are difficult to obtain, attempts should be abandoned.

Blood

Culture

Guthrie card 4 blood spots-for metabolic studies including acylcarnitines

Lithium heparin-for toxicology, amino acids, acylcarnitines. (Store red cells @ 4 C in 'fridge ,store plasma @ -20 C in freezer)

EDTA-store for DNA

Urine

Microscopy and culture

Plain tube-for organic acids-store @ -20 C (freezer). Consider freezing the nappy if no urine obtained

Toxicology

CSF

Microscopy and culture

Swabs

Pernasal - viral and bacterial

Abrasions – bacterial

Skeletal survey

Always performed for young children as soon as possible - either at post-mortem or prior to that. This should be a full skeletal survey not a "babygram". Ideally films should be seen urgently by an experienced Radiologist but will be needed by the pathologist. Local arrangements exist for obtaining x-rays.

The Paediatrician is responsible for informing the Pathologist about all investigations and should obtain and pass on the results.

NOTE: Investigations and resuscitation needle sites and details of other invasive procedures should be recorded for the pathologist on a body chart and sent with details of investigations taken and clinical history and examination to the pathologist.

16.8 Keep all clothing removed from the child in labelled specimen bags. 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.

16.9 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.

Mementos

Mementos should be offered routinely unless there are marks on the child's body which might be masked when mementos are taken. Details must be sent to the pathologist (e.g. lock of hair cut or palms or sole prints taken).

17.2 If mementos are not taken in the A&E department this should be highlighted in the transfer of information to the Pathologist with the aim of this being achieved at or after post mortem.

Speaking to the Coroner

18.1 The doctor who declares death cannot issue a death certificate. They must inform the Coroner or Coroners' Officer about the child's unexplained death.

Information for the Pathologist

19.1 The 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 including general care/state of cleanliness and any investigations. A pro-forma for this is available in A&E.

20. Check Child Protection Register Family support and follow up by hospital

21.1 Accident & Emergency informs all relevant professionals and agencies

21.2 Explain to parents about sudden unexpected death and the need for investigation, including by a specialist Pathologist, Coroner, Coroner's Officer and Police.

21.3 Encourage parents to hold their baby/child.

21.4 Paediatric follow-up:

- Early joint home visit by Paediatrician and police for a child under two years should be organised by the police.

- Discussion of preliminary post mortem results. Paediatrician should contact the Coroner's Officer for these results and agreement to discuss them with the family. (see notes re. Coroner 24)
- Late follow up either at home or hospital at about four to six weeks. Paediatrician should request copy of post mortem report from Coroner's office before this.
- Inform GP and Health Visitor of follow up plan.

If child is taken direct to mortuary

- 22.1 A young child who has died unexpectedly should be taken to the Accident and Emergency department to confirm that no resuscitation is possible and to address medical, child protection and bereavement issues. If, for some reason, a child's body is taken directly to the mortuary, the mortuary will inform the police.
- 22.2 The police child protection team will then be informed and will contact the duty Consultant Paediatrician to arrange their involvement at the hospital and an early joint home visit.
- 22.3 The Paediatrician's role includes taking a full medical history and if possible, doing a brief clinical examination and arranging any appropriate initial investigations. The aim is to help identify at an early stage possible underlying medical conditions or child protection concerns for the Pathologist, Police and Coroner.

23 Acute life threatening event

- 23.1 Most acute life threatening events have a medical or physiological basis, although a precise explanation is not always found. Some have unnatural causes and assessment should always include consideration of these through careful history taking, examination and investigation similar to the list for unexplained deaths.
If in doubt social services should be consulted to exclude previous child protection issues.

24 Post-mortem, Pathologist and Coroner

- 24.1 After death is declared, the Coroner has control of what happens to the body.
- 24.2 If there are no suspicious circumstances-after an evaluation of initial information from the ambulance service, hospital and previous records, primary care, police and social services records- the post-mortem can be conducted by a local Pathologist with an interest in paediatrics or by a Paediatric Pathologist. If during the post-mortem the Pathologist becomes at all concerned that there may be suspicious circumstances, he/she must halt the post-mortem and a Home Office Pathologist contacted.
- 24.3 If the 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.
- 24.4 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 Investigating Officer is responsible for ensuring that this is done. A pro-forma is available for the paediatrician. The medical notes will also usually be sent to the Pathologist.

- 24.5 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.
- 24.6 The Investigating Officer should attend the post-mortem. If this is not possible, then he/she must send a representative who is aware of all the facts of the case. A Scene of Crime Officer must attend all post-mortems conducted by a Home Office Pathologist. The Consultant Paediatrician should also be invited to attend by the Investigating Officer.
- 24.7 A number of investigations will be arranged by the Pathologist at post-mortem. If the Paediatrician has arranged any similar investigations before death, the Pathologist and Coroner must be informed and the results forwarded.
- 24.8 All professionals must endeavour to conclude their investigations expeditiously. This should include the post-mortem results such as histology. The funeral of the dead infant must not be delayed unnecessarily.
- 24.9 The interim or final findings of the post-mortem should be provided immediately after the post-mortem examination is completed. The interim result may well be "awaiting histology/virology/toxicology" etc.
- 24.10 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.
- 24.11 When a Home Office Pathologist has been used, the Pathologist should provide an interim report within two working days of the post-mortem, either orally or in pro-forma. A full written report should be provided to the Investigating Officer, normally via the Coroner, within 15 days or receipt of the exhibited photographs. Where the scientific examination extends beyond 20 days of the post-mortem, the Investigating Officer should be informed.
- 24.12 The Investigating Officer should ensure that a copy is forwarded to the Child Protection Team for inclusion on file for future reference. The report must not be shared with other agencies without the permission of the Coroner. Permission should always be sought by an agency if the content of the report could potentially affect the agency's future.
- 24.13 The Consultant Paediatrician and A&E Consultant may request a copy of the post-mortem from the Coroner's office. This cannot be released without the Coroner's permission.