Trust Policy	Worcestershire Acute Hospitals NHS Trust

Investigation of Sudden and Unexpected Deaths in Children Under 18 Years

Department / Service:	Paediatric Services	
Originator:	Dr Clare Onyon Dr Prakash Kalambettu	Consultant Paediatrician Consultant Paediatrician
Accountable Director:	Dr James West	
Approved by:	Clinical Governance Group Paediatric Quality Improvement Meeting	6th December 2022 19th October 2022
Review Date: **This is the most current document and should be used until a revised version is in place**	6th December 2025	
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust/Worcestershire Health & Care Trust NHS Trust)	

Policy Overview:
This policy outlines the WAHT responsibilities in accordance with both the West Mercia Multi-agency Protocol for the Joint Agency Response to Sudden and Unexpected Deaths in Children (2018); & the Kennedy Report (2016).

Key amendments to this Document:

Date	Amendment	By:
15.01.10	Approved by Trust Safeguarding Committee	
17.02.12	Approved to extend unchanged for a further year	Paediatric Clinical Governance Committee
08.03.13	Reviewed by Child Protection Lead Consultants and agreed to extend for a further year to await publication of reviewed West Mercia Policy.	Dr Tom Dawson Dr Doug Castling
23.02.14	Document extended for 6 months whilst awaiting west Mercia guidance to be released	Dr A Gallagher
01.05.15	Document extended for 3 months	Dr A Gallagher
10.08.15	Document extended for 12 months as per TMC paper approved on 22nd July 2015	TMC
October 2016	Further extension as per TMC paper approved on 22nd July 2015	TMC
October 2017	Document extended for 12 months whilst document is reviewed and new document approved	Dr Dawson
February 2019	Guideline reviewed and revised	Dr C Onyon Dr D Castling

24.08.2020	Amended to reflect agreement with WMAS for those children who decease / are brought in deceased to the Alexandra Hospital /MIU	Multi-agency agreement as to process to be followed
11.09.2020	Policy reviewed by HM Coroner who confirmed agreement with changes made.	HM Senior Coroner D Reid, Worcestershire
May 2022	Amendments made regarding flow chart, unusual circumstances and mortuary access, Escalation policy	Dr Kalambettu
December 2022	Amendments made regarding exceptional circumstances and transfer process	Dr Kalambettu Susan Smith

References:

West Mercia Multi-Agency Protocol, Joint Agency Response, Sudden and Unexpected Deaths in Children 2019.
Kennedy Report September 2016.
Skeletal Survey for Suspected NAI, SIDS and SUDI: guidance for Radiographers 2009

INITIAL RESPONSE TO DEATH **IN CHILDHOOD (UNDER 18 YEARS). DECISION MAKING REGARDING SUDIC PROCESS.**

ENSURE GOOD RECORD KEEPING AT ALL TIMES AND DOCUMENT CLEARLY

Child declared dead at scene (external to Acute Trust)

- Please see next page for full information (page 4)

Child declared dead at other Trust site (not WRH) e.g. ALX ED/MIU

- Clinical team to inform on-call Consultant Paediatrician at WRH
- Care of family – allocated ED/paediatric nurse
- Child's body may need to be transported to WRH if paediatrician unable to leave WRH site (in hours)
- Check if child is subject to a Child Protection Plan
- WMAS will transport any child declared dead at another trust site to WRH Mortuary (out of hours)

Child arrives in WRH ED receiving ongoing resuscitation

Paramedics to inform ED team in advance:

- Paediatric crash team alerted includes On-call Consultant Paediatrician
- Care of family – allocated to ED / Paediatric nurse
- Receptionist obtains child's and parents'/carers' medical notes
- Check if child subject to a Child Protection Plan

Child declared dead

Child dies unexpectedly whilst an inpatient at WRH Acute Trust

- Clinical team to inform On-call Consultant Paediatrician if not already in attendance
- Care of family – allocated ED/paediatric nurse
- Check if child subject to a Child Protection Plan

Child declared dead

In all circumstances the On-call Consultant Paediatrician must ensure:

1. Parents / carers informed of child's death
2. Senior Investigating Police Officer (SIPO) and (between 8:30 and 16:30 including weekends and bank holidays) SUDIC nurse co-ordinator is informed and initial information shared, Coroner notified, including notification of death form available from ED notes, (coroner's office is available between 8am – 4pm M-F, outside these hours inform SIPO in the first instance)
3. Unusual Clinical Situations considered see section 2 page 5 of this guideline
4. If applicable, a time of arrival at the mortuary/ED must be agreed with WMAS prior to the crew leaving the scene

Decision made to continue with SUDIC

Decision made **NOT** to continue with SUDIC process

Consultant led process of further management

Child declared dead at scene (external to Acute Trust) (signs of rigor mortis/dependent livido/resuscitation not appropriate)

Under 1 year old, WMAS doctor on scene can declare RIP if no signs of life

Over 1 year old, paramedics can certify RIP

Paramedics to call:
On-call Consultant Paediatrician
They will advise whether to take the child to WRH Emergency Department or direct to the Mortuary

If decision is for child to be conveyed to the Mortuary – **an agreed time of arrival** with WMAS, the police and the On-call Paediatrician must be decided.

This will avoid WMAS, the child and family arriving unexpectedly and the team not being ready to receive them appropriately (please bear in mind the mortuary team are on call out of hours and need to travel to WRH).

Prior to the ambulance leaving the scene, it is advised that they call the Paediatrician to let them know they are en-route

Please ensure you print off and complete pages 18-38 of this guideline:

- SUDIC Checklist 1 for Paediatric Consultant or Registrar to complete
- SUDIC Checklist 2 For Nurse Supporting Family to complete
- History Proforma (between 08:30 -16:30 completed by SUDIC nurse, between 16:30-08:30 completed by paediatric consultant or registrar)
- Examination Proforma
- Investigation Proforma
- Chain of evidence form

CONTACT NUMBERS

Coroner's Office (from 8am to 4pm M-F) WRH: 01905 822330

Senior Investigating Police Officer (24 hours) Tel: 0300 3333000

Designated SUDIC Consultant Paediatrician Dr J Edmunds - Tel: via switchboard

SUDIC Nurse on -call (08.30-16.30) Tel: via switchboard

On-call Paediatric Consultant Tel: via switchboard

WMAS Tactical incident Commander (transfer from ALEX to WRH)
Tel: 07391413384

WMAS Emergency Operations Centre (transfer from ALEX to WRH)
Tel: 01384 679040

Mortuary Techinican Tel: via switchboard

On-call Lab Services:

Haematology	WRH	Bleep: 848	Tel: 30213
	BCH		Tel: 0121 3339999
Biochemistry	WRH	Bleep: 849	Tel: 30215
	BCH		Tel: 0121 3339999
Radiology	WRH	Bleep: 154	Tel: 30575
	BCH		Tel: 0121 3339999

Children's Services/ Emergency Duty Team

Monday – Friday	Family front Door	Tel: 01905 822666
Out of hours	Emergency Duty Team	Tel: 01905 768020

Bereavement Midwifery Team (for infants <1 year)
01905 763333 Ext 30583 (leave a voicemail message)
wah-tr.bereavementmidwives@nhs.net

Contents

THE INITIAL PROCESS

1. SUDI /SUDC or SUDIC (sudden unexpected death in infancy/childhood)
This encompasses all cases in which there is death (or collapse leading to death) of a child, which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent. This is a descriptive term used at the point of presentation, and will include those deaths for which a cause is ultimately found ("explained SUDI/SUDC") and those that remain unexplained following investigation. While many of these guidelines may be applied if required, they are therefore not necessarily intended to be applied to cases with a previously diagnosed medical condition in which a medical certificate of cause of death can be provided.

PURPOSE OF SUDIC PROCESS

All children under 18 years old who die suddenly and unexpectedly.
A number of child death reviews have highlighted the need for coordinated inter-agency working immediately after the child's death, through the use of a multi-agency meeting to support the family, whilst also obtaining an understanding of why the child died.

2. UNUSUAL CLINICAL SITUATIONS

When to discuss use of SUDIC process:
When a child has died or in cardiac arrest the child would usually be brought to the emergency department at WRH except in exceptional circumstances.

There are situations that are not clear-cut and will need consultation with the designated paediatrician and others in the joint agency team, such as the following examples.

- **When a child has been declared dead at the scene external to the Acute trust and resuscitation has not been attempted**

In some circumstances, if a child has been found in the community who has clearly been dead for some time (for example if there is rigor mortis) it may have been decided that resuscitation was not appropriate and death will be confirmed external to the trust.

If the child is over 1 year of age, the paramedic team are able to certify the death in the community. English law does not require a doctor to confirm death has occurred. Any competent adult with the knowledge, skills and competencies required is able to confirm death.

If the child is under 1 year of age; The Royal College of Pathologists guidance advises "Unless there are exceptional reasons not to, the child should be brought immediately to an emergency department with paediatric care and resuscitation should be continued en route".

In many cases, resuscitation should be continued and in those cases, the child will be conveyed directly to the WRH Emergency Department.

However, WMAS are increasingly able to facilitate the attendance of highly-qualified Paramedic Doctors at situations where resuscitation of a child is required. These doctors are able to certify when child has sadly died and resuscitation should be stopped. As a direct result of this, there has been an increase in the number of children who have been certified as having died in the community. We, as a Trust, are very supportive of this, as it is felt this decision, made in a timely manner and by a suitably qualified professional, is in the best interests of the child and their family.

As a result, **in these circumstances it is possibly more appropriate for the child to be brought directly to the mortuary (not to a private funeral director) rather than WRH ED department.**

This is because the WRH ED is not an appropriate environment for a family and their deceased child to attend; in part due to the design of the environment (there is no dedicated Paediatric ED/quiet room) as well as the lack of a quiet space, with limited privacy and dignity and there is very often extremely high acuity and activity within the department which could add further distress and trauma to an already devastated family.

This has been discussed at the Trust's Serious Incident Review and Learning Group, and has been agreed as a sensible, pragmatic and sensitive approach by all attendees including the Clinical Director for Urgent and Emergency Care and the Deputy Chief Medical Officer. This has also been discussed and agreed at the Trust's Clinical Governance Group in December 2022.

However, before this decision is made, it MUST be discussed with the Consultant Paediatrician on call, taking into consideration the circumstances of the child's death as well as current patient numbers and acuity in the ED department.

The decision to attend Mortuary at WRH should be made **ONLY** following discussion between Paediatric Consultant, the ED Nurse In Charge (as they will have the best overview of the entire department at the time) and if required, the ED Consultant on call.

As well as an area suitable for taking samples (which must be taken in an area licensed by the HTA), there is also a quiet relative's room available in the Mortuary Department, which can be used for sensitive discussions by the Paediatric team and the police.

If the decision is made for the child to be conveyed to the mortuary directly, **the on-call mortuary technician (at WRH or ALX) must be informed by the on-call Consultant Paediatrician** via switchboard to gain access to the mortuary out of hours.

It is important to ensure the WMAS crew, police and family are aware of the potential time taken out of hours, for the mortuary to be opened and an agreed time of arrival MUST be CONFIRMED prior to the crew leaving the scene to prevent any undue delays or distress.

Ideally, the crew should also call to confirm they are on-route when leaving the scene so the team be fully prepared. This is particularly relevant if the journey time is very short.

The crew will be met at the mortuary either by the ED or Paediatric nurse (who must use a porter for escort out of hours) who will be assigned to take care of the parents / carers while the child is brought to the mortuary.

Please see Appendix 2 for the details of the procedure required to access the mortuary in order to take samples. A Joint Agency response must still be undertaken and information shared within 1-4 hours.

If the child was found hanged and declared dead at the scene, investigations such as urine toxicology may be considered. In these circumstances discussion between the police / coroner and the consultant paediatrician should take place.

This does not include children where the cause of death was clear e.g. road traffic accident or train track accidents. This does not include children where resuscitation is attempted and continued as these children will always be brought to ED.

- **A child dies whilst in the Emergency Dept (Alexandra Hospital) / is brought into the Emergency Dept (or MIU) deceased**

In this situation the on call Consultant Paediatrician should be notified immediately. In the event the on call Paediatrician is unable to attend the Alexandra Hospital site, or out of hours, the child, following discussion with the Police, Coroner, and Paediatrician, will be transported to the mortuary at WRH in order for the multi-agency SUDIC process to be undertaken. **Again, an agreed time of arrival must be CONFIRMED prior to the crew leaving the scene to prevent any undue delays or distress.**

Transfer arrangements to WRH of the deceased child:

- **Transfer of the child will be via West Midlands Ambulance Service:**
  On call Paediatrician to liaise with:
  WMAS Duty Tactical Incident Commander – mobile: 07391 413384
  WMAS Emergency Operations Centre – Tel: 01384 679040

• A baby is born out of hospital (e.g. home) with no healthcare professional in attendance (this may be as a result of a concealed pregnancy) and it is not clear if the baby was stillborn or born alive prior to death.

In this situation, the WMAS should transfer the baby to the **NEAREST** maternity unit. This may not be the unit the mother was booked at (if booked). This has been agreed locally at H&W CDOP.

A Joint Agency Response should be considered and a referral made to the Coroner and consideration as to whether a Post Mortem needs to take place should be discussed. Health professionals may be able to advise if the baby was stillborn.

- **The infant who is unwell at the time of presentation but who deteriorates rapidly and dies of possible septic shock and multi-organ failure due to presumed sepsis.**

In this situation, the condition has arisen suddenly and unexpectedly, as most life-threatening cases of sepsis in infants do, but from the time that septic shock has become established, death can be anticipated despite the best efforts of paediatric intensive care unit (PICU) staff. If the attending paediatrician can certify the death as being due to sepsis, there is no requirement for a SUDI investigation. If there is insufficient evidence to certify death, the case must be discussed with the Coroner and the SUDI process initiated. This can be modified if the Coroner feels that no

further investigation is required. In any event, a home visit would not normally be undertaken in such cases unless concerns were raised.

- **The infant who is successfully resuscitated from an out-of-hospital arrest but dies subsequently or who may survive for a period of time.**

In this situation, the infant might live for days or weeks before dying, usually through withdrawal of care following discussions with the family. As the out-of-hospital arrest was sudden and unexpected, and the prognosis was poor, the police may secure the scene but will not be able to do this indefinitely. Thus, such a presentation should be discussed with the designated paediatrician in order for a home visit to be undertaken, despite the infant remaining alive, as important information might be found that can assist the treating team and police.

- **The child with a life-limiting or life-threatening condition who dies suddenly and unexpectedly.**

If a child with a recognised life-limiting or life-threatening condition dies suddenly or following a brief illness, a SUDI investigation might not be required. If there are concerns, the lead health professional should liaise with the Coroner. In any event, if the death was not expected, the lead health professional should have a discussion with other members of the joint agency response team, and the clinical team who know the child and family, and reach a decision on whether a SUDI investigation should be initiated. Again, if in doubt, the designated lead health professional should consult with the Coroner.

- ***Twins and multiples***.

Twins and multiples have around twice the risk of SIDS compared with singletons.
When one twin dies from SIDS, the surviving twin should be admitted to an inpatient paediatric unit for close monitoring for at least 24 hours.
Investigations to exclude infection, inherited metabolic disease or an underlying cardiac condition should be undertaken. Follow-up support should be organised prior to discharge. In most areas, this will be provided by enrolling the infant on the 'Care of Next Infant' (CONI) programme a national programme managed by The Lullaby Trust, usually delivered by health visitors, which coordinates additional support to bereaved parents.

- **When a newborn infant suddenly collapses and dies on a neonatal unit**

Consideration should be given as to whether a joint agency response is required. In most situations this would not be appropriate.

- **When a child dies abroad**

If any CDOP is made aware of a child death abroad by any other source other than the Foreign and Commonwealth Office (FCO) then the FCO Global Response Centre should be contacted on 020 7008 1500. This is a 24/7 number which will ensure the caller is routed to the appropriate part of the FCO. They can also manage issues out of hours etc.

3. INITIAL ACTIONS
Print off and complete pages 16-35 of this guideline (appendix 1), which provides guidance and documentation through the required response

• SUDIC Checklist 1 for Paediatric Consultant or Registrar to complete
• SUDIC Checklist 2 for Nurse Supporting Family to complete
• History Proforma

• Examination Proforma
• Investigation Proforma
• Chain of evidence form

4. NOTIFICATION: MULTI-AGENCY WORKING

Inform: (see contact numbers on page 2)

- Consultant Paediatrician on-call
- Senior Investigating Police Officer
- SUDIC Nurse on call- 08.30-16.30 (including weekends and bank holidays) or during the same hours on next working day.
- Coroner's Officer through the coroner's portal
- Children's Social Care

This includes children from out of the local area.

5. COMPLETION OF IMMEDIATE INQUIRY

5.1 Remember Principles:

When dealing with an unexpected death of a child of any age, staff in all agencies must bear in mind that in most cases they are the result of natural causes and represent an unavoidable tragedy for any family.

The investigator should have knowledge of and adhere to the following five principles for dealing with unexpected infant deaths:

- Balanced approach between sensitivity and the investigative mindset.
- Multi-agency response
- Sharing of information.
- Appropriate response to the circumstances.
- Preservation of evidence.

5.2 Break news to parents:

Explain about the urgency and nature of investigations and the obligation to inform the Coroner.

See Appendix 4: Breaking the news and what to tell parents for further guidance
See Appendix 6: Resources for parents

If the child is under the age of 1 year the bereavement midwifery team can offer support to the family. They can be contacted on ext 30583 (a voicemail can be left on this number) or email at wah-tr.bereavementmidwives@nhs.net Please include the family's contact details.

Ensure that relevant consent has been ticked as yes/no for storing the sample on specimen forms (eg cytogenetics)

If biopsies are taken parents' wishes for retention, disposal (or return to them) should be documented in the notes.

5.3 HISTORY AND EXAMINATION

Between 16:30 and 08:30 the history is completed by the Consultant Paediatrician or registrar on-call (with consultant support). Between 08:30 and 16:30 (including weekends and bank holidays) this is completed by the SUDIC Nurse on-call, with police presence to complete the initial enquiry as well as completing the **History proforma** (see appendices). The examination and examination proforma is completed by the Consultant Paediatrician or registrar on-call (with consultant support) along with police.

The child should have **History & Examination proformas** completed and his/her own set of notes made up.

It is important to record all details accurately, note date and time and sign the records as they may form part of the evidence if there is subsequently a criminal investigation.

Questions need to be asked with great care and sensitivity to avoid any suggestion of criticism of care given or habits (e.g. smoking or not breast feeding).

5.4 INVESTIGATIONS

These are taken by the Consultant Paediatrician or registrar on-call (with consultant support). Take essential specimens: (blood, CSF, urine, swabs, skin biopsy) as soon after death as possible if not taken before (see investigations). **See investigation proforma**. If you suspect a metabolic cause, contact the Inherited Metabolic Disorder (IMD) Lab at Birmingham Childrens Hospital - 0121 333 9942.

Complete **Investigation Proforma** and **Chain of Evidence form.**

Samples are sent together in one large pathology specimen bag with separate chain of evidence form for each set of sample

In children less than 2 years of age, where the cause of death or factors contributing to it are uncertain, investigative samples should be taken once death is confirmed. These include the standard set for SUDIC and have been agreed with the Coroner.

For children over 2 years of age, investigations should be decided by the on-call consultant paediatrician in liaison with the coroner (out of hours this may need to be discussed with the SIPO in the first instance).

If there is definite external evidence of injury early samples should only be taken after discussion with the Coroner.

All specimens to be taken to the hospital laboratory by a member of staff, and having a laboratory technician sign upon receipt, whilst complying with the CHAIN OF EVIDENCE PROFORMA THROUGHOUT.

Ensure that relevant consent has been ticked as yes/no for storing the sample on relevant specimen forms (eg cytogenetics)

If biopsies are taken parents' wishes for retention, disposal (or return to them) should be documented in the notes.

5.5 Equipment required for investigation

For blood specimens:

- 2 x Lithium heparin bottles – Orange top
- 2 x EDTA (haematology) bottles – Purple top
- 2 x plain bottles (no anti coagulant)
- 1 x Fluoride bottle –Grey top
- 1 x Guthrie card
- Syringes and needles
- Cytogenetics form

For urine:

- 3 x plain bottles
- 20ml syringe and no 1 (green) needle for SPA

For microbiology:

- 3 x plain swabs
- Viral transport medium
- General transport medium
- Aerobic and anaerobic blood culture bottles
- LP needle

For skin biopsy:

- Forceps
- Size 15 scalpel and no 3 handle
- 23G (blue) needles
- Cotton wool balls
- Viral transport medium (use NPA sample bottle)

General:

- Large pathology specimen bag
- Individual specimen bags
- Specimen check list
- Chain of evidence proforma
- *Ensure that relevant consent has been ticked as yes/no for storing the sample on specimen forms (eg cytogenetics)*

5.6 Infections

Blood cultures, into aerobic and anaerobic bottles, but if only a small volume available use aerobic in preference.

Urine by SPA into sterile bottle for microscopy and culture, save in refrigerator.

Nasopharyngeal swab if <8hrs post mortem put in viral transport medium in fridge.
Swabs from any wounds or body fluids for microbiology into fridge.

5.7 Inherited Metabolic Disorders (IMD)

These are rare, but can cause death without significant prodromal symptoms and infection can precipitate an attack. Signs suggesting metabolic disorder include:

- Consanguineous parents
- Older age at death (over 6 months)
- Previous infant death in family
- History of hypotonia or developmental delay
- Hepatomegaly or hepatosplenomegaly

These disorders may result in hyperammonaeamia, hypoglycaemia without ketonuria, cardiomyopathy, or apnoeic attacks. Investigation is limited post mortem by specimens available and interval between death and tissue sampling time.

If you suspect a metabolic disorder contact the IMD lab at BCH for advice (0121 333 9942).

In addition to blood and urine samples, skin biopsy and muscle biopsies should be performed if possible. Skin biopsy should be possible in District hospitals, follow the technique below and put the specimen in viral culture medium in a fridge at +4°C until transported to IMD at BCH.

5.8 Technique of Skin Biopsy

Obtain a Pack for SUDIC skin biopsy kept in A&E and Riverbank Ward.

Procedure detailed below is for obtaining a skin biopsy suitable for culture and for subsequent investigations for inherited metabolic disorders.

The most important aspect is STRICT ASEPSIS using a “no touch” technique.

Materials

- Forceps – fine non bend watch-makers forceps are best but dissecting forceps may be used
- Size 15 scalpel blade and a No 3 handle
- 23 gauge blue needle
- Cotton wool ball and gallipots
- Bottles of viral culture medium from microbiology locally (use NPA sample bottle)

Sample Requirements

At least 1 cubic mm of skin, approximately 2mm x 2mm

Procedure

There is a high risk of infection in most post mortem specimens and possible failure of culture.

1. Take the biopsy from the inner arm or from over the scapula, as this leaves less obvious damage

2. Swab the area with Hibitane in alcohol

3. Pierce the skin with a modest sized needle (23 G blue) and lift up to produce tenting

4. Lop off the tip of the tent to produce a piece of skin about 2mm with a round "O" shape

5. Put immediately into a viral culture medium bottle

The biopsies should be obtained as soon as possible after death – delay may jeopardise the success of the fibroblast culture. Successful culture is unlikely if biopsy is taken more than 48 hours post mortem.

The sample should be labelled and sent to the Inherited Metabolic Disease laboratory as soon as possible by special transport. If transport cannot be arranged immediately, the sample should be stored at +4°C. The biopsy has to set up in culture or banked within 24 hours of being taken. (N.B. THE SAMPLE MUST **NOT** BE FROZEN.)

The request form accompanying the sample should give clinical details along with the date and time of sampling.

The specimen should be sent to bacteriology in viral culture medium (obtained from microbiology technician on call).

6 SKELETAL SURVEY

The skeletal survey should be performed in children under 2 years, and consideration given in cases of children over the age of 2, at the designated hospital. On the request for skeletal survey on ICE, please ask for images to be sent to BWCH.

The Society of Radiographers guidance on skeletal survey for SUDI recommends maximum patient dignity should be respected at all times: because of this these skeletal surveys are usually done after 5:30pm, when the radiology department is quieter. A witness from outside the radiology department is required to accompany the child's body to the radiology department and during the x-rays. The coroner has authorised us to undertake skeletal survey for all children under 2 years of age as default. For children over 2 years of age, authorisation from coroner is required for performing skeletal survey.

It is recommended that the x-rays be reviewed as soon as possible by a radiologist with experience in paediatrics (currently Dr Baxter and Dr Nilak).

This MUST be a full skeletal survey, not a babygram.

7 ABUSIVE HEAD TRAUMA:

a) If abusive head trauma is suspected, CT head is suggested. Discussion with Coroner's Office would be required for permission for CT head.

b) It has been described that retinal photographs can be useful. However, corneal clouding occurs after death rendering ophthalmological examination impossible. In addition, increased vascular leakage after death can lead to difficulty in the interpretation of post-mortem examination findings. It has been suggested that MRI (which would need to be discussed with the Coroner's office) may be preferable if retinal haemorrhages are suspected. A discussion for advice with ophthalmology should be considered if retinal haemorrhages are suspected.

c) These injuries present with non-specific symptoms ranging from apnoea, apparent life-threatening event (ATLE), seizures, unexplained drowsiness or "sudden loss of consciousness". An appropriate suspicious mindset can result in the identification of characteristic retinal haemorrhages on examination of fundi and subdural haemorrhages on CT scan.

d) During resuscitation, a screening test for blood clotting disorders should be carried out promptly as brain injuries will eventually cause a similar effect. A photographic record should be made of all injuries immediately, and again after 24 hours.

e) The pathologist's opinion following post-mortem examination is important, as to whether documented injuries are consistent with abusive head trauma.

8: FOLLOW UP ACTIONS

Following the initial inquiry including history examination and investigations the consultant paediatrician is required to:

1) Attend the Initial information sharing and planning meeting within 4 working hours. There is space for documentation of this meeting on the history Proforma.

2) Complete the notification of a child death (appendix 3). This should be sent via email to the email address on the form to notify CDOP (child death overview panel)

3) Dictate a medical report for the pathologist. This should be sent via secure email from an nhs.net account to the coroner's office to coroner@worcestershire.gov.uk

4) Prepare to attend CDOP meetings if possible and complete further information on form B (sent out by CDOP)

5) Arrangements to meet up with the family by Consultant Paediatrician either Acute or named to discuss PM findings and implications – Support / Screening.

8.1 INITIAL INFORMATION SHARING AND PLANNING MEETING (IDEALLY WITHIN FOUR WORKING HOURS)

The purpose of the initial information sharing and planning meeting is:

- For each agency to share information from previous knowledge of the family and records, with particular reference to the circumstances of the child's death. This would include details of previous or ongoing child protection concerns, previous unexplained or unusual deaths in the family, neglect, failure to thrive, parental substance misuse, parental mental ill-health, domestic abuse, previous hospitalisation and GP visits, etc. Is there a "Significant Concern"?

- To enable consideration of any child protection risks to siblings/any other children living or visiting the household, and to consider the need for child protection procedures.

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

- To decide which information may be shared with the family.

- To discuss any need for action in respect of other children in the family (e.g. health overview).

- To collate all relevant information to share with the Pathologist.

  Those involved should include:

  i) **Health** - On call consultant paediatrician and SUDIC nurse.

  ii) **Children's Services** - The Children's Services Team Manager or the Emergency duty team social worker.

  iii) **Police** - Child Abuse Investigation Unit Detective Inspector or appointed SIPO.

  If there are child protection concerns this meeting may become a strategy meeting under child protection procedures.

APPENDICES

APPENDIX 1

To print off and to be filed in patient notes: (pages 17-35)

- **SUDIC Checklist 1 for Paediatric Consultant or Registrar to complete**
- **SUDIC Checklist 2 For Nurse Supporting Family to complete**
- **History Proforma**
- **Examination Proforma**
- **Investigation Proforma**
- **Notification form for CDOP – Please click on the icon**
- **Chain of evidence form – Please use the latest version available on ICE**

SUDIC CHECKLIST 1
For Paediatric Consultant or Registrar on call to complete

Please attach patient sticker here or record: *Name:*…… *NHS No:* ☐☐☐☐☐☐☐☐☐☐ *Unit No:* ☐☐☐☐☐☐☐☐☐☐ *D.O.B:* …… *Male / Female*	Address: Postcode:
On-call Consultant Paediatrician:	
SUDIC Consultant / SUDIC Nurse Co-ordinator:	

			PLEASE TICK, SIGN AND DATE WHERE APPROPRIATE
1.	Documentation of any resuscitation and confirmation of death		Name: ……
2.	SUDIC nurse informed via switchboard (working hours from 08:30 to 16:30 including weekends and bank holidays)		
3.	Police informed (DI on call) via 0300 333000		
4.	Coroner's Office Informed on 01905 822330 Coroner's Notification Form completed (available to be printed off from ED notes) and send via nhs.net email to coroner@worcestershire.gov.uk		
5.	Senior Manager and Executive on-call for the Trust to be informed of the SUDIC by Consultant Paediatrician of child death (via switchboard)		
6.	History Proforma Completed (to be completed by SUDIC nurse on call between 08:30 and 16:30)		
7.	Examination Proforma Completed		
8.	Investigations taken blood and urine, CSF, skin biopsy if required, (consider CT head + clotting screen if abusive head injury) Requests made on ICE (paper forms completed for Guthrie / newborn screening blood spot card, chromosomes, and skin biopsy)		
9.	Chain of evidence checklist form completed		
10.	Request skeletal survey on ICE (if <2 years) Discuss request with radiographers		
11.	Take part in immediate information sharing meeting (with SUDIC nurse, police and children's services)		
12.	Consider examination, investigation, admission of siblings (especially if <2y or twin)		
13.	Complete Notification form and initial ICR (to email form) along with DATIX		
14.	Prepare to complete medical report for pathologist and Form B Multiagency Information Sheet (for CDOP process)		

SUDIC CHECKLIST 2
For Nurse Supporting Family to complete

Please attach patient sticker here or record: *Name:……* *NHS No:* ☐☐☐☐☐☐☐☐☐☐ *Unit No:* ☐☐☐☐☐☐☐☐☐☐ *D.O.B: …… Male / Female* Address: Postcode:
On-call Consultant Paediatrician:
SUDIC Consultant / SUDIC Nurse Co-ordinator:

			PLEASE TICK, SIGN AND DATE WHERE APPROPRIATE
1.	Nurse allocated to support parents.		
2.	Parents given opportunity to be present during any resuscitation.		
3.	Correct wrist bands and identification on wrist and leg		
4.	Parents given opportunity to see/ hold child (with discreet supervision)		
5.	Facility provided (eg quiet private room & drinks)		
6.	Assist with completing investigations		
7.	Mementoes offered to parents, to be gathered in to memory box (which are kept on Riverbank ward) Please tick: ☐ Photographs taken ☐ Accepted by parents ☐ Kept in notes ☐ Lock of hair ☐ Name band ☐ Foot / hand prints		
8.	Religious advisory notified (if desired by parents). Appropriate religious ceremony offered.		
9.	Telephone numbers for support organisations are offered to parents (see appendix 6). If <1 y contact bereavement midwives on ext 30583 & leave voicemail message or email wah-tr.bereavementmidwives@nhs.net		
10.	GP and Child Health informed (cancels appointments for immunisations) and Neonatal outreach or Orchard Service if appropriate		

Proforma 1 – History
Between 08:30 and 16:30 this is completed by the SUDIC Nurse on-call, between 16:30 and 08:30 this is completed by the paediatric consultant or registrar
Taken from Appendix 1 West Mercia Regional Protocol 2008.

Investigation of Sudden Unexplained Death in Children under 18 years old

HISTORY PROFORMA

IDENTIFICATION DATA:

Please attach patient sticker here or record: *Name:*…… *NHS No:* ☐☐☐☐☐☐☐☐☐☐ *Unit No:* ☐☐☐☐☐☐☐☐☐☐ *D.O.B:* …….. *Male / Female*	**Other Names Known By:** **Place of birth:** **Ethnicity:** **Date of Death:**

Address:			
Postcode:			
Name of Father:		**Date of Birth:**	
Address: **(if different from child)**			
Name of Father's Partner: (if relevant)		**Date of Birth:**	
Address: **(if relevant)**			
Name of Mother		**Date of Birth:**	
Address : **(if different from child)**			
Name of Mother's Partner (if relevant)		**Date of Birth:**	
Address: **(if relevant)**			
GP Name:			
GP Address:			
Hospital Number:			
Consultant:			
SUDC Professional:			

2. DETAILS OF TRANSPORT OF CHILD TO HOSPITAL:													
Please attach patient sticker here or record: *Name:……* *NHS No:* ☐☐☐☐☐☐☐☐☐☐ *Unit No:* ☐☐☐☐☐☐☐☐☐☐ *D.O.B: …….. Male / Female*		**Place of Death:** Home address as above: DGH (specify): Another Location specify)											
Time Found:													
Time Arrived in A&E:													
Resuscitation carried out:									Yes		No		
Where:			At scene of death		Ambulance		A&E						
By whom:	Carers		GP		Ambulance Crew		Hospital		Other				
Confirmation of death:	**Date**		**Time**		**Location**		**By whom**						
3. HISTORY													
Taken into A&E by:													
Taken at home visit by:													
History given by:													
Relationship to child:													
EVENTS SURROUNDING DEATH:													
Child found by:	Mother		Father		Partner		Other						
Time found:													
Who called emergency services:													
Access to Emergency Phone:													
Child last seen alive:	Date:				Time:								
By whom:													
Who looked after child in last 24 hours:													
Resuscitation:									Yes		No		
By whom:													
If yes, describe how? (basic life support, blew on face, slapped on back etc)													
Any response?									Yes		No		

4. *THE FINAL SLEEP* **(description of when and where the baby was put to sleep)**	*Please attach patient sticker here or record:* *Name:……* *NHS No:* ☐☐☐☐☐☐☐☐☐☐ *Unit No:* ☐☐☐☐☐☐☐☐☐☐ *D.O.B: …….. Male / Female*

When put down?							
Where?							
Any change from usual?							
How was the child placed down to sleep?	prone		supine		side		
How was the child found?	prone		supine		side		
Anyone else in the bed/cot?			Yes		No		
Dummy?			Yes		No		
What was child wearing?							
Bed coverings?							
Type, condition and quality of Mattress?							
How often checked?							
Who by?							
Time Last checked?							
Time Last heard?							
Did child wake?			Yes		No		
When?							
Who found the child?							
What time?							
Position of bedding/covers?							
What did the child look like?							
Any blood in mouth of nostrils?			Yes		No		
Additional Comments:							

Diagram of Scene : To be completed by the SUDIC Nurse on-call

Note: North/South orientation; room measurements
Location of doors, windows, heating
Any furniture and objects in the room

Please attach patient sticker here or record:

Name: ……

NHS No: ☐☐☐☐☐☐☐☐☐☐

Unit No: ☐☐☐☐☐☐☐☐☐☐

D.O.B: …… *Male / Female*

	Please attach patient sticker here or record: *Name:……* *NHS No:* ☐☐☐☐☐☐☐☐☐☐ *Unit No:* ☐☐☐☐☐☐☐☐☐☐ *D.O.B:* …….. *Male / Female*				
5. *THE FINAL SLEEP* (*The Room*)					
Does anyone else sleep in the room usually?	Yes		No		
Anyone else in the room this time?	Yes		No		
Objects in or near the bed?	Yes		No		
Was the heating on?	Yes		No		
What type of heating?					
What was the temperature in the room?					
Was there evidence of over wrapping or overheating?					
Were the windows/doors open?	Yes		No		
Was there any restriction or potential restriction to ventilation or breathing?					
6. *FEEDING (where applicable)*					
Time of last feed?					
Type of feed?					
Quantity?					
Any change from usual?	Yes		No		
Was the baby feeding as well or less well than usual in the past 24-48 hours?					
Any vomiting in last 48 hours?	Yes		No		
Any vomitus when found?	Yes		No		
Other Comments:					
7. *DETAILED ACCOUNT OF LAST 24-48 HOURS*					
Any changes to routine or feeding?	Yes		No		
Unusual cry/irritability/fever/medication given?	Yes		No		
Breathing difficulties or coughing?	Yes		No		
Wet nappies in 24 hours?	Yes		No		
Difficulties with sleeping or walking?	Yes		No		
Unusual activity or alertness?	Yes		No		
Cyanotic/Apnoeic Episodes?	Yes		No		
Changes in Environment Temperature?	Yes		No		
Other Comments:					
8. *LAST SEEN BY A DOCTOR*					
Date:					
Time:					
Where:					
Why:					

Please attach patient sticker here or record:

Name:……

NHS No: ☐☐☐☐☐☐☐☐☐☐

Unit No: ☐☐☐☐☐☐☐☐☐☐

D.O.B: …….. Male / Female

9. *FAMILY HISTORY*

MOTHER:				
Age:	**Marital Status:**			
Occupation:	**Ethnic Group:**			
Past marriages/live-in relationships?	Yes		No	
How long has mother lived with father?				
Was Mother living with child at time of death?				
Children from other Partners?	Yes		No	
Drugs (including habit forming)?	Yes		No	
Smoking?	Yes		No	
Alcohol?	Yes		No	
Illness/Disabilities?	Yes		No	
Other comments:				
Father				
Age:	**Marital Status:**			
Occupation:	**Ethnic Group:**			
Past marriages/live-in relationships?	Yes		No	
How long has father lived with mother?				
Was father living with child at time of death?	Yes		No	
Children from other Partners?	Yes		No	
Drugs (including habit forming)?	Yes		No	
Smoking?	Yes		No	
Alcohol?	Yes		No	
Illness/Disabilities?	Yes		No	
Other comments:				

Children in the family:
(Including any children by previous partners)

Please attach patient sticker here or record:

Name:……

NHS No: ☐☐☐☐☐☐☐☐☐☐

Unit No: ☐☐☐☐☐☐☐☐☐☐

D.O.B: …….. *Male / Female*

	Age:	
	Age:	
	Age:	
	Age:	

Any previous childhood deaths in the family?	Yes		No	

Additional Comments:

Please attach patient sticker here or record:

Name:……

NHS No: ☐☐☐☐☐☐☐☐☐☐

Unit No: ☐☐☐☐☐☐☐☐☐☐

D.O.B: ……..... *Male / Female*

10. *PAST MEDICAL HISTORY*

BIRTH HISTORY:				
Height/Weight of Mother prior to pregnancy?				
Pregnancy:				
Delivery:				
Gestation:				
Birth Weight:				
Apgar score:				
Perinatal problems?	Yes		No	
Neonatal Admission?	Yes		No	
Type of feeding at birth?				
Feeding now? Breast, bottle? If latter – what milk formula?				
Any recent changes to feeding routines?				
Weight gain in last few weeks?	Yes		No	
Routine checks e.g. 6 week medical?	Yes		No	
Immunisations?	Yes		No	
Previous illnesses?	Yes		No	
Previous hospital admissions?	Yes		No	
Previous unexplained illness e.g. cyanotic episodes, acute life threatening events (ALTE):	Yes		No	
Excessive sweating?	Yes		No	
Episodes of pallor?	Yes		No	
Any past respiratory difficulties e.g. noisy breathers or wheezing?	Yes		No	
Contacts with infections?	Yes		No	
Allergies?				
Medication?				
Over the counter medicines (Gripe Water/Paracetamol, etc)?				
Other Comments:				

MOTHER'S OBSTETRIC HISTORY:	*Please attach patient sticker here or record:* *Name:……* *NHS No:* ☐☐☐☐☐☐☐☐☐☐ *Unit No:* ☐☐☐☐☐☐☐☐☐☐ *D.O.B: …….. Male / Female*

Details of previous pregnancies and pregnancy outcomes:

11. *SOCIAL HISTORY*

Type of housing?				
Number of people in household?				
Family on benefits or income support?	Yes		No	
Recent major life events in family ?	Yes		No	
Child or family known to Social Services?	Yes		No	
Any family mental health problems?	Yes		No	
Maternal depression PNDS?	Yes		No	

Other Comments:

12. *IMMEDIATE INFORMATION SHARING AND PLANNING MEETING/DISCUSSION*	*Please attach patient sticker here or record:* *Name:……* *NHS No:* ☐☐☐☐☐☐☐☐☐☐ *Unit No:* ☐☐☐☐☐☐☐☐☐☐ *D.O.B: …….. Male / Female*

Signed:		**Date:**	
Designation:		**Base:**	
Signed:		**Date:**	
Designation:		**Base:**	
Signed:		**Date:**	
Designation:		**Base:**	
Home visit on:	**(date)**	**By:**	

SUDIC EXAMINATION PROFORMA: To be completed by the paediatric consultant or registrar

Examination:

- Careful and complete physical examination, including looking for organomegaly, weight and height
- Look for any **external marks** – bruises or injuries and petechiae, **palpate skull** for fracture or bogginess, look in fundus for **retinal haemorrhages**, examination of frenum and genitalia
- Record **rectal temperature** and any other signs of illness

However, the following should be noted and are present in many infant deaths:

- Froth emerging from the mouth and nose. This froth results from the expulsion of air and mucus from the lungs after death. Sometimes the froth may be blood-stained – this does not mean that the death was unnatural.

- Small quantities of gastric contents around the mouth. This does not mean that death was caused by inhalation of vomit. Often there is slight regurgitation after death.

- Purple discoloration of the parts of the face and body that were lying downwards. This is not bruising, but is caused by the draining of blood in the skin after death. For the same reason the parts that were lying upwards may be very pale.

- Covering of the child's head by the bedclothes. This has often been a feature of cot death in the past, and probably contributes to death through accidental asphyxia or overheating.

- Wet clothing or bedding (this is usually caused by excessive sweating before death).

- If the child looks as though he/she has been roughly handled, remember that this may be the result of attempts at resuscitation.

- If resuscitation has been attempted, any intravenous, intra-arterial or intra-osseous lines inserted for the purpose should only be removed following discussion with the police or coroner. All medical interventions, including sites of attempted vascular access should be carefully documented on a body chart. If an intravenous cannula has been inserted and it is thought that it may have contributed to failed resuscitation (for example, by causing a pneumothorax), it should not be removed.

- If an endotracheal tube has been inserted, this may be removed after its correct placement in the trachea has been confirmed by direct laryngoscopy (preferably by someone other than the person who inserted it) and the case discussed with the police or coroner. The size and position of the tube should be documented.

To be completed by the paediatric consultant / registrar

EXAMINATION : SUDIC	
Please attach patient sticker here or record: *Name:……* *NHS No:* ☐☐☐☐☐☐☐☐☐☐ *Unit No:* ☐☐☐☐☐☐☐☐☐☐ *D.O.B: …… Male / Female*	**Date of examination:** **Examination undertaken by:**
Height: cm	Percentile:
Weight: kgs	Percentile:
Head circumference cm	Percentile:
Systemic examination:	
Skin / Injuries: Use body charts but summarise here	

Please attach patient sticker here or record:

Name: ……

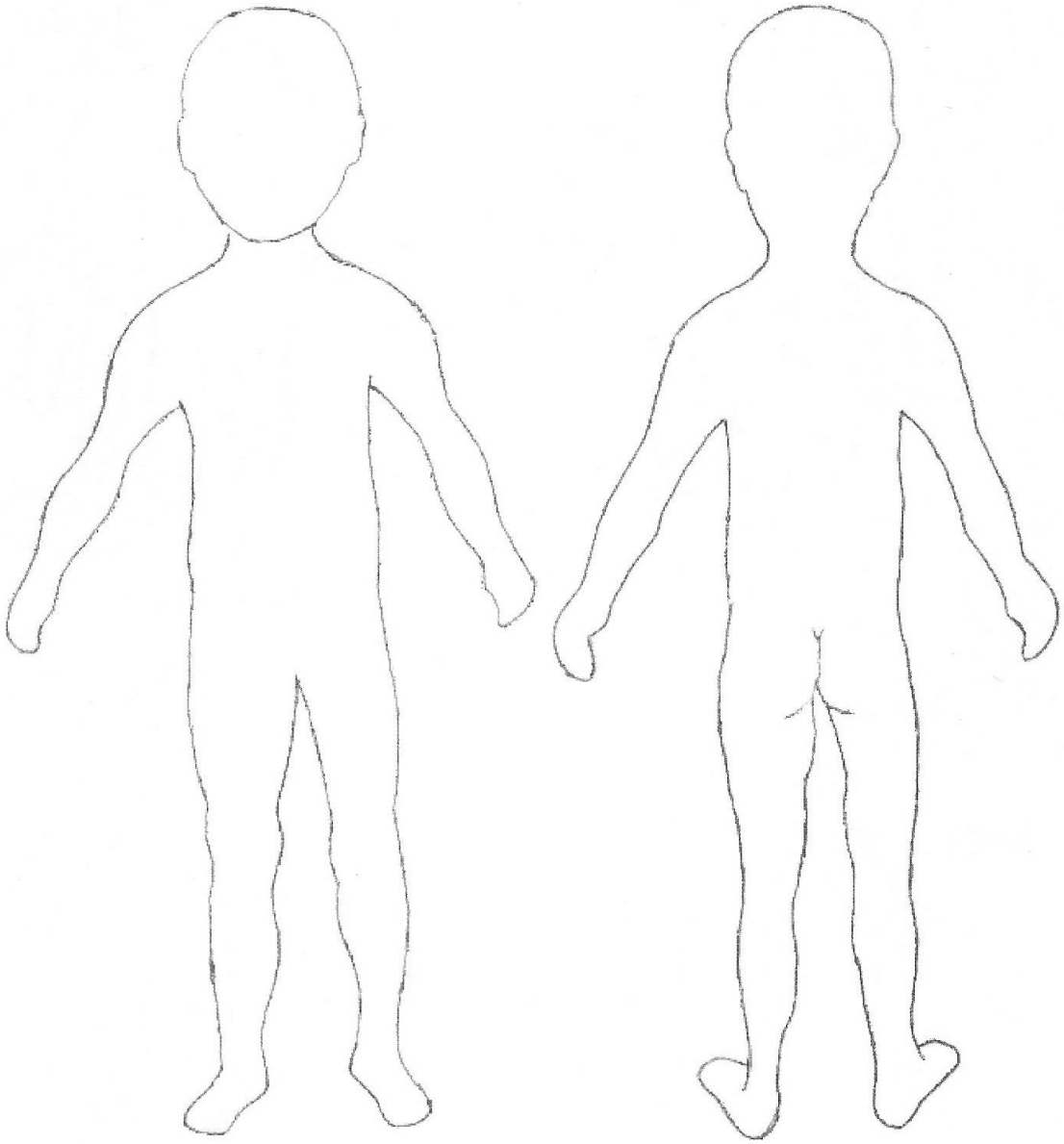
NHS No: ☐☐☐☐☐☐☐☐☐☐

Unit No: ☐☐☐☐☐☐☐☐☐☐

D.O.B: …… *Male / Female*

Appendix 12

Body Chart 1



Mercia Region Multi-Agency Protocol for the Management of Sudden and Unexpected Deaths in Children and Infants.

Worcestershire Acute Hospitals NHS Trust

Please attach patient sticker here or record:

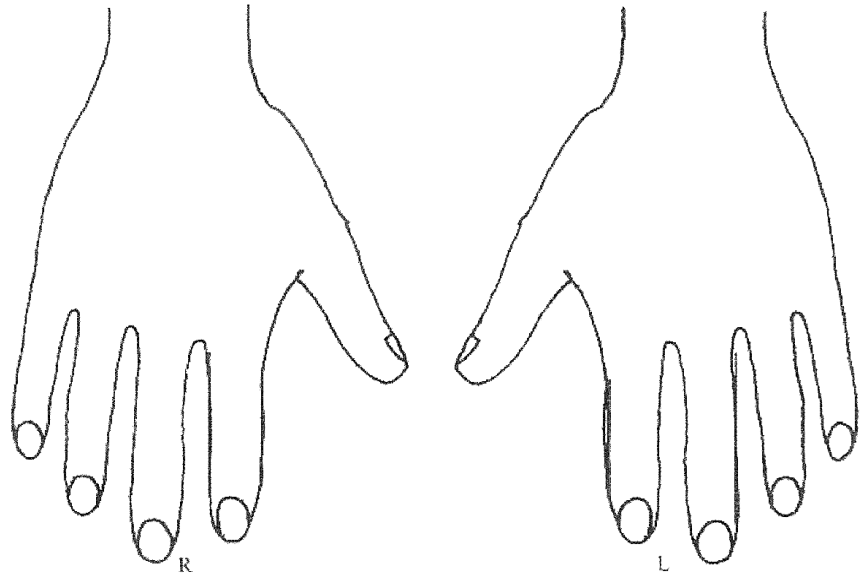
Name: ……

NHS No: ☐☐☐☐☐☐☐☐☐☐

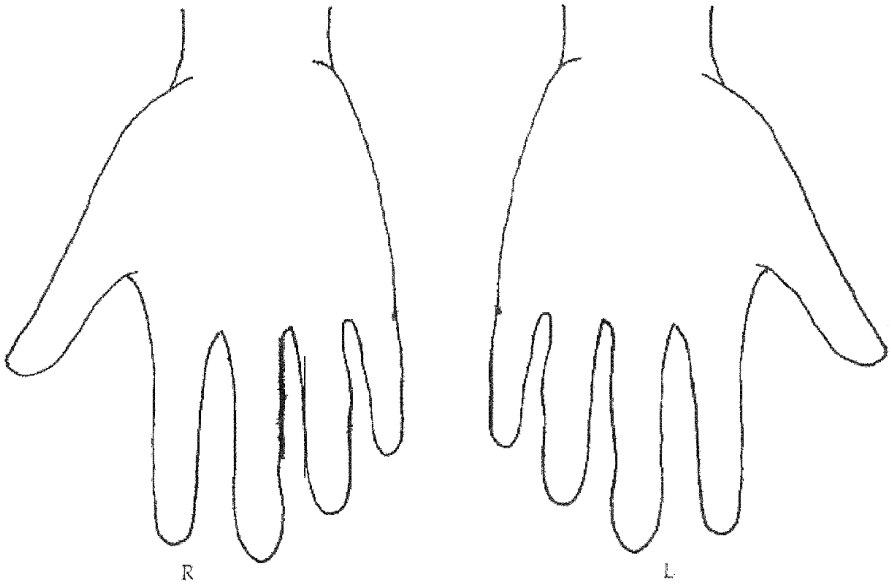
Unit No: ☐☐☐☐☐☐☐☐☐☐

D.O.B: …… *Male / Female*

Body Chart 2

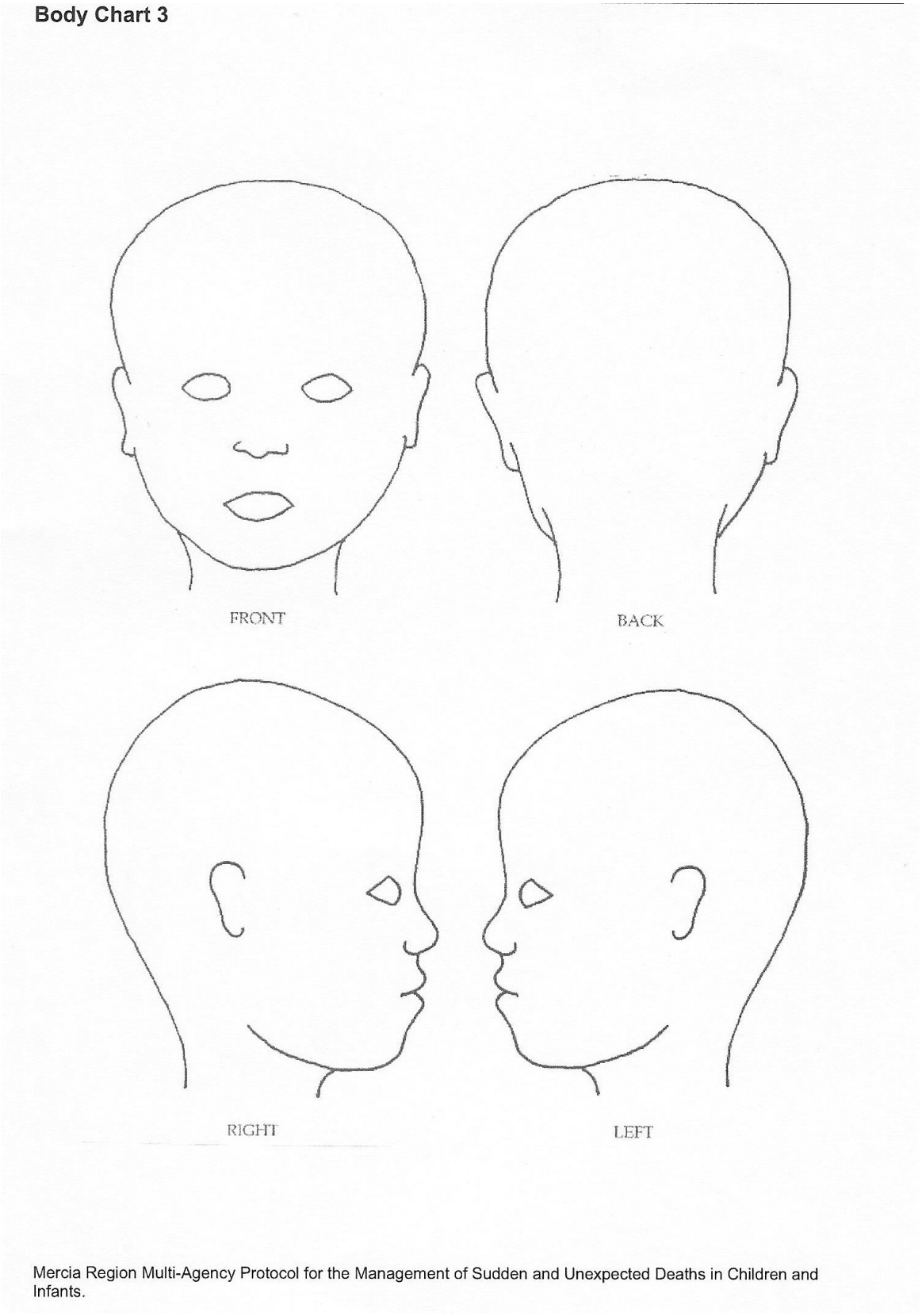


BACK



PALM

Body Chart 3



Mercia Region Multi-Agency Protocol for the Management of Sudden and Unexpected Deaths in Children and Infants.

Please attach patient sticker here or record:

Name:……

NHS No: ☐☐☐☐☐☐☐☐☐☐

Unit No: ☐☐☐☐☐☐☐☐☐☐

D.O.B: …….. Male / Female

SUDIC INVESTIGATIONS PROFORMA
Page 1 of 2

All specimens initially to be taken to the appropriate hospital laboratory (not via pod system) complying with the Chain of Evidence

note send samples in transit bags together with one chain of evidence form within second large pathology specimen bag

Specimen and Technique	Sample	Handling /Destination	Test	?Taken (sign)
Blood 10-15 ml in total Cardiac stab only if sufficient blood not available via large artery / vein **Single attempt at femoral or cardiac stab**	**Blood** (serum 1ml)	Clinical chemistry Normal	U+E creatinine	
	Blood (fluoride 2ml)	Clinical chemistry Collect pre-mortem, spin, store plasma minus 20°C	Glucose, lactate, 3-OH butyrate, FFA,	
	Blood (Li heparin 0.5 - 1ml)	Clinical chemistry Spin, store plasma minus 20°C	Amino acids acylcarnitine	
	Blood (serum 0.5-1 ml)	Clinical chemistry Spin, store serum at minus 20°C	Toxicology	
	Blood (EDTA 1ml)	Normal Haematology	Full blood count Clotting Consider carboxyhaemoglobin	
	Blood cultures (aerobic and anaerobic 1 ml)	Microbiology If insufficient blood, aerobic only. May be obtained from femoral puncture.	Culture and sensitivity	
	Blood (Li heparin) 1–2 ml	Cytogenetics BWCH Normal – keep unseparated ***ensure consent to store sample is ticked yes / no***	Cytogenetics (if dysmorphic)	
	Blood from syringe onto newborn blood spot (Guthrie) screening card	Normal (fill in card; do not put into plastic bag)	Inherited metabolic diseases, carnitine	
Only take if indicated on clinical history or examination. Do not take if suspicion of cranial trauma **Single attempt at LP**	**Cerebrospinal fluid** (CSF) (a few drops)	Microbiology Normal	Microscopy, culture and sensitivity Filmarray PCR testing	
Swabs and Secretions Send in all cases	**Nasopharyngeal aspirate** (viral culture medium)	Virology Normal	Extended Respiraory Panel PCR	

Specimen and Technique	Sample	Handling /Destination	Test	?Taken (sign)
	Nasopharyngeal aspirate (viral culture medium)	Microbiology Normal	Culture and sensitivity	

Please attach patient sticker here or record:

Name:……

NHS No: ☐☐☐☐☐☐☐☐☐☐

Unit No: ☐☐☐☐☐☐☐☐☐☐

D.O.B: …….. Male / Female

SUDIC INVESTIGATIONS PROFORMA
Page 2 of 2

All specimens initially to be taken to the appropriate hospital laboratory (not via pod system) complying with the Chain of Evidence.

note send samples in transit bags together with one chain of evidence form within second large pathology specimen bag

Specimen and Technique	Sample	Handling /Destination	Test	?Taken (sign)
Swabs and Secretions (continued) Send in all cases	**Throat Swab**	Microbiology Normal	Culture and sensitivity	
	Swabs from any identifiable lesions	Microbiology Normal	Culture and sensitivity	
<u>Single attempt</u> at SPA or aseptic urethral catheterisation	**Urine** (if available)	Clinical chemistry Obtain on filter paper by squeezing nappy Spin, store supernatant at minus 20°C metabolic	Toxicology	
	Urine (if available)	Clinical chemistry Spin, store supernatant at minus 20°C metabolic	Amino and organic acids, oligosaccharides	
	Urine (if available)	Microbiology Normal	Microscopy, culture and sensitivity	
Skin biopsy Take in cases of suspected metabolic disease, especially <2 years	**Skin biopsy** (use viral culture medium)	Will need co-ordination with on-call pathology team: request transfer to BCH metabolic lab within 24 hours. Unless post mortem will be done within 24 hours	Fibroblast culture	

Please attach the chain of evidence form for each type of sample.

The form is also available in the safeguarding section

Appendix 2: Community SUDIC Deaths – Sample Taking - Access into the Mortuary. (WRH)

1. The attending paediatric registrar or consultant (taking samples) will contact the on-call mortuary technician via switchboard for advice on gaining access to the mortuary out of hours. Due to time constraints the on-call technician may not always be required to attend as this could take an extra 45 mins to an hour for the technician to arrive at the mortuary department and delay the process.
   The on-call mortuary technician MUST confirm that the attending paediatric doctors and police have 3 points of identification (e.g. name, address or place of death, DOB) for the deceased BEFORE the samples are taken.

2. If there is difficulty in contacting on call mortuary technician for WRH, then please contact on call technician at ALX as a buddy approach has been agreed.

3. **Paediatric / ED nurse will meet the paramedics at the mortuary and will come through the gates and parents will be let in through the doors. The storage section will be covered with sheets.**

4. **Access to confidential conversation will be available for professionals.**

5. If the on-call mortuary technician doesn't attend, the paediatric registrar or consultant will contact the porters via helpdesk/switchboard in order to gain access to the mortuary department.

6. The porter will provide entry to the mortuary department for the paediatric registrar or consultant / police, via the shutter door (WRH) or from the main corridor (AHR). The paediatric registrar or consultant and police must sign into the mortuary visitors register.

7. The porter will locate the correct deceased and remove them from the fridge using a suitable hoist. The porters **will not** open the body bag to confirm identification.

8. The paediatric registrar or consultant and the police will confirm the 3 points of identity of the deceased from the ID tag against the details they have brought with them.

9. The deceased is transferred to the post mortem room by the porter for the samples to be taken. Once this has happened, the porter can leave the mortuary department.

10. PPE (Gloves, Aprons and Overshoes) can be located in the fridge areas and PM suite on both sites.

11. Once the samples have been taken, the porter can be contacted through switchboard (using the phone in the fridge room) for the patient to be returned to the correct fridge space. The porters will return the deceased to the correct fridge location.

The paediatric registrar or consultant and police CANNOT leave the department until a porter has returned the deceased to the allocated fridge space.

9. No samples are to be left with the deceased.

10. The visitors register must be signed by the paediatric registrar or consultant and police on leaving the mortuary department.

11. The department is locked by the porters on departure from the mortuary.

ALL VIEWINGS MUST BE ORGANISED THROUGH THE ON-CALL MORTUARY TECHNICIAN FOR SUDIC CASES.

APPENDIX 3:

Notification Form.pdf

APPENDIX 4: BREAKING THE NEWS AND WHAT TO TELL PARENTS

Regardless of the cause, unexpected children's deaths are always a tragedy and source of distress to families. Professionals should at all times strive to keep an appropriate balance between the investigative functions, both forensic and medical with ensuring that families are treated sensitively and given the support required.

Local processes should provide for:

- An allocated member of hospital staff for the family to support them throughout the process
- An identified professional for similar support for families where the deceased child has not been taken to the hospital
- An identified person to make and maintain contact with parents living abroad (where the child has lived and died in the UK) to offer them support through the bereavement.

Someone with responsibility for keeping parents up-to-date with information about the death and professional involvement – provided where to do so does not jeopardise police or criminal investigations

- *When you arrive always say who you are and why you are there, and how sorry you are about what has happened to the child.*
- *The parents will be in the first stages of grief and may react in a variety of ways, such as shock, numbness, anger or hysteria. Allow the parents space and time to cry, to talk together and to comfort any other children. These early moments of grieving are very important. Parents may want to hold their child and this can be facilitated, if appropriate, but may need to be supervised.*
- *In talking about the child preferably use the first name, or, if you don't yet know the name, say 'your child', or 'he' or 'she'. Don't refer to the child as 'it'.*
- *Have respect of the family's religious beliefs and culture.*

- ***If English is not the family's first language, or communication difficulties are identified, relevant support should be arranged. Please see the 'interpreting and translation services' page accessed via the Departments A-Z guide on the intranet homepage for instructions on how to book an interpreter. The emergency / out of hours telephone interpreter number is 033 3344 1192. Family members should not be used as translators.***

- *Take things slowly, allowing the parents to gather their thoughts and tell the story in their own way.*

- *Be prepared to answer practical questions, for example about where the child will be taken and when they can next see him/her.*

- *Most parents feel guilty when their child has died. When talking to them try to ask questions in a neutral way, e.g. 'Would you like to tell me what happened?' Avoid questions that sound critical, such as 'Why didn't you?'*

- *Don't use such phrases as 'suspicious death' or 'scene of crime', and try to avoid comments that might be misunderstood by, or distressing to, the parents.*

- Find a quiet room and give your bleep to another doctor, take a nurse with you.

- Know the name and sex of the child.

- Make sure that there is another relative or friend to support the parent and if possible both parents are present – don't start until everyone has arrived unless this will cause undue delay.

- Don't take a long time telling them what has happened, they will probably have guessed already and will appreciate you getting to the point.

- If the child was brought in dead, explain that it wasn't possible to do anything that would have brought the child back to life.

- If resuscitation was attempted explain that everything possible was done to save the child but unfortunately he/she died.

- Explain the need to take specimens as soon as possible and if skin or muscle biopsies are being performed explain how and why. It may be appropriate for another doctor to take specimens whilst the senior doctor talks to parents. <u>If biopsies are taken, parents' wishes for retention, disposal (or return to them) should be documented in the notes.</u>

- Go slowly, leaving pauses for them to take in what you have said, ask questions or just to have a cry.

- Answer questions and give whatever explanations are available but tell them that the Coroner has to be informed and a post mortem has to take place to find out whether there was an identifiable cause for the child's death.

- Explain that a consultant paediatrician will see them after the Coroner's investigations are completed and this will take a few weeks.

- If mother was breast feeding, advise about stopping lactation
- Encourage parents to hold their child, offer photos and bereavement support (SANDS, local cot death support group etc)

APPENDIX 5: SOME FACTS ABOUT Sudden Infant Death Syndrome

- **Age : 2-4 months – 95% under 6 months**
- **Rare under 1 month or over 1 year**
- **Males>females**
- **Winter**
- **Minor illness common in preceding 24 hours but most are healthy.**
- **Incidence 0.4-1.3 per 1000 live births**
- **Aetiology unknown likely to be multi factorial**
- **SIDS is not caused by immunisations (they decrease the risk)**

High Risk

Maternal factors – young age, increased parity, short inter-pregnancy interval, twin pregnancy, poor antenatal care, anaemia, UTI in pregnancy, low socio-economic status, drug use, family history of SIDS.

Neonatal factors – IUGR, birth asphyxia, prematurity, <1500g, apnoeas.

Post Natal factors – cigarette smoke exposure, prone sleeping, thermal stress, bottle fed, non central heating, recent febrile illness, soft sleeping surface, swaddling, co-sleeping combined other risk factors (see guidance below)

NB Similar risk factors for SIDS, prematurity and NAI

Reduce the Risk
Back to sleep and feet to foot (put feet to foot of cot, lying on back)
No smoking
Avoid over heating
Breast feed and seek medical help if concerned about baby

Advice and Risk factors produced by the Foundation for the Study of Infant Deaths and endorsed by the DOH:

The safest place for your baby to sleep is in a cot in a room with you for the first 6 months:
If you or your partner:
- Are smokers (no matter where or when you smoke and even if you never smoke in bed)
- Have recently drunk alcohol
- Have taken medication or drugs that make you sleep more heavily

do NOT share a bed with your baby.

The risks of bedsharing are also increased if your baby:
- Was premature (born before 37 weeks)
- Was of low birth weight (less than 2.5 kg or 5.5lb)

- Place your baby on the back to sleep in a cot in a room with you
- Do not smoke in pregnancy or let anyone smoke in the same room as your baby
- Do not share a bed with your baby if you have been drinking alcohol, if you take drugs or if you are a smoker
- Never sleep with your baby on sofa or armchair
- Do not let your baby get too hot – keep baby's head uncovered – place your baby in the 'feet to foot' position

APPENDIX 6: RESOURCES FOR PARENTS

LOCAL: If the child is under the age of 1 year the bereavement midwifery team can offer support to the family contacted via ext 30583 or email at wah-tr.bereavementmidwives@nhs.net

ACORNS CHILDREN'S HOSPICE WORCESTERSHIRE

Offers a network of specialist care and support to children and young people with life limiting or life threatening illnesses, and their families; includes bereavement support to known families

01905 767676 www.acorns.org.uk

BEREAVEMENT SUPPORT SOUTH WORCESTERSHIRE

Bereavement support and counselling for anyone living in South Worcestershire

01905 760934 www.bereavementsupportworcestershire.org.uk

PRIMROSE HOSPICE BROMSGROVE & REDDITCH

Offering advice, support and counselling services

01527 871051 www.primrosehospice.org.uk

KEMP HOSPICE KIDDERMINSTER

Offering advice, support and counselling for anyone living in Wyre Forest and surrounding area

01562 756060 www.kemphospice.org.uk

EDWARD'S TRUST BIRMINGHAM

Support and counselling for children and adults affected by the death of a child

0121 454 1705 www.edwardstrust.org.uk

TOUCHSTONES NORTH EAST WORCESTERSHIRE

Support for bereaved children and young people

07547 367 267 www.touchstones-support.org.uk

FOOTSTEPS WORCESTERSHIRE

Support for bereaved children and families

0845 467 6065 www.talktofootsteps.co.uk

BRAIN TUMOUR SUPPORT GROUP WORCESTER

Offers information and support to anyone affected in any way by a brain tumour

07804 820351

www.thebraintumourcharity.org/get-support/support-your-local-area/worcestershire-

NATIONAL

LULLABY TRUST (formerly FSID)

Provides specialist support for bereaved families
and anyone after the sudden death of an infant
0808 802 6868 www.lullabytrust.org.uk

CHILD BEREAVEMENT CHARITY

Supporting families and educating professionals when a child dies and when a child is bereaved
0800 02 888 40 www.childbereavement.org.uk

CHILD DEATH HELPLINE

A FREEPHONE service offering support for anyone affected by the death of a child

0800 282 986 / 0808 800 6019 www.childdeathhelpline.org.uk

WINSTON'S WISH

The largest UK charity provider of support to
bereaved children, young people and their families

08452 03 04 05 www.winstonswish.org.uk

SANDS

Stillbirth and Neonatal Death organisation supporting anyone
affected by the death of a baby
020 7436 5881 www.uk-sands.org.uk

CHILDREN OF JANNAH

Support for Muslim parents and families following the death of a child or baby, whether through illness, miscarriage or stillbirth. *Jannah* is a belief that children who die enter Paradise and it is a key message used in helping bereaved Muslim parents and families heal from grief.
www.childrenofjannah.com 0161 480 5156
Monday to Thursday 10am to 2 pm

CRUSE BEREAVEMENT CARE

Bereavement support for all the family
0800 808 1677 www.cruse.org.uk

COMPASSIONATE FRIENDS

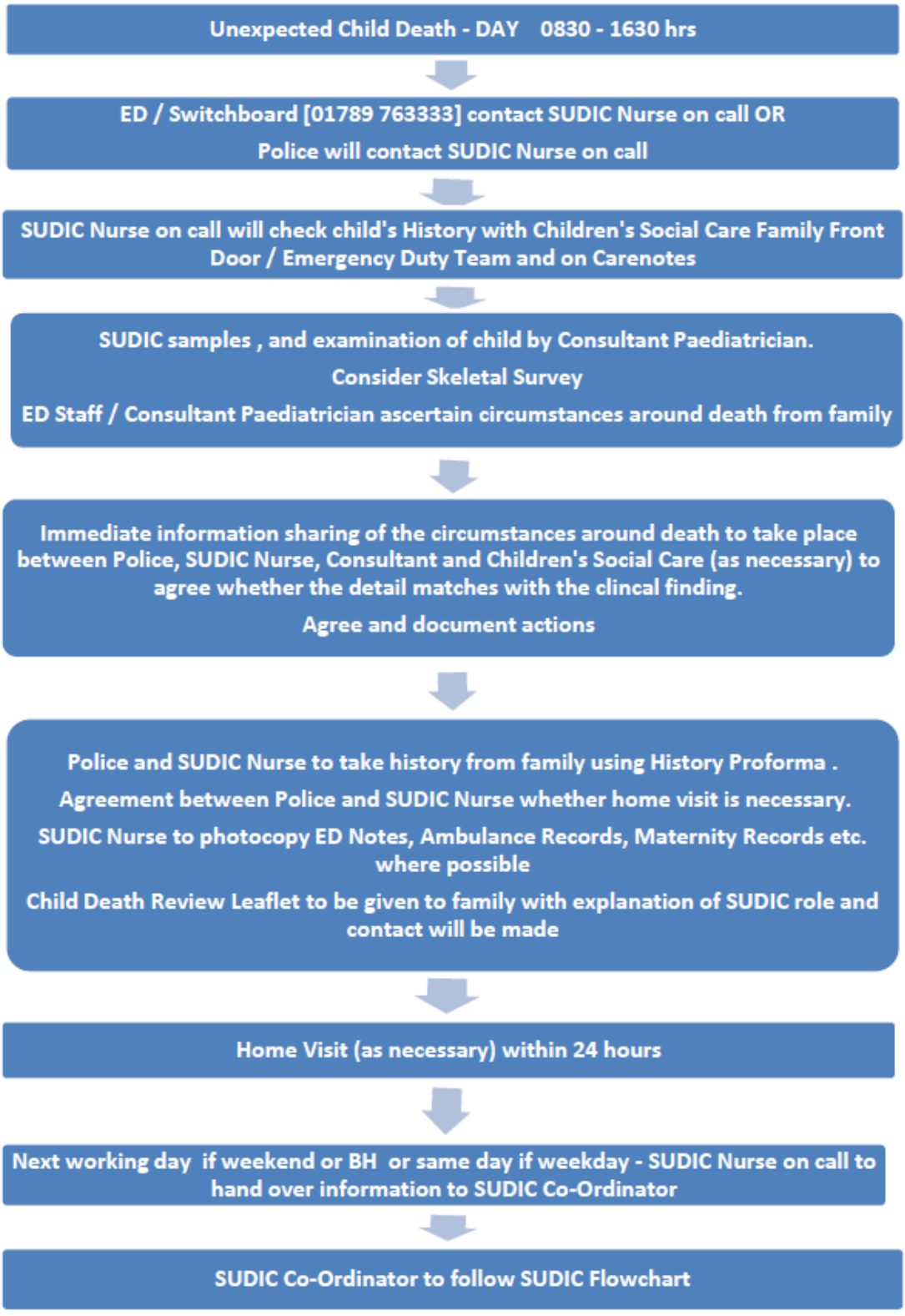
Supporting the bereaved and their families by those similarly bereaved
0845 423 2304 www.tcf.orguk

For further details about CONI (care of next infant) and the availability of CONI in your area, please contact The Lullaby Trust 0808 802 6869 or email info@lullabytrust.org.

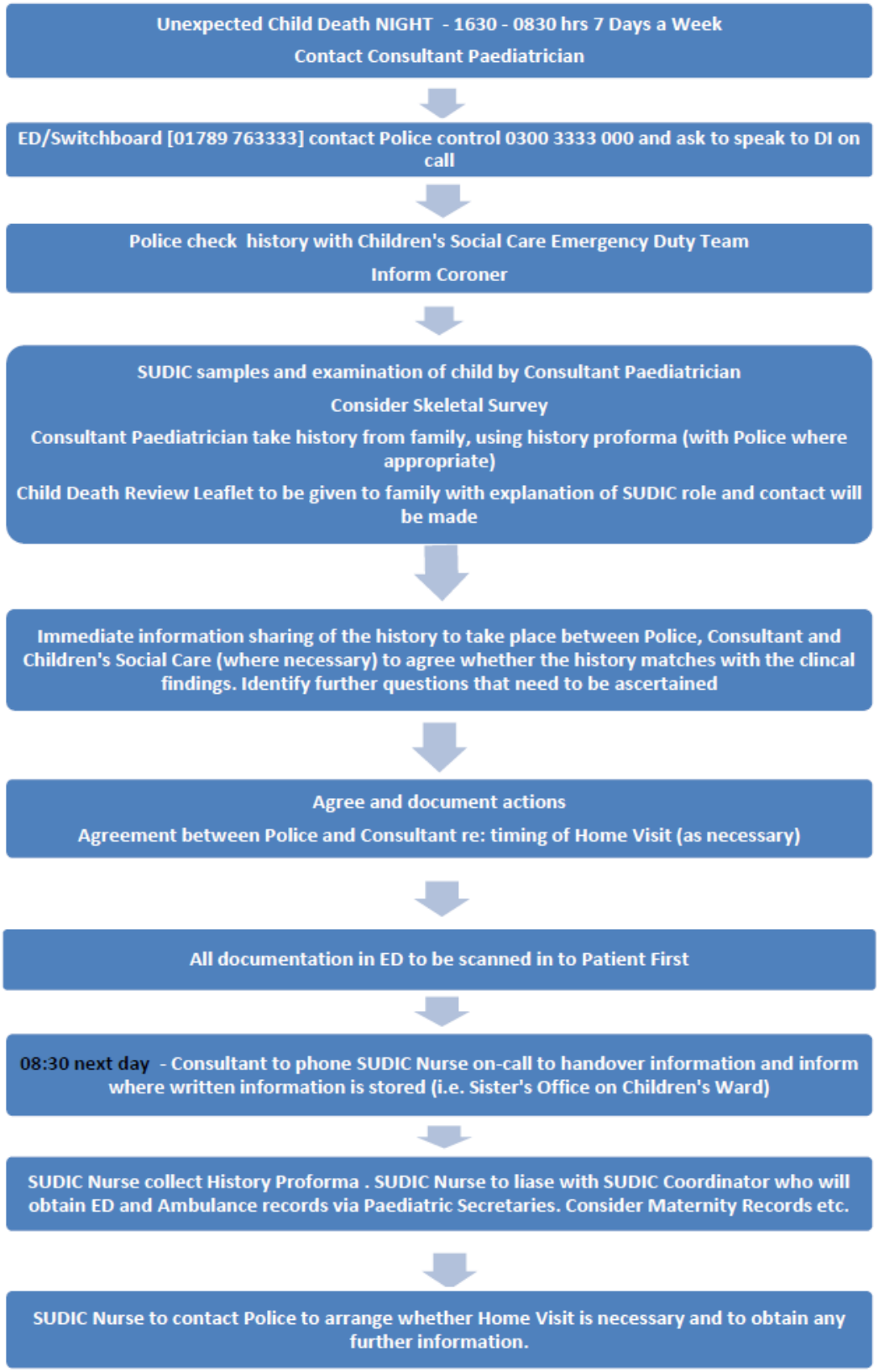
APPENDIX 7: Joint Agency Response taken from West Mericia SUDI PROTOCOL

Worcestershire JAR Arrangements [Health]

SUDIC FLOWCHART FOR SUDIC NURSE ON CALL: 08.30-16.30 Inclusive of WEEKENDS AND BANK HOLIDAYS



SUDIC FLOWCHART FOR CONSULTANT PAEDIATRICIANS ON DUTY; OUT OF HOURS UNEXPECTED DEATHS: [16:30 to 08:30 hrs] 7 Days a Week



APPENDIX 8:

Consent letters (if child died from natural causes and a death certificate can be issued):
Consent Letter to take a Child's Body Home from Worcestershire Acute Hospital
Consent Letter to take a Child's Body from Worcestershire Acute Hospital to Acorns
Consent Letter to take a Child's Body from Home to Acorns Hospice

Worcestershire Health and Care NHS
NHS Trust

ORCHARD SERVICE
(Community Children's Nursing & Palliative Care Team)

Non-emergency Health/OOH GP – 111
Non-emergency Police – 101

Consent Letter to take a Child's Body Home from Worcestershire Acute Hospital

Letter of Consent to take a Child's Body Home by Car.

Date & Time :

To whom it may concern.

Re : name : _____

NHS no : _____

D.O.B : _____ Date and time of death _____

Address : _____
_____

G.P : _____

The family of the above named child is taking their child home from hospital.

The child died at Worcestershire Acute Hospital on Riverbank/…….. and their family wish to have their child at home.

The child died of natural causes and the doctor/s is /are happy to issue the Death Certificate.
Name of doctor/s :

If you need confirmation of these details please contact the Hospital on:

…… , but additional information cannot be given without the permission of the parents.

Yours faithfully ,

Nurse in charge : ……..

Print name ……..

Worcestershire Health and Care NHS
NHS Trust

ORCHARD SERVICE
(Community Children's Nursing & Palliative Care Team)

Non-emergency Health/OOH GP – 111
Non-emergency Police – 101

Consent Letter to take a Child's Body from Worcestershire Acute Hospital to Acorns

Letter of Consent to take a Child's Body by Car to Acorns Hospice.

Date & time :

To whom it may concern.

Re : name : _____

NHS no : _____

D.O.B : _____

Address : _____

_____

G.P : _____

The family of the above named child is taking their child from hospital to Acorns Hospice.

The child died at Worcestershire Acute Hospital on Riverbank/…….. and their family wish to have their child cared for in Special Bedroom at Acorns Hospice.

The child died of natural causes and the doctor/s is /are happy to issue the Death Certificate.
Name of doctor/s :

If you need confirmation of these details please contact the Hospital on:

…… , but additional information cannot be given

without the permission of the parents.

Yours faithfully ,

Nurse in charge : ……..

Print name ……..

Worcestershire Health and Care NHS
NHS Trust

ORCHARD SERVICE
(Community Children's Nursing & Palliative Care Team)

Non-emergency Health/OOH GP – 111
Non-emergency Police – 101

Consent Letter to take a Child's Body from Home to Acorns Hospice

Date & time :

To whom it may concern.

Re : Name : _____

NHS no : _____

D.O.B : _____ Date and time of death : _____

Address : _____

_____

G.P : _____

The family of the above named child is taking their child from home from Acorns hospice.

The child died of natural causes .

If you need confirmation of these details please contact the Consultant on:

…… , but no additional information cannot be given without the permission of the parents.

Yours faithfully ,

Orchard Nurse : ……..

Print name ……..

APPENDIX 9:
Equality Impact Assessment Tool

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire and Worcestershire Safe and effective health and care services

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	X	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Susan Smith + Prakash Kalambettu**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Susan Smith	W&C Governance Lead	Susansmith36@nhs.net
Date assessment completed			

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Clinical Guideline			
What is the aim, purpose and/or intended outcomes of this Activity?	To provide guidance Investigation of Sudden and Unexpected Deaths in Children Under 18 Years			
Who will be affected by the development & implementation of this activity?	❑ ❑ ❑	Service User Patient Carers Visitors	❑ ❑ ❑ ❑	Staff Communities Other _____

Is this:	❑ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	N/A
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	
Summary of relevant findings	

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		X		
Disability		X		
Gender Reassignment		X		
Marriage & Civil Partnerships		X		
Pregnancy & Maternity		X		
Race including Traveling Communities		X		
Religion & Belief		X		
Sex		X		
Sexual Orientation		X		
Other		X		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)				
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		X		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	With any changes to national guidance and policy about regarding Investigation of Sudden and Unexpected Deaths in Children Under 18 Years			

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	Susan Smith
Date signed	06.02.2023
Comments:	
Signature of person the Leader Person for this activity	Susan Smith
Date signed	06.02.2023
Comments:	

Financial Risk Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document: SUDIC Policy	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.

Contribution/Consultation List: SUDIC Policy

Key individuals involved in developing the document

Name	Designation
Dr Clare Onyon	Named Consultant Paediatrician for SUDIC (WAHT)
Dr P Kalambettu	Named Consultant Paediatrician for Safeguarding Children (WAHT)

Circulated to the following individuals for comments

Name	Designation
Paula Gardner	Chief Nursing Officer
Dr Christine Blanshard	Chief Medical Officer
Becky Williams	Director of Operations, W&C
Dr Jenny Edmunds	Designated SUDIC Paediatrician for County
Ellen Footman	Designated Nurse Safeguarding Children
Deborah Narburgh	Head of Safeguarding (WAHT)
Dr Mary Hanlon	Named Consultant Paediatrician for Safeguarding Children (WAHT)
Julia Greer	Lead SUDIC Coordinator for County
Mr D D W Reid	HM Senior Coroner for Worcestershire
Chris Watson	DCI for SUDIC
Dr B Kamalarajan	Consultant Paediatrician
Mr A Thompson	Consultant Obstetrician-Gynaecologist/Clinical Director
Dr N Ahmad	Consultant Paediatrician
Dr M Ahmed	Consultant Paediatrician
Dr T Dawson	Consultant Paediatrician
Dr A Gallagher	Consultant Paediatrician
Dr L Harry	Consultant Paediatrician
Dr K Nathavitharana	Consultant Paediatrician
Dr W Shinwari	Consultant Paediatrician
Dr P Van Der Velde	Consultant Paediatrician
Dr V Weckemann	Consultant Paediatrician
Dr J West	Consultant Paediatrician / Clinical Director
Dr P Watson	Consultant Paediatrician
Dr D Lewis	Designated Doctor for Childrens Safeguarding and community Paediatric consultant
Mrs B Williams	Consultant A&E, WRH
Mr R Hodson	Consultant A&E, WRH
Mr Abdul Jalil	Consultant A&E, Alexandra Hospital
Gemma Watkin	Senior Nurse - A&E AH
Clare Bush	Matron – A&E WRH
Dana Picken	Matron, Paediatrics
Lara Greenway	Matron Neonates
Becky Magan	Ward Manager, Riverbank Ward
Trudy Berlet	Bereavement Support Midwife
Kate Birch	Named Midwife Safeguarding
Sam Dixon	Named Nurse Safeguarding Children
Dr Mary Ashcroft	Laboratory Director Microbiology
Dr Thekli Gee	Laboratory Director Microbiology
Dr Chandrashekar Shetty	Laboratory director Clinical Biochemistry
Dr Mike Cornes	Laboratory Director Cellular Pathology
Dr I Nagra	Clinical Director - Radiology
Dee Johnson	Head of Clinical Governance and Clinical Risk
Jane Clavey	Head of Legal Service
Susan Smith	Quality Governance Lead for Women's and Childrens
Sheryl Thomas	Mortuary Manager