



GIG  
CYMRU  
NHS  
WALES

Iechyd Cyhoeddus  
Cymru  
Public Health  
Wales

# Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 1 of 48	

## Table of Contents

<b>1. Introduction</b>	3
<b>2. Flowchart of PRUDiC</b>	5
<b>3. Definition of an Unexpected Death of a Child</b>	7
<b>4. Expected Deaths in Childhood</b>	9
<b>5. Children with a Reduced Life Expectancy</b>	9
<b>6. When a Child Dies Unexpectedly in Another Area</b>	9
<b>7. Principles of the Procedural Response to Unexpected Deaths in Childhood</b>	10
<b>8. Professionals involved in the PRUDiC</b>	11
<b>9. General Advice for all Professionals when Dealing with the Family</b>	15
<b>10. Issues for Consideration in Relation to the PRUDiC</b>	15
<b>11. PRUDiC Timeline</b>	16
11.4. <b>Phase 1: The Information Sharing and Planning Meeting (within 2 working days)</b>	17
11.5. <b>Phase 1: The Potential Visit to the Place where the Child Died (within 24 hours)</b>	20
11.6. <b>Phase 1: The Post Mortem Examination (within 5 days)</b>	22
11.7. <b>Phase 2: The Case Discussion/Meeting (within 5-7 days)</b>	25
11.8. <b>Phase 3: The Case Review Meeting (within 3-6 months)</b>	26
<b>Appendix 1 Glossary of Terms</b>	30
<b>Appendix 2 Pointers for all Professionals in talking with Bereaved Parents</b>	31
<b>Appendix 3 Sources of Family Support</b>	33
<b>Appendix 4 Seven Key Strands for all Agencies to Consider when a Child dies Unexpectedly</b>	35
<b>Appendix 5 Resources</b>	37
<b>Appendix 6 Role of Police</b>	40
<b>Appendix 7 Role of HM Coroner</b>	41
<b>Appendix 8 Audit Tool for PRUDiC</b>	43
<b>Appendix 9 Membership of the Working Group</b>	48

## 1. Introduction

- 1.1. This procedure sets a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the process of communication, collaborative action and information sharing following the unexpected death of a child.
- 1.2. The procedural response begins at the point of death and ends with the completed report to the National Child Death Review (NCDR) Panel, following the Case Review Meeting when the final results of the post mortem examination have been shared or the inquest or trial has taken place.
- 1.3. This procedural response will be followed when:
- a decision has been made that the death of a child is unexpected or
  - there is a lack of clarity about whether the death of a child is unexpected or
  - the cause of a child's death is not apparent and it is not possible to issue a death certificate
- 1.4. The aim of the PRUDiC is to ensure that the response is safe, consistent and sensitive to those concerned, and that there is uniformity across Wales in the multi-agency response to unexpected child deaths.
- 1.5. This is a multi-agency procedural response, and is not agency or discipline specific. It outlines what needs to be achieved and gives broad suggestions about the roles of agencies. It does not replace existing internal agency or professional procedures, although it may generate a review of those procedures to ensure consistency across Wales.
- 1.6. The procedural response sets out a structure within which reasoned judgements can be made when evaluating an unexpected child death on the basis of all available information. It is important therefore that all staff remain open-minded when considering any death and avoid reaching conclusions inappropriately outside of the agreed processes.

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 3 of 48	

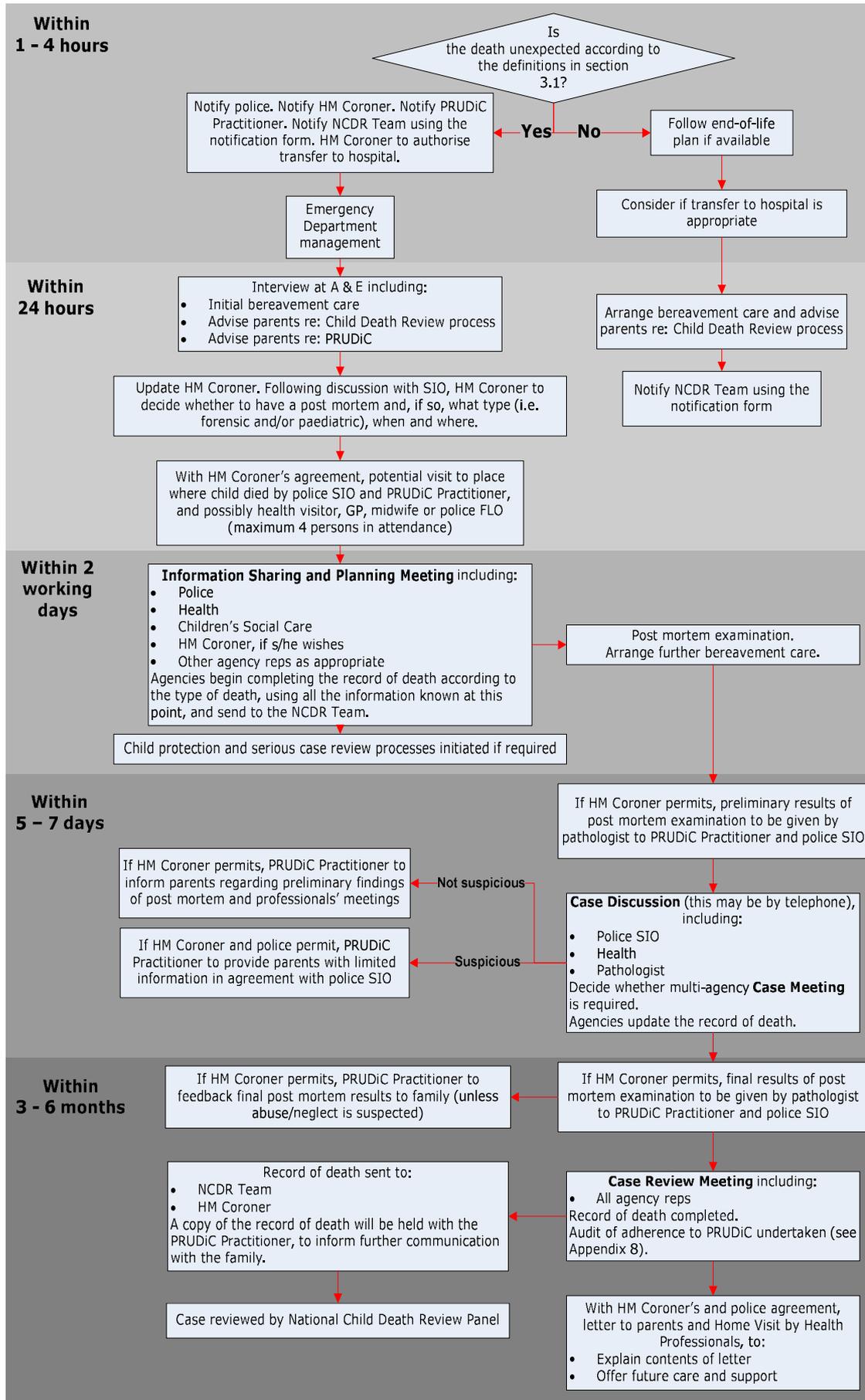
- 1.7. The procedural response will be coordinated on behalf of HM Coroner by the police, or by local agreement the PRUDiC Practitioner (a specialist health professional). It recognises that HM Coroners are independent judicial officers and it does not create any legally enforceable rights, obligations or restrictions upon them.
- 1.8. The role of the PRUDiC Practitioner is described in Section 8.5. The PRUDiC Team consists of professionals who were involved with the child before their death, or as a result.
- 1.9. Throughout this procedure, the term 'parent' is used to refer to any parent or carer, including the person with a Special Guardianship Order or Residence Order, foster parents and the local authority for looked after children.
- 1.10. All child deaths that are unexplained or unnatural are notified to HM Coroner as soon as the fact of death has been confirmed and consideration is given to the need for a full police/coroner's investigation, including an inquest.
- 1.11. HM Coroner, through the police Senior Investigating Officer (SIO) and the PRUDiC Practitioner, will decide which elements of this PRUDiC are to be followed depending on the circumstances of that particular case. For example, where the death does not occur at home it may not be appropriate or necessary for a home visit to be done. At each stage in the process, explicit consideration must be given to whether child abuse/neglect may have been a contributory factor.
- 1.12. The procedural response will enable the capturing of immediate information about unexpected child deaths. At a national level, a number of templates have been developed to assist in the collection of information regarding child deaths: a notification form and a record of death according to the type of death (see Appendix 5 for a link to Forms). Collective information on cases will inform the NCDR Panel Meeting and consequently the learning about trends and patterns in child deaths, to generate and influence future prevention strategies.

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 4 of 48	

## 2. Flowchart of PRUDiC

HM Coroner, through the police SIO and PRUDiC Practitioner, will decide which elements of this flowchart are to be followed depending on the circumstances of the particular case. For example, if the child is obviously dead **AND** there are suspicious circumstances the body should **NOT** be moved, or in the case of a clear homicide, elements of the flowchart may be inappropriate.

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 5 of 48	



### 3. Definition of an Unexpected Death of a Child

#### 3.1. The unexpected death of a child has been defined as:

'The death of a child which was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death'.<sup>1</sup>

However, it is recognised that this definition may have limitations in that many children with a reduced life expectancy will not be seen by any professional 24 hours before their death due to the chronic nature of their conditions and the unpredictability of death in childhood. Where an end-of-life plan is in place for such children, the following definition of the unexpected death of a child will be considered:

'The death of a child where there is no known antecedent condition that might be expected to cause the death at that time, and the child dies either immediately or subsequently from the consequences of the precipitating event or collapse'.<sup>2</sup>

The second part of this definition is especially relevant when there is a significant time delay between the collapse of the child and the eventual death.

#### 3.2. The PRUDiC applies to all unexpected deaths in children from birth until the 18<sup>th</sup> birthday, whether from natural, unnatural, known or unknown causes, at home, in hospital or in the community. This includes road traffic collisions, apparent suicides and murders. This does not include stillbirths and the death of pre-viable babies born before 24 weeks.

#### 3.3. If a baby dies within 24 hours of birth whilst under medical supervision, (whether in a medical setting or not), with **no** immediate medical explanation apparent for the death, the situation will be discussed with

<sup>1</sup> Fleming et al.

<sup>2</sup> American Academy of Paediatrics

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 7 of 48	

the PRUDiC Practitioner. The PRUDiC Practitioner and the responsible paediatrician will make a decision, informed by the circumstances surrounding the death and information available to them within health, as to whether the case should be regarded as an unexpected death and so fall within the PRUDiC.

- 3.4. If a baby dies within 24 hours of birth whilst under medical supervision, (whether in a medical setting or not), and there is a clear medical explanation for the death, this will **not** be treated as an unexpected death.
- 3.5. Unexpected deaths include those of children with existing medical conditions or disabilities (including those that are life limiting or life threatening), when death **at the time that it occurred** was not expected as a natural consequence of that condition. End-of-life plans and discussion with the child's palliative care team may assist in determining whether a child death is unexpected.
- 3.6. Where professionals are uncertain about whether the death is unexpected, the PRUDiC Practitioner will be consulted. The PRUDiC Practitioner will make a decision on whether or not the PRUDiC should be followed based on the information available to them at the time and liaison with the coroner. In such cases of uncertainty about whether the death is unexpected, an interim decision may be made by the nominated healthcare professional when the PRUDiC Practitioner is unavailable e.g. on leave, unwell etc., but this must be reviewed by the PRUDiC Practitioner on return. The final decision cannot be delegated, and must be recorded with clear reference to who was involved in the discussion. If in doubt, the death will be treated as unexpected and this procedure will be followed until the available evidence enables a different decision to be made.
- 3.7. The PRUDiC Practitioner and the nominated healthcare professional can access support and guidance from the National Child Death Review (NCDR) Team in undertaking their role.

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 8 of 48	

#### **4. Expected Deaths in Childhood**

- 4.1. Deaths identified from the outset as falling outside the definition of an unexpected death need not be subject to this PRUDiC but must be notified to the NCDR Team by the professional who confirms the fact of death, using the notification form (see Appendix 5 for a link to Forms).
- 4.2. Care and support should be provided to the family by the Health Team involved with the child and the family should be informed at an appropriate time of the National Child Death Review process.

#### **5. Children with a Reduced Life Expectancy**

- 5.1. There will be some deaths, for example in children with a life limiting illness or in profoundly disabled children with a reduced life expectancy, where the death at that time is unexpected. The police and/or PRUDiC Practitioner must ensure that full consultation takes place with the palliative care professionals working with the child and family, who will have an understanding of the child's condition and the nature of life limiting/life threatening conditions of childhood. If necessary, other involved professionals e.g. community paediatricians/neurologists, will also be consulted, in order to determine whether the PRUDiC should be triggered.
- 5.2. If the PRUDiC has been triggered, the palliative care lead paediatrician will be invited to participate in the subsequent process including the information sharing meetings.
- 5.3. For deaths that are expected, and where the doctor is able to issue a medical certificate of the cause of death, any end-of-life plan will be followed where possible, in discussion with the team who knew the child.

#### **6. When a Child Dies Unexpectedly in Another Area**

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 9 of 48	

- 6.1. The area in which the death of a child has been declared must take initial responsibility for convening and coordinating the PRUDiC, and may decide to implement the PRUDiC in its entirety depending on the circumstances of the case. Otherwise, agreement for handover will be secured with the area where the child is normally resident and the PRUDiC will be completed at that location.
- 6.2. When a child who is normally resident in a particular area dies in a different area, the medically qualified practitioner who confirms the death will inform the NCDR Team using the notification form. This will be done as soon as possible after the child has been confirmed dead. The NCDR Team will inform the PRUDiC Practitioner where the child normally resided of the death, and that PRUDiC Practitioner will inform the relevant professionals in that area.
- 6.3. Where notified of a death abroad, the professionals responsible for child death in the local authority where the child is normally resident will consider implementing this procedure as far as is practically possible and fully record any decisions made.

## **7. Principles of the Procedural Response to Unexpected Deaths in Childhood**

- 7.1. The following principles will be adhered to at all times:
- respect, sensitivity, open mind, and discretion
  - achieving a balance between forensic and medical requirements and family support
  - a multi-disciplinary approach
  - sharing of information
  - ensuring equality of service, including the access and communication needs of disabled people
  - recognising cultural needs, including language, faith and ethnicity
  - preserving evidence
  - good record keeping

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 10 of 48	

- conducting enquiries expeditiously so that there are no unnecessary delays to the funeral
- working to the guidance as set out in this procedural response

7.2. In applying the above principles, individuals and agencies should ensure that their actions are legal, necessary, relevant and proportionate in order to comply with the [Children Act 1989](#), [Health Records Act 1990](#), [Human Rights Act 1998](#), [Children Act 2004](#) and [The United Nations Convention on the Rights of the Child](#).

## 8. Professionals involved in the PRUDiC

8.1. **Emergency Services** - will follow their own protocols to ensure life is preserved, and the child will be taken directly to an A & E department, unless that child is obviously dead **AND** there are suspicious circumstances where removing the body from the scene could cause loss of evidence. The first police officer on the scene will make this decision, seeking advice from a police SIO where necessary (see Appendix 5 for a link to JRCALC guidelines).

8.2. **Responsible Paediatrician** - all children who have died unexpectedly will be taken to A & E at the appropriate hospital, unless removal of the body could cause loss of evidence (see section 8.1). The death of the child will be confirmed by a medically qualified practitioner, usually the paediatric consultant. It is this medically qualified practitioner's responsibility to:

- notify the NCDR Team of the death using the notification form, by the next working day at the latest
- inform key professionals as quickly as possible following the death, which includes the police SIO, the PRUDiC Practitioner and the coroner. The police SIO will be informed via the Police Public Protection Unit or the Police Operations Room. **The relevant professionals will be informed by the next working day at the latest.**

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 11 of 48	

- liaise with the coroner regarding samples or specimens that may require to be taken before the post mortem examination<sup>3</sup>
- provide the coroner and pathologist with a full briefing on the history and physical findings at presentation.

Subsequent management within Health will remain with the PRUDiC Practitioner.

8.3. **HM Coroner/Coroner's Officer** – local arrangements may allow for a coroner's officer in attendance at the hospital to take an initial history and to inform the PRUDiC Practitioner of any relevant information by the next working day.

8.4. **National Child Death Review (NCDR) Team** – must be informed of all child deaths by the notification form (see Appendix 5 for a link to Forms) as soon as is reasonably practicable and in any case on the next working day. The NCDR Team will provide a single point of contact and consistency in the gathering of information. The NCDR Team will notify the PRUDiC Practitioner in the area in which the child resided, if this is different from the area in which the hospital is located. It is unlikely that unexpected child deaths will not come to the immediate attention of the relevant agencies. However, in order to ensure that no child death is missed, the NCDR Team will develop relationships with the coroner's office, the Registrar of Deaths and LSCBs.

8.5. **PRUDiC Practitioner** –

This role involves:

- making the final decision regarding whether a death is unexpected, in consultation with the responsible paediatrician (only where professionals are uncertain about whether the death is unexpected)

<sup>3</sup> Material can only be taken from a body after death on premises that are licensed by the Human Tissue Authority.

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 12 of 48	

- leading the coordination of multi-agency activity and information sharing within Health, throughout the PRUDiC
- leading the collation of agency information held in relation to the child or family
- notifying the relevant agencies, including the coroner, of the death
- notifying the police (if not already aware)
- notifying the Named and/or Designated Doctor for Child Protection
- checking whether the child is known to children’s social care
- informing key senior service managers within children’s social care who may have contact with the family
- arranging with medical staff for the documentation of initial findings and interventions, examination of the child, initial support for families, and initial history taking
- liaising where necessary with the coroner in respect of timing of the post mortem examination
- agreeing the timing of the visit to the place where the child died with the police
- undertaking the visit to the place where the child died
- providing the coroner and pathologist with a full briefing on the findings of the visit to the place where the child died, with the police SIO
- ensuring full liaison with the police in the event of a suspicious death (in which case the police SIO will decide what information is disclosed to parents and how)
- ensuring all agencies are notified and actions are agreed, with support from the NCDR Team
- ensuring the notification form is completed (see Appendix 5 for a link to Forms) and sent to the NCDR Team
- ensuring that a full and accurate record of death is provided to the NCDR Team, to be completed where appropriate according to the type of death (see Appendix 5 for a link to Forms).
- ensuring an audit of adherence to this PRUDiC is undertaken for each case using the form in Appendix 8.

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 13 of 48	

The following actions will normally be undertaken by the police, but may be assigned to the PRUDiC Practitioner by local agreement:

- ensuring an initial Information Sharing and Planning Meeting takes place, usually within 2 working days of the death
- ensuring a Case Discussion/Meeting takes place, usually within 5-7 days of the death
- ensuring a formal Case Review Meeting takes place, usually within 3-6 months of the death, although this may be predicated by the post mortem examination, inquest or other investigations

**8.6. Police SIO (Senior Investigating Officer)** – where the provisions set at 1.3 of this procedure are met, an SIO will be appointed and take responsibility for the management of police resources and for ensuring appropriate and proportional lines of enquiry are instigated. SIO appointments will be in accordance with Force policy and in consideration of ACPO national guidance. For Road Death the SIO responsibilities will be performed by a Road Death SIO. Where circumstances indicate that attendance at the scene will benefit the enquiry, an experienced detective officer will be tasked to immediately attend the scene. SIOs should be mindful that there may not be any obvious suspicious circumstances and that scene attendance by appropriately experienced officers or staff may benefit the enquiry. This is the case if the child is still at the scene or if the child has been removed to hospital. Where the possibility of child abuse or neglect is present, it is further recommended that this detective officer has child protection experience. The police SIO may allocate a police SPOC (Single Point of Contact) to assist with inter-agency communication.

**8.7. Additional Professionals** – include the GP, health visitor, school nurse, children’s community nurse, midwife, pathologist, social worker, head teacher and any other relevant professionals, e.g. palliative care, adult psychiatrist or community psychiatric nurse if there are parental mental health problems.

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 14 of 48	

## 9. General Advice for all Professionals when Dealing with the Family

9.1 This is a very difficult time for everyone. The time spent with the family may be brief but actions will greatly influence how the family deals with the bereavement for a long time afterwards. A sympathetic and supportive attitude whilst maintaining professionalism towards the investigation is essential. Grief reactions will vary; individuals may be shocked, numb, withdrawn or hysterical. (See Appendix 2 for Pointers for all Professionals in talking with Bereaved Parents and Appendix 3 for Sources of Family Support).

- Handle the child with naturalness and respect, as if the child were still alive.
- Always refer to the child by name.
- Deal sensitively with religious beliefs and cultural differences, while remembering the importance of evidence preservation.
- Give families time and opportunity to ask questions.
- Give your written contact name and telephone number to the family.
- Address practical issues e.g. where the child will go, what will happen including the PRUDiC, when they will see the child, and communicate sensitively to families.

## 10. Issues for Consideration in Relation to the PRUDiC

10.1. The PRUDiC timeline (involving three phases) is described in section 11. Within the three phases there are seven key strands for all agencies to consider when a child dies unexpectedly. (See Appendix 4 for further information on the seven key strands.)

The seven key strands are:

**a) Care of the Bereaved Family** (see Appendix 3 for Sources of Family Support)

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 15 of 48	

**b) Deciding on the Response**

**c) Notification to the NCDR Team** (see Appendix 5 for a link to Forms)

**d) Child Protection** (see Appendix 5 for a link to All Wales Child Protection Procedures)

**e) Serious Case Review****f) Media Issues****g) Support to Staff****11. PRUDiC Timeline**

11.1. The PRUDiC timeline involves three phases:

- Phase one (usually 0-5 days): the management of information sharing from the point at which the child's death becomes known to any agency until the initial post mortem examination has been completed
- Phase two (usually 5-7 days): the management of information sharing once the initial results of the post mortem examination are available
- Phase three (usually 3-6 months): the management of information sharing including the Case Review Meeting when the final post mortem report is available

11.2. In principle it is recognised that all information relevant to the enquiry should be shared by all agencies. However the police and coroner may consider certain information sub judice or subject to continuing investigation which may preclude it being released in an open forum. In some circumstances this may include the preliminary and final results of the post mortem examination. In these cases the amount of information released from the police investigation to these meetings

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 16 of 48	

must be considered sufficient to inform on the relevant issues. In particular, information shared must have regard to the welfare of other children in the household who may be at risk of harm. Any decision not to share information will be recorded by the police SIO in the police policy book.

11.3. The police SIO, or by local agreement the PRUDiC Practitioner, is responsible for ensuring that accurate records of each information sharing meeting/discussion are maintained and all decisions documented.

11.4. **Phase 1: The Information Sharing and Planning Meeting (within 2 working days)**

The police SIO, or by local agreement the PRUDiC Practitioner, will convene and chair an initial information sharing and planning meeting. The meeting will be convened within two working days of the unexpected or unexplained death, and in most cases prior to the post mortem examination. In some circumstances a discussion may take place by telephone, for example, in order to arrange a visit to the place where the child died and determine who will attend (which should be undertaken within 24 hours of the child's death), or if relevant professionals are unable to attend this meeting within the timescale.

11.4.1. The purpose of the Information Sharing and Planning Meeting is:

- to plan and determine the process of the investigation and arrange for the family support needs to be met
- to determine which professional/agency will lead the multi-agency investigation
- to collate all relevant information to share with the coroner and pathologist prior to the post mortem examination
- to arrange the visit to the place where the child died (see section 11.5), if this has not yet taken place

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 17 of 48	

- to review the findings from the visit to the place where the child died (see section 11.5), if this has already taken place
- to determine which professional/agency will inform families and carers of the National Child Death Review process and provide them with an 'Information for Families and Carers' leaflet
- to determine which professional/agency will be a single point of contact for the family
- to agree who will have responsibility for any actions agreed and for convening future information sharing meetings including when and where these will take place
- 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 or child care concerns, previous unexplained or unusual deaths in the family, neglect, failure to thrive, medical conditions including family history of medical conditions, 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 in the household, and to consider the need for child protection procedures
- to ensure a coordinated bereavement care plan for the family including siblings
- to ensure a coordinated bereavement care plan for the child's immediate peer group, who may benefit from counselling and informed liaison with school teachers
- to discuss any need for action in respect of other children in the family e.g. health overview
- to ensure the notification form has been completed (see Appendix 5 for a link to Forms) and sent to the NCDR Team

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 18 of 48	

- to complete the record of death according to the type of death (see Appendix 5 for a link to Forms), using all information known at this point, and send to the NCDR Team
- to ensure agencies are collecting information in order that the record of death may be completed at the final Case Review Meeting

11.4.2. Where child protection (CP) concerns are identified, the CP and PRUDiC processes will run in parallel. The CP process will not be a substitute for the PRUDiC process, but one will inform the other and vice versa. If CP concerns are identified when the information is shared, a Strategy Meeting will be held chaired by the lead agency (Social Services), according to timescales and processes defined within the All Wales Child Protection Procedures. The Chair of the Local Safeguarding Children Board (LSCB) will be notified for consideration of a Serious Case Review.

11.4.3. The Information Sharing and Planning Meeting will include:

- **Police** – The police SIO/detective inspector who ideally has child protection experience.
- **Health** – Where appropriate, the PRUDiC Practitioner, the responsible paediatrician, the child’s consultants pre-death, the pathologist, the named health visitor, the school nurse, the children’s community nurse, the community midwife, the general practitioner, psychiatrist/community psychiatric nurse and the ambulance service.
- **Local Authority Children’s Social Care** – A senior children’s social care representative (Senior Practitioner or Team Manager).
- **HM Coroner/Coroner’s Officer** – Attending this meeting will be a matter for the coroner’s professional judgement.

Some coroners will not attend, given that the verdict at inquest must be based solely on the evidence given in court; other coroners will attend, given that the meeting may inform and assist the course of their investigation leading to inquest.

- **Other contributors** - Education (where the child was attending school or nursery), the named professionals for child protection, and any other agency/person that may have a contribution to make, e.g. drug/alcohol services, Youth Offending Team.

11.4.4. This meeting will not be delayed if professionals outside of the PRUDiC core membership (paediatrics, social care, police) are unavailable.

#### 11.5. **Phase 1: The Potential Visit to the Place where the Child Died (within 24 hours)**

11.5.1. The purpose of the home visit is to:

- review initial history taken in the emergency department and obtain further details particularly in relation to the circumstances of the death
- review whether there is any additional information that could raise concerns about the possibility of abuse or neglect having contributed to the death
- evaluate the environment where the child died/collapsed
- provide support to the family
- inform the family of further stages of the investigation, including the need for and nature of the post mortem examination

11.5.2. The following principles will be taken into account when deciding whether a home visit will take place:

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 20 of 48	

- Visits will not be made to scenes of crime, without the consent of the police
- Visits will not take place to scenes of road traffic collisions
- Visits must add value to the process
- Safety is paramount, and health professionals will not attend the homes of families *on their own*, where a child died under suspicious circumstances

11.5.3. **For all children under two years of age who have died suddenly and unexpectedly, a home visit will be undertaken within 24 hours (usually the same day). If it is a suspected scene of crime, consent from the police will be required before undertaking the visit.**

11.5.4. In respect of older children, decisions regarding the appropriateness of a visit to the place where a child died will be taken by the police SIO, in discussion with the PRUDiC Practitioner. Where agreed, this visit will take place **within 24 hours** of the child's death. If the visit is not undertaken within this timescale, the reasons for this will be documented by the PRUDiC Practitioner.

11.5.5. If it is deemed appropriate to undertake a visit to the scene of death, the police SIO and PRUDiC Practitioner will plan the arrangements including when to undertake the visit and who will provide the lead, taking into account the need to be sensitive to bereaved families. The reason for the scene/home visit must be explained fully to parents and informed consent obtained from the parents and/or other appropriate person e.g. house or premise owner, if the death did not occur in the family home.

11.5.6. The visit ideally will be undertaken by the police SIO and PRUDiC Practitioner but the task can be delegated by the police SIO to other professionals within the police, as appropriate.

- 11.5.7. Where possible, a health visitor, GP, midwife or other similar professional who has had previous contact with the family may also participate in the home visit to provide support. If a family liaison officer has been deployed at this stage, that FLO will attend as well. There should be no more than four persons in attendance at any one time.
- 11.5.8. There may be situations where, for pragmatic reasons, or because of the nature of the death, a joint visit is not possible or appropriate, or where the police need to visit the scene of death early to gather forensic evidence. If separate visits are conducted, the relevant professionals will confer in their assessment.
- 11.5.9. It is important that detailed records of the history and examination findings are made, which must be dated and signed by the health professionals making the visit. As far as possible, accounts will be recorded using the parent's own words.
- 11.5.10. Permission for any information to be shared with the parents will need to be sought from the police if a criminal investigation is ongoing, and in all cases from the coroner, and agreed with other professionals as appropriate.
- 11.5.11. The coroner's officer will be provided with a summary of the information obtained from the home/scene visit by the police SIO.

#### **11.6. Phase 1: The Post Mortem Examination (within 5 days)**

- 11.6.1. In all cases a post mortem examination will be performed unless a registered medical practitioner is able to provide a Medical Certificate of Cause of Death, or the coroner otherwise decides.

- 11.6.2. The post mortem examination will be authorised by the coroner, and should be carried out as soon as possible after the visit to the place where the child died and the Information Sharing and Planning Meeting, unless dictated by a possible public health issue. Any decisions relating to the process and location of the post mortem examination are a matter for the coroner. The post mortem examination will be undertaken in accordance with the guidelines and protocols laid down by the Royal College of Pathologists (see Appendix 5 for a link).
- 11.6.3. Prior to commencing the post mortem examination, the coroner and pathologist will be given a full briefing on the history and the physical findings at presentation, and the findings of the death scene investigation by the police SIO and the PRUDiC Practitioner.
- 11.6.4. Any photographs or video recordings of the child or the scene will be made available to the coroner and pathologist. The pathologist will also be provided with a report and/or images from the paediatric radiologist relating to the skeletal survey. It is the responsibility of the pathologist to ensure the skeletal survey is completed prior to the post mortem examination.
- 11.6.5. Where possible there will be an information sharing discussion between the PRUDiC Practitioner and the pathologist before the post mortem examination to identify outstanding or unsuspected issues and to ensure accurate understanding of information.
- 11.6.6. If the responsible paediatrician has arranged any laboratory investigations before death, the coroner and the pathologist will be informed prior to the post mortem examination, and the results made available as soon as possible.
- 11.6.7. The coroner's officer will on request inform all relevant professionals of the time and place of the post mortem examination, including the police SIO and the PRUDiC

Practitioner. The family will also be informed by the coroner's officer or the FLO (if an FLO has been deployed).

- 11.6.8. Where the possibility of neglect or abuse is raised, the involvement of a pathologist with forensic skills is essential.
- 11.6.9. When the death is thought to have been from natural causes but the possibility of neglect or abuse in the past is considered, the All Wales Child Protection Procedures must be followed where this raises concerns for other children.
- 11.6.10. The police SIO or their deputy will attend the post mortem examination, if the police have sought from HM Coroner a forensic post mortem examination conducted by a Home Office pathologist. If it is not possible for the police SIO to attend, then s/he must send a representative who is aware of all of the facts of the case and who can provide a full briefing of relevant information which may assist the pathologist. The police SIO will decide appropriate resources to attend in line with ACPO guidelines. As a minimum this would normally involve an experienced detective who can represent the interests of the investigative team. S/he may be supported by the Crime Scene Investigator, Crime Scene Manager and Exhibits Officer, as directed by the police SIO.
- 11.6.11. The interim and final findings of the post mortem will be sent to the coroner immediately the post mortem examination is completed. A copy of the post mortem report will then be sent to the police SIO if a forensic post mortem examination has been conducted and, if the coroner consents, to the PRUDiC Practitioner.
- 11.6.12. The release of the child's body is a matter for the coroner, in consultation with the police SIO if a forensic post mortem examination has been conducted.

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 24 of 48	

- 11.6.13. If the coroner consents, the PRUDiC Practitioner will feedback the preliminary and final post mortem results to the family. If abuse or neglect is suspected and/or the police are undertaking a criminal investigation, the coroner and police will advise the PRUDiC Practitioner what information can be shared with the parents and when.
- 11.6.14. The PRUDiC Practitioner will inform children’s social care if child protection concerns have arisen during the post mortem examination and there are other children living in the household.
- 11.6.15. Where the cause of death has not been determined at the post mortem examination or the death may have been unnatural, the coroner will in due course hold an inquest.
- 11.6.16. The police/coroner’s officer will prepare a report for the coroner once information relevant to the investigation has been gathered. This report is intended to form the basis of the coroner’s inquest.

**11.7. Phase 2: The Case Discussion/Meeting (within 5-7 days)**

- 11.7.1. There will be a further Case Discussion convened by the police SIO or by local agreement the PRUDiC Practitioner. This will also involve the pathologist, and may take place by telephone. If permission is given by the coroner, the preliminary results of the post mortem examination will be made available to inform this discussion.
- 11.7.2. If necessary, a Case Meeting may be held at this stage, to ensure that all agencies are informed and updated and that any concerns are identified and managed. The decision to hold the Case Meeting rests with the police SIO or by local agreement the PRUDiC Practitioner, however all agencies have a responsibility to ensure that any concerns they may have surrounding the death are passed to the police SIO or

the PRUDiC Practitioner to inform this decision. All relevant health and children's social care professionals and relevant professionals from other agencies will be invited to attend the Case Meeting.

11.7.3. The purpose of the Case Discussion/Meeting is to:

- ensure the right support is available to the family
- ensure all agencies are aware of their roles and responsibilities
- review the findings from the visit to the place where the child died (see section 11.5)
- review the preliminary results of the post mortem examination (if available)
- identify any safeguarding concerns around surviving children and refer accordingly to children's social care according to All Wales Child Protection Procedures
- ensure agencies are collecting information for the record of death (see Appendix 5 for a link to Forms), in order that this form may be completed at the final Case Review Meeting
- identify what further investigations or enquiries are required, agree which agency will undertake each task and agree timescales (which may not exceed those set out in this PRUDiC) for doing so. If abuse or neglect appears to be possible, children's social care, the LSCB Chair and the police will be informed and serious case review procedures considered.

11.7.4. The coroner will be informed of any relevant new information coming to light as a result of these considerations. This will be the responsibility of the police SIO.

### 11.8. Phase 3: The Case Review Meeting (within 3-6 months)

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 26 of 48	

- 11.8.1. A multi-agency Case Review Meeting is to be held as soon as possible once the results of all relevant investigations have been obtained. The final results of the post mortem examination will be necessary to inform this Meeting. These are usually available within three months of the child's death, but may not be available until after the inquest. Release of the final results of the post mortem examination is at the coroner's discretion. This is more likely if the inquest or trial has been concluded.
- 11.8.2. All relevant records will be available at this meeting, including the minutes and decisions of the initial Information Sharing and Planning Meeting and the Case Discussion/Meeting. If this meeting is held after the inquest, consideration should be given to applying to the coroner for a transcript of the evidence, particularly if no professional at the meeting attended the inquest and significant issues have arisen.
- 11.8.3. This meeting will be convened and chaired by the police SIO, or by local agreement the PRUDiC Practitioner, and will involve those invited to the previous information sharing meetings.
- 11.8.4. The purpose of the Case Review Meeting is to:
- share information to identify those factors that may have contributed to the death, and where an inquest has **not** been opened, to identify the cause of death
  - explicitly address the possibility of abuse or neglect as causes or contributory factors in the death; this will be recorded. Consideration will be given to whether a Serious Case Review is required. If no evidence is identified to suggest abuse or neglect, this will be documented as part of the report of the meeting.
  - identify potential lessons to be learnt
  - identify issues for consideration by the NCDR Panel

- identify training requirements
- agree how the parents will be informed about the outcome of the meeting, including the results of the post mortem examination (if the coroner has given prior permission and the parents have not already been notified). Information sharing with families must be consistent with the requirements of the coroner and the police enquiries.
- agree how families will be provided with on-going support, giving consideration to siblings and the immediate peer group who may require specialist support services, experienced in working with children and young people. Referral to a school based counselling service, if available, may be necessary.
- agree how families will be given the opportunity to have their views taken into account by the NCDR Panel.
- complete the record of death according to the type of death (see Appendix 5 for a link to Forms). This will be done by the PRUDiC Practitioner. The completed form will be sent to the NCDR Team and to the coroner, who will take this information into consideration in the conduct of the inquest, if this has not already taken place. A copy of the completed form will be held with the PRUDiC Practitioner, to inform further communication with the family. Where other investigations are ongoing, the meeting will conclude with a record of the current situation.
- ensure that cases are audited/reviewed against the standards set out in this PRUDiC (see Appendix 8 for Audit Tool for PRUDiC).

11.8.5. All available evidence, including the pathologist's report, must be fully reviewed by the police SIO prior to the conclusion of the final Case Review Meeting.

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 28 of 48	

- 11.8.6. The PRUDiC Practitioner will, subject to the coroner's and police approval, write a detailed letter to the parents, giving information concerning the cause of the child's death. Arrangements will be made for the PRUDiC Practitioner and the general practitioner/health visitor/school nurse/midwife jointly to see the parents to explain the contents of the letter, answer any questions, and offer future care and support.
- 11.8.7. If this meeting has taken place before the inquest, consideration will be given to a further meeting after the inquest, including offering the parents an opportunity to ask the PRUDiC Practitioner further questions, if necessary.
- 11.8.8. The National Child Death Review (NCDR) Panel will undertake a review of all deaths of children. This will be a paper exercise based on the information available from those who were involved in the care of the child, before and after the death, and will include the record of death. This information will be used by the NCDR Panel to provide a summary of the case (see Appendix 5 for a link to Forms). The NCDR Team will produce periodic (interval to be agreed) reports for the respective LSCBs listing all deaths and broad category of death e.g. infection, cancer, congenital abnormality, accident. The NCDR Team will facilitate the identification of preventable factors to enable recommendations to be published. These recommendations in particular will focus on issues that may be preventable.

## **Appendix 1 Glossary of Terms**

ACPO – Association of Chief Police Officers

A & E – Accident and Emergency Department

CP – Child Protection

CPS – Crown Prosecution Service

DI – Detective Inspector (Police)

FLO – Family Liaison Officer (Police)

FSID – Foundation for the Study of Infant Deaths

GP – General Practitioner

HMC – Her Majesty's Coroner

JRCALC – Joint Royal Colleges Ambulance Liaison Committee

LSCB – Local Safeguarding Children Board

NCDR – National Child Death Review

NPIA – National Policing Improvement Agency

PRUDiC – Procedural Response to Unexpected Deaths in Childhood

RCPCH – Royal College of Paediatrics and Child Health

RCR – Royal College of Radiologists

SIO – Senior Investigating Officer (Police)

SPOC – Single Point of Contact

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 30 of 48	

## **Appendix 2 Pointers for all Professionals in talking with Bereaved**

### **Parents**

*Adapted from advice given by the Foundation for the Study of Infant Deaths (FSID)*

- 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 for the family's religious beliefs and culture, including burial practices. Be aware that individuals may only adhere to parts of a religion and that there are enormous variations within every set of beliefs.
- Be sensitive to non-traditional family structures, e.g. same sex relationships, stepfamilies, foster parents and grandparents as guardians.
- If English or Welsh are not their first language, an interpreter should be arranged.
- Ask the family how they wish to be addressed, how to pronounce their name and how to spell it. Do not record or address a Muslim man or a Sikh man or woman by his/her religious name alone.
- 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.

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 31 of 48	

- 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.

### Appendix 3 Sources of Family Support

- **The Child Bereavement Charity**

Support for parents and children who have been bereaved.

Helpline: 01494 446648

09.00 - 17.00, Monday - Friday

[www.childbereavement.org.uk](http://www.childbereavement.org.uk)

- **The Child Death Helpline**

The Child Death Helpline is a helpline for anyone affected by the death of a child of any age, from prebirth to adult, under any circumstances, however recently or long ago. Calls are answered by a bereaved parent, trained and supported by professional staff. Please note this is a listening service not a counselling service although they can provide details of services in local areas.

Helpline (Freephone): 0800 282 986

19.00 - 22.00, every evening

10.00 - 13.00, Monday - Friday

13.00 - 16.00, Tuesday - Wednesday

<http://www.childdeathhelpline.org.uk/>

- **The Compassionate Friends**

Support for bereaved parents and their families.

Helpline: 0845 123 2304

10.00 - 16.00/ 19.00 - 22.00, every day

[www.tcf.org.uk](http://www.tcf.org.uk)

- **Cruse Bereavement Care**

Support for anyone who is bereaved.

Helpline: 0844 477 9400

Children and Young People's Helpline (Freephone):

0808 808 1677

09.30 - 17.00, Monday - Friday

[www.cruse.org.uk](http://www.cruse.org.uk)

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 33 of 48	

- **The Foundation for the Study of Infant Deaths**

Support and information for anyone who has suffered the sudden death of an infant, including their family, friends and professionals involved with the death. The Foundation has a wide range of leaflets and information for bereaved families and professionals. It also has a network of befrienders who are bereaved parents. Arrangements can be made for a befriender to contact the bereaved family to offer additional support.

Helpline (Freephone): 0808 802 6868

10.00 - 23.00, Monday - Friday

18.00 - 23.00, Weekends & Bank Holidays

<http://fsid.org.uk>

- **Survivors of Bereavement by Suicide**

Support for those bereaved by suicide.

Helpline: 0844 561 6855

09.00 - 21.00, every day

[www.uk-sobs.org.uk](http://www.uk-sobs.org.uk)

- **Winston's Wish**

Support for bereaved children and young people aged up to 18 years.

An interactive website is also available.

Helpline: 0845 203 0405

09.00 - 17.00, Monday - Friday

[www.winstonswish.org.uk](http://www.winstonswish.org.uk)

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 34 of 48	

## **Appendix 4 Seven Key Strands for all Agencies to Consider when a Child Dies Unexpectedly**

All of these strands will need management throughout the PRUDiC. Deaths involving child protection concerns and those needing a serious case review and/or attracting media attention will be especially challenging and will be managed by the LSCBs. The seven key strands are:

**a) Care of the bereaved family:** Ensuring at every phase that the needs of the bereaved family are of paramount consideration to any professional involved with a family where a child is dying or has died. This includes the welfare and protection of remaining siblings, spiritual needs and possible involvement of the extended family. (See Appendix 3 for Sources of Family Support).

**b) Deciding on response:** Deciding on whether the death is unexpected and whether to implement the PRUDiC. Where professionals are uncertain about whether the death is unexpected, the PRUDiC Practitioner is responsible for making the final decision.

**c) Notification to the NCDR Team:** The NCDR Team will be notified of all child deaths by the professional confirming the fact of death, using the notification form (see Appendix 5 for a link to Forms). Notification must be made by the next working day.

**d) Child Protection:** Emerging information giving rise to child protection concerns about remaining siblings and/or other children in the household or peer group must take priority and will require formal referral to children's social care in line with All Wales Child Protection Procedures (see Appendix 5 for a link to All Wales Child Protection Procedures).

**e) Serious Case Review:** All agencies need to be mindful of any emerging information giving rise to the need for the LSCB to consider conducting a serious case review. The decision to undertake the review must be taken by the Chair of the LSCB where the child normally resided.

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 35 of 48	

**f) Media issues:** All Local Safeguarding Children Boards should have a process for managing media interest. Staff must be enabled to proceed with their functions without intrusion and the family provided with privacy. There should be a coordinated response to media enquiries and press releases, agreed by all relevant agencies (where possible at the information sharing meetings). Agencies must be mindful of not compromising potential criminal investigations. Media attention and enquiries will be managed by the police press office where the child actually died.

**g) Support to staff:** Child deaths will have varying degrees of impact on staff. Agencies need to be aware that clear procedures, effective communication and leadership, will provide staff with confidence and enable them to respond appropriately to families. Agencies should have arrangements in place to support staff who may be affected by the issues involved.

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 36 of 48	

## Appendix 5 Resources

- Association of Chief Police Officers (ACPO) 2006 Guidelines Infant Death: Murder Investigation Manual

- All Wales Child Protection Procedures  
<http://www.ssiacymru.org.uk/index.cfm?articleid=298>

- Care Pathways  
Agencies are encouraged to develop local operational care pathways, e.g. flowcharts of responsibilities, laboratory investigations, history proformas including physical examination and scene examination.  
Two particularly helpful models may be found at:

Sudden Unexpected Deaths in Childhood: A Joint Agency Protocol for Investigation and Management in Avon & Somerset (Appendix II: Flowchart of Responsibilities, page 30)

[http://www.n-somerset.gov.uk/NR/rdonlyres/2F2B5356-CE46-4D83-83BE-E8F4223F9896/0/document\\_20020601\\_Protocol26SuddenUnexpectedDeathsInChildhood.pdf](http://www.n-somerset.gov.uk/NR/rdonlyres/2F2B5356-CE46-4D83-83BE-E8F4223F9896/0/document_20020601_Protocol26SuddenUnexpectedDeathsInChildhood.pdf)

West Midlands Best Practice Multi-Agency Protocol for the Management of Sudden Unexpected Deaths in Infants & Children under 18 (SUDC) (Appendices 3 and 4, pages 26 to 34)

[http://www.docstoc.com/docs/28043882/SUDDEN-UNEXPECTED-DEATHS-IN-INFANTS-and-CHILDREN-UNDER-18-\(SUDC\)/](http://www.docstoc.com/docs/28043882/SUDDEN-UNEXPECTED-DEATHS-IN-INFANTS-and-CHILDREN-UNDER-18-(SUDC)/)

- End-of-Life Plans  
[www.act.org.uk/page.asp?section=99&search=end+of+life+plan](http://www.act.org.uk/page.asp?section=99&search=end+of+life+plan)

- Forms  
Notification form  
Record of death form (according to the type of death)  
<http://www.wales.nhs.uk/sitesplus/888/page/44355>

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 37 of 48	

- Information Sheets related to responding when a child dies, on the Department for Children, Schools and Families website, including:
  - Death Registration and Inquests
  - Deaths in Children with Life-Limiting Conditions
  - Organ and Tissue Donation
  - Supporting Families
  - The Home Visit – Reviewing the Circumstances of Death
  - The Role of Children’s Social Care
  - The Role of Health Professionals

<http://childdeath.ocbmedia.com/Information-sheets-and-proformas/>
- Human Tissue Authority Guidelines
 

<http://www.hta.gov.uk/licensingandinspections/sectorspecificinformation/postmortem.cfm>
- JR CALC Guidelines
 

<http://jrcalc.org.uk/guidelines.html>
- Kennedy Report (Sudden unexpected death in infancy: A multi-agency protocol for care and investigation)
 

<http://www.rcpath.org/resources/pdf/SUDI%20report%20for%20web.pdf>
- Pathology guidelines
  - The Royal College of Pathologists: Code of Practice and Performance Standards for Forensic Pathologists
 

<http://www.rcpath.org/resources/pdf/CodeOfPracForensicPath1104.pdf>
  - The Royal College of Pathologists: Guidelines on Autopsy Practice (Neonatal)
 

<http://www.rcpath.org/resources/pdf/G002Autopsy-NeonatalDeath-Jun06.pdf>
  - The Royal College of Pathologists: Guidelines on Autopsy Practice (SUDI)
 

<http://www.rcpath.org/resources/pdf/AutopsyScenario8Jan05.pdf>

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 38 of 48	

- Standards for Radiological Investigations of Suspected Non-accidental Injury RCR and RCPCH March 2008

[http://www.rcr.ac.uk/docs/radiology/pdf/RCPCH\\_RCR\\_final.pdf](http://www.rcr.ac.uk/docs/radiology/pdf/RCPCH_RCR_final.pdf)

## **Appendix 6 Role of Police**

The relevant guidance for the police is the Association of Chief Police Officers (ACPO) 2006 Guidelines on Infant Death Investigation. The full guidelines must be referred to during an investigation. These guidelines are available within Force and within the Murder Investigation Manual 2006 (supplementary reading CD-ROM).

### **Road Traffic Collision**

In a road traffic collision a Roads Policing SIO would take responsibility for the investigation unless criminal conduct is suspected and a Crime SIO is allocated to the case. In such cases the Roads Policing SIO will perform the role of the SIO and will seek appropriate guidance from colleagues as required to meet the circumstances presented.

### **Homicide and Suspicious Child Death Summary Sheet**

The topic of child death investigation has received unprecedented media coverage in the current political climate following the case of Baby Peter ('P'). ACPO Homicide sub-group are currently reviewing suspicious child death cases in order to assess if there are similar circumstances apparent which could assist investigators in future investigations. In order to facilitate this the NPJA are coordinating the responses from SIOs who are asked to submit form 76 to the NPJA at the outcome of any child homicide investigation or suspicious death enquiry (coroners inquest verdict). Your support and cooperation in supplying this valuable data would be greatly appreciated.

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 40 of 48	

## Appendix 7 Role of HM Coroner

HM Coroner must be informed of any death, the cause of which is apparently unknown or apparently unnatural, or in certain other specified circumstances, and will order an investigation into the circumstances and cause of that death. After the death is pronounced, the coroner has control of the body until s/he releases it. If an inquest is to be opened then it is usually at this point that the body is released by the coroner.

The coroner's officer will inform the family of HM Coroner's roles and procedures and keep the family informed of the child's whereabouts until the coroner has signed release paperwork for the child at the opening of the inquest. It is important this information is shared only by the coroner's officer as any misinformation may cause additional distress to the family.

As the legal authority charged with the investigation and certification of all unexpected deaths, the coroner must be kept informed of all significant information obtained from the multi-agency communications and interviews with parents.

The coroner, usually via a coroner's officer, is responsible for informing the family about what organs and/or tissue samples have been retained to allow discussion of options for disposal. The family's wishes regarding disposal must be made known to the pathologist and the coroner.

The record of death from the multi-agency Case Review Meeting will in all cases be sent to the coroner, and in some instances the coroner's officer will choose to be present at this meeting. This completed form will ensure that, where the cause of death has been certified by the coroner without an inquest, any new or more accurate information is appropriately notified to the registrar of births and deaths for onward transmission to the Office for National Statistics.

For those instances in which the coroner has ordered an inquest, the information from the Case Review Meeting may inform and assist the conduct of the inquest.

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 41 of 48	

If the death is recognised from the outset as being from natural causes, the attending doctor will sign the medical certificate of cause of death. The coroner may notify the registrar that no coronial inquiry is to be held. The death can then be registered and a death certificate issued. If there is to be a post mortem examination and/or an inquest or trial, the coroner will notify the registrar of the medical cause of death at the appropriate time.

**Appendix 8 Audit Tool for PRUDiC**

<b>1.</b>	<b>Date of Death:</b>	/ /	
	<b>Age of Child:</b>	y m d	Age Not known <input type="checkbox"/>
<b>2.</b>	<b>Who notified the PRUDiC Practitioner of the death?</b> (Please tick all that apply)		
	Ambulance Control	<input type="checkbox"/>	Hospital Emergency Dept <input type="checkbox"/>
	Not notified	<input type="checkbox"/>	Not known <input type="checkbox"/>
	Other (please specify)		
<b>3.</b>	<b>How soon after discovery of the death was the child notified to the PRUDiC Practitioner?</b>		
	Within 2 hours	<input type="checkbox"/>	Within 24 hours <input type="checkbox"/>
	Next working day	<input type="checkbox"/>	Not known <input type="checkbox"/>
	Later (please specify)		
<b>4.</b>	<b>How soon after discovery of the death was the child notified to the NCDR Team?</b>		
	Within 2 hours	<input type="checkbox"/>	Within 24 hours <input type="checkbox"/>
	Next working day	<input type="checkbox"/>	Not known <input type="checkbox"/>
	Later (please specify)		
<b>5.</b>	<b>Was an initial history taken in hospital? If so by whom?</b> (tick all that apply)		
	Paediatrician	<input type="checkbox"/>	Emergency Dept Doctor <input type="checkbox"/>
	Police Officer	<input type="checkbox"/>	No history taken <input type="checkbox"/>
	PRUDiC Practitioner	<input type="checkbox"/>	Not known <input type="checkbox"/>
	Other (please specify)		
<b>6.</b>	<b>Was the child examined in hospital? If so by whom?</b> (tick all that apply)		
	Paediatrician	<input type="checkbox"/>	Child not examined <input type="checkbox"/>
	Emergency Dept Doctor	<input type="checkbox"/>	Not known <input type="checkbox"/>
	Police Officer	<input type="checkbox"/>	
	Other (please specify)		

<b>7.</b>	<b>Were appropriate investigations carried out e.g. laboratory, imaging?</b>			
	All investigations according to local protocol	<input type="checkbox"/>	Not appropriate	<input type="checkbox"/>
	Some investigations	<input type="checkbox"/>	Not known	<input type="checkbox"/>
	No investigations	<input type="checkbox"/>		
	<b>If there were any difficulties in carrying out investigations, what were the reasons for this?</b>			
<b>8.</b>	<b>Were the parents offered the following care and support? (tick all that apply)</b>			
	Allowed to hold their child	<input type="checkbox"/>	Offered written information	<input type="checkbox"/>
	Offered photographs and mementos	<input type="checkbox"/>	Given contact numbers	<input type="checkbox"/>
	Offered bereavement counselling or religious support	<input type="checkbox"/>	Informed about the post mortem	<input type="checkbox"/>
	Given information about the PRUDiC process	<input type="checkbox"/>	Given information about the National Child Death Review process	<input type="checkbox"/>
	Not known	<input type="checkbox"/>	Not appropriate	<input type="checkbox"/>
<b>9.</b>	<b>Was an early multi-agency Information Sharing and Planning Meeting held? If so, when was this held? (tick all that apply)</b>			
	Yes – telephone discussions	<input type="checkbox"/>	Same day	<input type="checkbox"/>
	Yes – sit down meeting	<input type="checkbox"/>	Later (please specify)	
	No	<input type="checkbox"/>	Not known	<input type="checkbox"/>
	<b>Who attended the Information Sharing and Planning Meeting?</b>			
	Responsible Paediatrician	<input type="checkbox"/>	General Practitioner	<input type="checkbox"/>
	PRUDiC Practitioner	<input type="checkbox"/>	Health Visitor / Midwife	<input type="checkbox"/>
	Police Officer (Child Abuse Investigation Unit)	<input type="checkbox"/>	Police Officer (other)	<input type="checkbox"/>
	Coroner/Coroner's Officer	<input type="checkbox"/>	Social Worker	<input type="checkbox"/>

	Nurse	<input type="checkbox"/>	Bereavement Support Worker	<input type="checkbox"/>
	Pathologist	<input type="checkbox"/>		
	Other (please specify)			
<b>10.</b>	<b>Did a joint agency visit to the place where the child died take place?</b>			
	Yes	<input type="checkbox"/>	Not appropriate	<input type="checkbox"/>
	No	<input type="checkbox"/>	Not known	<input type="checkbox"/>
	<b>If so, when did this take place?</b>			
	Same day	<input type="checkbox"/>	Later (please specify)	
	Next working day	<input type="checkbox"/>	Not known	<input type="checkbox"/>
	<b>Who took part in the visit to the place where the child died?</b> (tick all that apply)			
	Responsible Paediatrician	<input type="checkbox"/>	General Practitioner	<input type="checkbox"/>
	PRUDiC Practitioner	<input type="checkbox"/>	Health Visitor / Midwife	<input type="checkbox"/>
	Police Officer (Child Abuse Investigation Unit)	<input type="checkbox"/>	Bereavement Support Worker	<input type="checkbox"/>
	Police Officer (other)	<input type="checkbox"/>	Social Worker	<input type="checkbox"/>
	Scenes of Crime / Forensic Officer	<input type="checkbox"/>	Not known	<input type="checkbox"/>
	Other (please specify)			
	<b>If a joint agency visit to the place where the child died did not take place, please specify why.</b>			
<b>11.</b>	<b>Was a post mortem carried out? If so by whom?</b> (tick all that apply)			
	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	General Hospital Pathologist	<input type="checkbox"/>	Paediatric Pathologist	<input type="checkbox"/>
	Forensic Pathologist	<input type="checkbox"/>	Not known	<input type="checkbox"/>
	Other (please specify)			
	<b>If so, when did this take place?</b>			
	Same day	<input type="checkbox"/>	Later (please specify)	

	Next working day	<input type="checkbox"/>	Not known	<input type="checkbox"/>
<b>12.</b>	<b>Was there a Case Discussion/Meeting?</b>			
	Yes – telephone discussions	<input type="checkbox"/>	No	<input type="checkbox"/>
	Yes – sit down meeting	<input type="checkbox"/>	Not known	<input type="checkbox"/>
	<b>How long after the death did this take place?</b>			
	Within 5 – 7 days	<input type="checkbox"/>	Later (please specify)	
	1 – 2 weeks	<input type="checkbox"/>	Not known	<input type="checkbox"/>
<b>13.</b>	<b>Was there a final Case Review Meeting?</b>			
	Yes	<input type="checkbox"/>	Not yet, but planned	<input type="checkbox"/>
	No	<input type="checkbox"/>	Not known	<input type="checkbox"/>
	<b>How long after the death did this take place?</b>			
	Within 3 months	<input type="checkbox"/>	Later (please specify)	
	3 - 6 months	<input type="checkbox"/>	Not known	<input type="checkbox"/>
	<b>If an inquest was held / planned, did the final Case Review Meeting precede or follow the inquest?</b>			
	Preceded the inquest	<input type="checkbox"/>	Followed the inquest	<input type="checkbox"/>
	No inquest held	<input type="checkbox"/>	Not known	<input type="checkbox"/>
	<b>Who attended the final Case Review Meeting? (tick all that apply)</b>			
	Responsible Paediatrician	<input type="checkbox"/>	General Practitioner	<input type="checkbox"/>
	PRUDiC Practitioner	<input type="checkbox"/>	Health Visitor / Midwife	<input type="checkbox"/>
	Police Officer (Child Abuse Investigation Unit)	<input type="checkbox"/>	Police Officer (other)	<input type="checkbox"/>
	Coroner/Coroner's Officer	<input type="checkbox"/>	Social Worker	<input type="checkbox"/>
	Bereavement Support Worker	<input type="checkbox"/>	Nurse	<input type="checkbox"/>
	Pathologist	<input type="checkbox"/>		
	Other (please specify)			
	<b>Were the family informed of the outcome of the Case Review Meeting?</b>			
	Yes – through a home	<input type="checkbox"/>	Yes – by letter	<input type="checkbox"/>

	visit			
	Yes – by telephone	<input type="checkbox"/>	Yes – other	<input type="checkbox"/>
	No	<input type="checkbox"/>	Not known	<input type="checkbox"/>
<b>14.</b>	<b>What was the final cause of death?</b>			
	Death from natural causes	<input type="checkbox"/>	SIDS	<input type="checkbox"/>
	Accident	<input type="checkbox"/>	Homicide	<input type="checkbox"/>
	Suicide	<input type="checkbox"/>	Cause of death not established	<input type="checkbox"/>
	Not known	<input type="checkbox"/>		
	Other (please specify)			
<b>15.</b>	<b>Were any concerns of a child protection nature identified?</b>			
	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Not known	<input type="checkbox"/>		
<b>16.</b>	<b>Was the case referred on to the CPS for a criminal investigation?</b>			
	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Not known	<input type="checkbox"/>		

## **Appendix 9 Membership of the Working Group**

### **Dr Aideen Naughton, CHAIR Designated Doctor Safeguarding Children, Public Health Wales**

Ms Rhiannon Beaumont-Wood  
Named Nurse Safeguarding Children, Welsh Ambulance Services NHS Trust

Ms Linda Brown  
Named Nurse Child Protection, Aneurin Bevan Local Health Board

DCI Martin Davies  
Senior Investigating Officer, Dyfed Powys Police

Dr Paul Davis  
Consultant Paediatrician, St David's Children's Centre, Cardiff

Mr Philip Diamond  
Partnership Support Officer, Blaenau Gwent County Borough Council

Mrs Denise Evans  
Service Manager (Social Services), Rhondda Cynon Taff Borough Council

Dr Nigel Farr  
General Practitioner, Newbridge Surgery, Newport

Dr Joanne Griffiths  
Consultant Paediatrician, Abertawe Bro Morgannwg Local Health Board

Ms Mary Hassell  
HM Coroner, Cardiff & Vale of Glamorgan

Dr Sarah Horrocks  
Consultant Community Paediatrician, Betsi Cadwaladr University Health Board

Mr Peter Hosking  
Policy Officer, Children's Commissioner for Wales

Dr Ryk James  
Consultant Forensic Pathologist, University Hospital of Wales, Cardiff

Dr Stephen Leadbeatter  
Director, The Wales Institute of Forensic Medicine

Dr Sian Moynihan  
Consultant Paediatrician, St David's Children's Centre, Cardiff

Mrs Zarah Newman  
Safeguarding Coordinator, Caerphilly Safeguarding Children Board

Miss Lucy Wood  
Support Officer, Public Health Wales

Version: 1	Date: 18/10/10	Status: Approved
Authors: Dr Aideen Naughton & Lucy Wood	Page: 48 of 48	