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# Procedural Response to Unexpected Deaths in Childhood (PRUDiC) 2018

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Authors: Dr Lorna Price - Designated Doctor Safeguarding and Debbie Pachu - Designated Nurse Safeguarding National Safeguarding Team (NHS Wales)	Page: Page <b>1</b> of <b>43</b>	

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## 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 This procedural response will be followed when a decision has been made by the police that the death of a child is unexpected and the Procedural Response to Unexpected Deaths in Childhood (PRUDiC) is to be initiated (see Section 3).
- 1.3 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.
- 1.4 This is a multi-agency procedural response intended to ensure a minimum standard across Wales, and is not agency or discipline specific. It outlines what needs to be achieved and gives broad suggestions about the roles of agencies. Any variance should be recorded along with the rationale for digressing from the process. The guidance does not prohibit any existing good practice by agencies or professionals to enhance this procedural response.
- 1.5 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.
- 1.6 The procedural response on behalf of Her Majesty’s Coroner (HM Coroner) will be coordinated by the Police. The PRUDiC recognises that HM Coroners are independent judicial officers and it does not create any legally enforceable rights, obligations or restrictions upon them.
- 1.7 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/HM Coroner’s investigation, including an inquest.
- 1.8 HM Coroner has a duty to conduct an investigation into any violent or unnatural death or where the cause of death is unknown, to ascertain how, when and where the deceased came by his or her death. The scope of PRUDiC is wider than this and the procedure will be implemented in all unexpected child deaths whether or not the cause of death can be explained.
- 1.9 The Regional Safeguarding Children Boards will monitor the PRUDiC processes initiated in their regions and ensure that the procedural response is followed to completion.
- 1.10 The Child Death Review Programme (CDRP) will receive a Child Death Notification and the final Case Summary from the Health Board Head of Safeguarding. This will enable the Child Death Review Programme to determine patterns and trends pertaining to child deaths in Wales, and will inform thematic reviews to identify opportunities for future prevention.

- 1.11 The Child Death Review Programme will produce reports which describe findings on patterns and trends of child deaths in Wales as well as a regional profile for each Regional Safeguarding Children Board.
- 1.12 Hospitals will offer parents a 'Memory Box' containing bereavement support information and mementoes of their child, as well as offering a referral to '2 Wish Upon A Star' or other support organisation as deemed appropriate by their staff.
- 1.13 The Health Board Head of Safeguarding (or their delegate) will lead and co-ordinate the health response to PRUDiC including information sharing with other agencies.
- 1.14 Whenever a child dies unexpectedly health professionals will consider the need to report as a Serious Incident or No Surprises Incident to Welsh Government in accordance with the 'Putting Things Right' Guidance.
- 1.15 Throughout this procedure, the term 'Parent' is used to refer to any Parent or Carer, including persons with a Special Guardianship Order or Child Arrangement Order, Foster Carers and the Local Authority for Looked After Children.

## 2. Unexpected Death of a Child

2.1 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>*

and as

*'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.

2.2 The PRUDiC applies to all deaths in children from birth until their 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. It does not include;

- Stillbirths.
- Neonates where the birth was in hospital and was attended by a professional, who have never been discharged into the community **and where the death was expected.**

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

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

- Those with a life-limiting condition known to the Palliative Care Team **and where death was expected.**

### 3. Children with an All Wales Paediatric Advance Care (PAC) Plan

- 3.1 Children who are known to have a life limiting condition may have an All Wales PAC-Plan in place. This plan should facilitate multi-professional communication before and around the time of death in the event of the child dying in an expected way.
- 3.2 Some children who are expected to die may choose to have palliative care involvement without having an All Wales PAC-Plan. In these circumstances the Consultant in Children’s Palliative Care can be contacted for advice via University Hospital of Wales switchboard (02920 747747) at any time.
- 3.3 If a child who has a life limiting condition dies in an unexpected way then PRUDiC will apply.

### 4. Expected Death of a Child

- 4.1 Expected child deaths that are not subject to PRUDiC must be notified to the Child Death Review Programme by the doctor who confirms the fact of death (see Child Death Notification Form Appendix 5).
- 4.2 Initial bereavement care and support should be provided to the family by the Health Board involved with the child, and the family should be informed at an appropriate time of the Child Death Review Programme.

### 5. When a Child Dies Unexpectedly in Another Area

- 5.1 When a child dies in Wales, but outside of their normal area of residence in Wales, wherever practicable the PRUDiC will occur in the Police Force area where the child normally resides.
- 5.2 When a child dies in England, but is normally resident in Wales, the PRUDiC process should be followed in the area where the child normally resides and relevant information shared by the Welsh Police Force with the English Child Death Overview Panel.
- 5.3 If a child dies in Wales the PRUDiC will be implemented even if the child is normally resident in a country other than Wales.
- 5.4 Health Boards who routinely send children to English Hospitals for secondary/tertiary care should ensure that those Hospitals are aware of the PRUDiC process so that their Head of Safeguarding can be promptly informed when a Welsh child dies and the PRUDiC process initiated.
- 5.5 When notified of a death elsewhere (other than in Wales or England) professionals where the child is normally resident in Wales will consider

implementing this procedure as far as is practically possible and fully record any decisions made.

## 6. The Role of the Welsh Ambulance Services NHS Trust (WAST)

- 6.1 The Emergency Services will follow their own protocols. For Welsh Ambulance Services NHS Trust please see Appendix 7.
- 6.2 Even if the child is obviously dead and resuscitation is not attempted the body should be transported by Welsh Ambulance Services NHS Trust to an Emergency Department.
- 6.3 Where a mother gives birth in the community without a health professional in attendance and the baby dies, the mother and baby should be taken by ambulance to the nearest Maternity Unit where the baby can be examined by a Neonatologist (or Paediatrician) and the mother can be supported.
- 6.4 In exceptional circumstances it may be necessary to transport the child directly to the Mortuary if the condition of the body is such that it would be inappropriate to take the child to the Emergency Department e.g. decapitation, decomposition, incineration. However, all other deceased children should be taken to the Emergency Department to be examined by a Paediatrician.
- 6.5 If the child is obviously dead **AND** there are suspicious circumstances where removing the child from the scene could cause loss of evidence WAST will leave the child in situ and inform the Police (if they are not already on scene).
- 6.6 Welsh Ambulance Services NHS Trust personnel will consider the need to report (as a Serious Incident or No Surprises Incident) to Welsh Government in accordance with the 'Putting Things Right' Guidance'.

## 7. The Role of the Police – Police Senior Investigating Officer (SIO)

- 7.1 The Emergency Services will follow their own protocols. For the Police see Appendices 3, 4 and 8.
- 7.2 When a child dies unexpectedly a Police Senior Investigating Officer will be appointed and take responsibility for the management of Police resources and for ensuring appropriate and proportional lines of enquiry are instigated. Senior Investigating Officer appointments will be in accordance with Force Policy and in consideration of the National Police Chiefs' Council (NPCC) Guidelines. For Road Death the Senior Investigating Officer responsibilities will be performed by a Road Death Senior Investigating Officer.
- 7.3 Where circumstances indicate that attendance at the scene will benefit the enquiry, an experienced Detective Officer will be tasked to immediately attend the scene. Where the possibility of child maltreatment is present, it is essential that the Detective Officer has child protection experience or liaises with a colleague who has child protection experience. Senior Investigating Officers should be mindful that there may not be any obvious suspicious circumstances and that scene attendance by appropriately experienced officers or staff may still benefit the enquiry. This is the case if the child is still at the scene **or** if the child

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has been removed to Hospital. (Refer to Appendix 4: Scene Examination Checklist).

- 7.4 Police must ensure that the Nurse in Charge at the Emergency Department is informed about the death if the child is taken directly to the mortuary.
- 7.5 The Police Senior Investigating Officer may allocate a Police Single Point of Contact (SPOC) to assist with inter-agency communication. Whether the death appears suspicious or not the Police will allocate a Family Liaison Officer (FLO) whenever the Senior Investigating Officer deems it appropriate.
- 7.6 A Detective Inspector or Senior Protecting Vulnerable Persons Unit Officer or Public Protection Unit Officer will be responsible for chairing, taking and distributing minutes for all meetings held throughout the PRUDiC process.
- 7.7 At the Case Discussion Meeting the Chair or their delegate will complete the Child Death Notification (Appendix 5) and forward it to the Business Manager of the Regional Safeguarding Children Board and the Child Death Review Programme.
- 7.8 At the Case Review Meeting the Chair or their delegate will complete the Case Summary Template (Appendix 6) and forward it to the Business Manager of the Regional Safeguarding Board and the Child Death Review Programme.

## 8. The Role of Children’s Social Care

- 8.1 The Lead Safeguarding Manager in Children’s Social Care will be notified by the Police of any unexpected child death in their Local Authority area.
- 8.2 The Lead Safeguarding Manager in Children’s Social Care:-
  - Will liaise with other agencies and lead the coordination of information gathering within social care to be shared throughout the PRUDiC.
  - Will ensure full liaison with the Police in the event of a suspicious death. (In which case the Police Senior Investigating Officer will decide what information is disclosed to parents and how.)
  - Will ensure that the risk to any siblings or other children is assessed as a priority on receipt of notification of the unexpected child death.
  - Will ensure that the Regional Safeguarding Children Board’s Business Unit is informed of the child’s death.
  - Will ensure that appropriate representation from Children’s Social Care is present at all meetings throughout the PRUDiC process.
  - Will ensure that any child protection investigation or safeguarding actions for Children’s Social Care which may arise during the PRUDiC process are completed.
  - Will provide information, advice and support to any social care professional who is unfamiliar with the PRUDiC process, including those working in Adult Services.

## 9. The Role of Health Professionals

### 9.1 Emergency Department Keyworker

Immediately upon their arrival at the Hospital, the family should be allocated a member of staff to care for them, explain what is happening and provide them with facilities to contact other family members, friends and cultural or religious support. Before they leave the department the family must be given clear details of whom to contact both in working hours and out of hours should they have questions or concerns.

### 9.2 Consultant Paediatrician

On arrival at the Emergency Department the child will be attended by a doctor, usually the Consultant Paediatrician. Once death has been confirmed the Doctor will be responsible for:

- Examining the body of the child. This should be done with the Police present, but this examination should not be delayed if Police are not yet available.
- Taking a full history from the parents. This should be done with the Police present. But should not be delayed if Police are not yet available. See Appendix 3.
- Ensuring the Health Board Head of Safeguarding and the child’s General Practitioner are informed **as soon as possible** of the death and **by the next working day at the latest**.
- Providing a full report on the history and physical findings at presentation to HM Coroner and Pathologist.
- Fully documenting any samples taken from the child before death, providing available results to the Pathologist and recording those still outstanding on transfer to the mortuary.
- Seeking advice regarding sampling from the Pathologist if the history or examination suggests a metabolic disorder. (The Doctor does not need to take any other samples from the body).
- Informing parents of the PRUDiC process.
- Attending the Information Sharing and Planning Meeting.
- Attending the Case Discussion Meeting (5-28 days). With the agreement of the Chair and depending on circumstances and on the course of any criminal investigation, the Consultant Paediatrician will write a letter to the parents following this meeting offering to meet them to discuss the events surrounding the child’s death and answer any questions they may have.

### 9.3 The Health Board’s Head of Safeguarding

- Will provide information, advice and support to any health professional who is unfamiliar with the PRUDiC process, including those working in Adult Services.

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- Will liaise with other agencies and lead the coordination of information gathering within Health to be shared throughout the PRUDiC.
- Will ensure full liaison with the Police in the event of a suspicious death. (In which case the Police Senior Investigating Officer will decide what information is disclosed to parents and how.)
- Will consider the need to report (as Serious Incident or No Surprises Incident) to Welsh Government in accordance with the 'Putting Things Right' Guidance.

**NB: It is recognised that the Head of Safeguarding may choose to delegate some or all of these responsibilities to another member of the Health Board/Trust Safeguarding Children Team.**

#### 9.4 The Named Midwife for Safeguarding Children

- Will be informed, and contribute to the PRUDiC process, if a child dies unexpectedly before the age of 28 days.

#### 9.5 The General Practitioner

- Will be fully informed of the unexpected death of a child registered with their practice by the Consultant Paediatrician to ensure that General Practitioners are forewarned should they be contacted by the child's family for support.
- Will consult the records of known immediate family members to see whether they have any particular vulnerability and take appropriate action, e.g. inform Adult Mental Health or other services involved with parents.
- Will be invited to attend the Information Sharing and Planning Meeting, Case Discussion Meeting and Case Review Meeting and will receive all minutes.
- If unable to attend any meeting the GP will share any relevant information about the child or other family/household members with the Health Board Head of Safeguarding in advance of the meeting.
- Will consider the need to report (as a Serious Incident or No Surprises Incident) to Welsh Government in accordance with the 'Putting Things Right' guidance.

The General Practice should make contact with the family to offer condolences and support.

#### 9.6 The Independent Medical Examiner

It is anticipated that from April 2019 Independent Medical Examiners will be appointed in all Welsh Health Boards. Their role will be to confirm the cause of all deaths that do not need to be investigated by HM Coroner. They may therefore have an interest or contribute to the PRUDiC process.

#### 9.7 The Pathologist (see 11.6)

## 10. The Role of the Regional Safeguarding Children Board

10.1 The Regional Safeguarding Children Board’s Business Unit Manager will:

- Be informed by the Lead Safeguarding Manager in Children’s Social Care of any unexpected child death which occurs within their region.
- Receive the Child Death Notification (Appendix 5) from the Police following the Case Discussion Meeting and provide pertinent information about all unexpected child deaths to the Regional Safeguarding Children Board Child Practice Review Management Sub-Group.
- Receive the Case Summary Template (Appendix 6) from the Police following the Case Review Meeting.
- Monitor the progress of each PRUDiC process and ensure that timescales are met. Any exceptions will be reported to the Board.

10.2 The Child Practice Review Management Sub-Group will:

- Receive the pertinent information from the Regional Safeguarding Children Board’s Business Unit and consider whether the death meets the criteria for a Child Practice Review (CPR) or Multi-Agency Professional Forum (MAPF), and determine whether to make a recommendation to the Chair of the Regional Safeguarding Children Board.

## 11. PRUDiC Timeline

11.1 The PRUDiC timeline involves three phases:

- Phase one (usually 0-5 days): The management of information sharing, including the **Information Sharing and Planning Meeting**, 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 (5-28 days): The management of information sharing, including the **Case Discussion Meeting**, once the preliminary results of the post mortem examination are available.
- Phase three (within 12 months): The management of information sharing, including the **Case Review Meeting**, when the final Post Mortem Report is available.

11.2 In order to facilitate participation of key professionals at meetings video conferencing or teleconferencing may be utilised.

11.3 In principle it is recognised that all information relevant to the enquiry should be shared by all agencies. However, the Police and HM Coroner may consider certain information Sub Judice (i.e. under judicial consideration and therefore prohibited from public discussion elsewhere) or subject to continuing investigation which may preclude it being shared. 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 must be 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. The paramountcy principle will apply. Any decision not to share information will be recorded by the Police Senior Investigating Officer in the Police Policy Book.

11.4 It is not usual practice to share meeting minutes with parents however on occasion parents have requested copies of meeting minutes. The decision to share minutes will be at the discretion of the Police who will be able to consider any necessary restrictions given the circumstances of the case and the extent of any criminal or coronial investigations which may be prejudiced by disclosure at that stage.

11.5 The Police are responsible for ensuring that accurate minutes of every meeting are recorded, all decisions are documented and that the minutes are distributed to all invitees within 5 working days of the meeting.

11.6 **Phase 1: The Information Sharing and Planning Meeting (to be held within 2 working days)**

11.6.1 This meeting will be convened within two working days of the unexpected death and prior to the post mortem examination.

11.6.2 The Police will ensure that the family are informed about the PRUDiC process ideally prior to the Information Sharing and Planning Meeting or as soon as possible thereafter.

11.6.3 A Detective Inspector or Senior Protecting Vulnerable Persons Unit Officer or Public Protection Unit Officer will convene, chair and minute an initial Information Sharing and Planning Meeting. As a minimum the Senior Police Officer (as defined above), Health Board Head of Safeguarding, Consultant Paediatrician who attended the child, and a Children’s Social Care representative of appropriate seniority will attend. It is desirable that the Pathologist is included in the meeting and may contribute by telephone. Other professionals will be included as deemed appropriate by the Chair (e.g. Education for a school aged child) whilst keeping numbers to a minimum and on a need to be there basis. Minutes should be drafted and circulated to all invitees within 5 working days of the meeting.

11.6.4 The purpose of the Information Sharing and Planning Meeting is:

- To determine which professional is the most appropriate person to be the single point of contact for supporting the family.
- To ensure appropriate support is provided to the family including siblings.
- To ensure appropriate support is provided to the child’s immediate peer group.
- For each agency to share information from previous knowledge of the family and records, with particular reference to the environment and circumstances of the child’s death. This would include details of previous or ongoing child protection or child care concerns, history of previous

unexplained injury, abuse or neglect, previous unexplained or unusual deaths in the family, medical conditions including any disability, parental substance misuse, parental mental ill health, domestic abuse, parental criminal convictions, previous hospitalisation and General Practice visits.

- To collate all relevant information to share with the HM Coroner and Pathologist prior to the post mortem examination.
- To plan and determine the process of the investigation.
- To enable consideration of any child protection risks to siblings/any other children, and to consider the need for child protection procedures.
- To consider the need for referral to the Regional Safeguarding Children Board for consideration of a Child Practice Review.
- To ensure appropriate support is provided to all professionals who attended the child and family.
- To consider and plan for any media interest in the death.
- To agree who will have responsibility for any actions agreed and by when.
- To make arrangements to convene the Case Discussion Meeting within five to twenty-eight days.

11.6.5 Where Child Protection concerns are identified, the Child Protection and PRUDiC processes will run in parallel. The Child Protection process will not be a substitute for the PRUDiC process, but one will inform the other and vice versa. If Child Protection concerns are identified a Strategy Meeting will be held chaired by Children’s Social Care, according to timescales and processes defined within the All Wales Child Protection Procedures 2008 (until superseded by the All Wales Protection Procedures).

11.7 **Phase 1: The Pathologist and the Post Mortem Examination**

11.7.1 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 HM Coroner otherwise decides.

11.7.2 The post mortem examination will be authorised by HM Coroner, and should be carried out by a pathologist with up-to-date expertise in paediatric pathology. Where neglect or abuse is suspected a Home Office Pathologist should be involved.

11.7.3 Any decisions relating to the process and location of the post mortem examination are a matter for the HM Coroner.

11.7.4 The examination should take place as soon as possible after the Information Sharing and Planning Meeting and within five days, unless dictated by a possible public health issue.

11.7.5 Prior to commencing the post mortem examination, HM Coroner and the Pathologist will be given a full report of the history and the physical findings

at presentation by the Consultant Paediatrician, and the findings of the death scene investigation by the Police Senior Investigating Officer.

- 11.7.6 Any photographs or video recordings of the child or the scene will be made available to HM Coroner and the Pathologist.
- 11.7.7 If appropriate radiological investigations<sup>3</sup> have not been done the Pathologist should request them prior to commencing the post mortem examination. The Pathologist will be provided with a report by the radiologist relating to the imaging which has been carried out. The results of the radiological investigations may determine which Pathologist should lead the post mortem examination.
- 11.7.8 If the Pathologist has not attended the Information Sharing and Planning Meeting there will be a discussion between the Chair of the Information Sharing and Planning Meeting (usually a Senior Police Public Protection Unit Officer) and the Pathologist before the post mortem examination to identify outstanding or unsuspected issues and to ensure accurate understanding of information.
- 11.7.9 If the Consultant Paediatrician has arranged any laboratory investigations before death, HM Coroner and the Pathologist will be informed prior to the post mortem examination, and the results made available as soon as possible.
- 11.7.10 The HM Coroner's Officer will inform all relevant professionals of the time and place of the post mortem examination, including the Police and the Consultant Paediatrician. The family will also be informed by the HM Coroner's Officer or the Family Liaison Officer (if a Family Liaison Officer has been deployed).
- 11.7.11 Where the possibility of sexual abuse of a child is raised the Pathologist may consult a clinician skilled in the assessment and examination of children for alleged sexual abuse.
- 11.7.12 The Pathologist will immediately inform the Police Senior Investigating Officer and Children's Social Care if child protection concerns have arisen during the post mortem examination.
- 11.7.13 The Police Senior Investigating Officer or their Deputy may 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 Senior Investigating Officer 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 Senior Investigating Officer will decide appropriate resources to attend in line with National Police Chiefs' Council (NPCC) Guidelines. As a minimum this would normally involve an experienced Detective who can represent the interests of the investigative team. S/he will be supported by the Crime Scene Investigator, Crime Scene Manager and Exhibits Officer, as directed by the Police Senior Investigating Officer.

<sup>3</sup> The Society and College of Radiographers and the Royal College of Radiologists. *The radiological investigation of suspected physical abuse in children*. London: The Royal College of Radiologists, 2017.

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- 11.7.14 The interim findings of the post mortem will be sent by the Pathologist to HM Coroner as soon as the post mortem examination is completed.
- 11.7.15 A copy of the final post mortem report will be sent by the Pathologist to HM Coroner, to the Police Senior Investigating Officer, General Practitioner and the Consultant Paediatrician unless contraindicated by the criminal justice process.
- 11.7.16 The release of the child’s body is a matter for the HM Coroner, in consultation with the Police Senior Investigating Officer if a forensic post mortem examination has been conducted.
- 11.7.17 HM Coroner will feed back the preliminary and final post mortem results to the family as soon as these are available. If abuse or neglect is suspected and/or the Police are undertaking a criminal investigation, HM Coroner through the Police Senior Investigating Officer will advise the other professionals involved in the PRUDiC process. Individual agency representatives will advise those professionals working closely with the family as to what and when information can be shared with the parents.
- 11.7.18 Where the cause of death has not been determined at the post mortem examination or the death may have been unnatural, HM Coroner will in due course hold an Inquest.
- 11.7.19 The Police/HM Coroner’s Officer will prepare a report for HM Coroner once information relevant to the investigation has been gathered. This report is intended to form the basis of the HM Coroner’s Inquest.

**11.8 Phase 2: The Case Discussion Meeting (Within 5-28 days)**

- 11.8.1 All professionals have a responsibility to ensure that any concerns they may have surrounding the death are passed to the Police Senior Investigating Officer as soon as possible.
- 11.8.2 A Case Discussion Meeting must be convened within 5 to 28 days. A Detective Inspector or Senior Protecting Vulnerable Persons Unit Officer or Public Protection Unit Officer will convene, chair and minute the meeting. As a minimum the Senior Police Officer (as defined above), Health Board Head of Safeguarding, and a Children’s Social Care representative of appropriate seniority will attend. The meeting should also include the Consultant Paediatrician and the Pathologist. Other professionals will be included as deemed appropriate by the Chair whilst keeping numbers to a minimum and on a need to be there basis. With the agreement of HM Coroner, the preliminary results of the post mortem examination will be made available.
- 11.8.3 The purpose of the Case Discussion Meeting is to:
  - Receive any information which was not available at the Information Sharing and Planning Meeting.
  - Discuss any further investigations which are ongoing.
  - Discuss the preliminary results of the post mortem examination.
  - Consider any safeguarding or child protection concerns.

- Consider any disclosure issues and any necessary restrictions according to the nature of the case and the extent of any criminal or coronial investigations.
- Consider the need for referral to the Regional Safeguarding Children Board for a Child Practice Review.
- Ensure the right support is available to the family.
- Ensure appropriate support is provided to all professionals who attended the child and family.
- Consider and plan for any media interest in the death.
- Agree which agency will undertake each action and agree timescales (which may not exceed those set out in this PRUDiC) for doing so.

11.8.4 Minutes will be circulated to all invitees within 5 working days of the meeting.

11.8.5 The Chair (or their delegate) will provide available information to the Child Death Review Programme using the Child Death Notification Form. (Appendix 5)

11.8.6 With the agreement of the Chair and depending on circumstances and on the course of any criminal investigation, the Consultant Paediatrician will write a letter to the parents offering to meet them to discuss the available information concerning the cause of their child’s death, answer any questions, and offer future care and support.

11.8.7 HM Coroner will be informed of any relevant new information shared at this meeting. This will be the responsibility of the Police Senior Investigation Officer.

11.9 **Phase 3: The Case Review Meeting (Within 12 months)**

11.9.1 The purpose of the Case Review Meeting is to provide assurance to the Regional Safeguarding Children Board that every unexpected child death has been thoroughly investigated and all learning identified.

11.9.2 A Case Review Meeting must be held as soon as possible once the results of all relevant investigations have been obtained. The final report of the post mortem examination will be necessary to inform this meeting. Sharing of the final report of the post mortem examination is at the HM Coroner’s discretion and may not be possible until the Inquest or Trial has been concluded.

11.9.3 All relevant records will be available to this meeting, including the minutes and decisions of the 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 HM Coroner for the recording of the Inquest.

11.9.4 The meeting will be convened and chaired by a Detective Inspector or Senior Protecting Vulnerable Persons Unit Officer or Public Protection Unit Officer. The meeting will involve as a minimum, the Senior Police Officer (as defined above), Health Board Head of Safeguarding, a Children’s Social Care representative of appropriate seniority and others if helpful to the process. Minutes should be drafted and circulated to all invitees within 5 working days of this meeting.

11.9.5 The Case Review Meeting will:

- Consider whether the family require any ongoing professional support.
- Consider any safeguarding or child protection concerns.
- Consider the need for referral to the Regional Safeguarding Children Board for consideration of a Child Practice Review.
- Consider information about the cause of death and those factors that may have contributed to the death including;
  - Factors intrinsic to the child.
  - Factors in the social environment including family and parenting capacity.
  - Factors in the physical environment.
  - Factors in relation to service provision.
- Identify learning from any Health Board Child Mortality Review and any other single agency internal review process.
- Identify the learning from any Regional Safeguarding Children Board Child Practice Review or Multi-Agency Professional Forum.
- Share the family’s views about the PRUDiC process and the care and support they have received where these have been shared with professionals.

11.9.6 At this meeting the Chair or their delegate will complete the Case Summary Template (Appendix 6) and forward it to the Regional Safeguarding Children Board Business Manager and the Child Death Review Programme.

11.9.7 Each agency will ensure that learning shared at the Case Review Meeting is disseminated within their agency and in particular to those involved with the child and family prior to or at the time of the child’s death.

## 12. Supporting Bereaved Families

The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and others who were involved in caring for the child. Families experiencing such a tragedy need to be met and supported with empathy and compassion. They need clear and sensitive communication. They also need to understand what happened to their child, and want to know that people will learn from what happened<sup>4</sup>.

The time spent with the family may be brief but professionals’ actions may influence how the family deals with the bereavement for a long time afterwards. A sympathetic and supportive attitude whilst maintaining professionalism is essential. Grief reactions will vary; individuals may be shocked, numb, withdrawn or very distressed. (See Appendix 1 for Pointers for all Professionals in talking with Bereaved Parents and Appendix 2 for Sources of Family Support).

<sup>4</sup> Child Death Review Statutory Guidance, HM Government October 2017

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Authors: Dr Lorna Price - Designated Doctor Safeguarding and Debbie Pachu - Designated Nurse Safeguarding National Safeguarding Team (NHS Wales)	Page: Page 16 of 43	



All professionals should:

- Handle the child with naturalness and respect, as if the child were still alive.
- Always refer to the child by name.
- Give families time and opportunity to ask questions.
- Address practical issues e.g. where the child will go, what will happen, when they will see the child.
- Communicate sensitively with families in a way and in a language which they understand, taking into account their religious beliefs and cultural differences.

All Health Boards should:

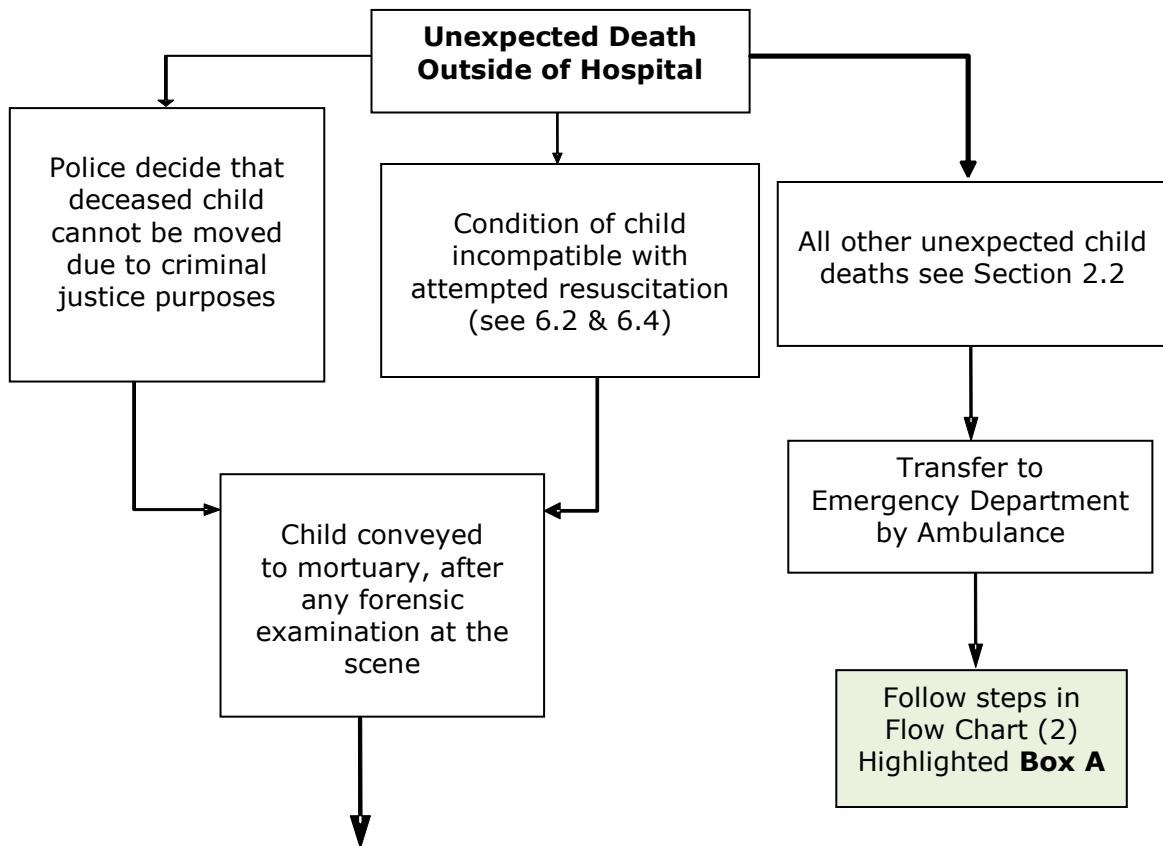
- Have a Bereavement Service with one or more Bereavement Advisers to provide a service to families and train other staff.
- Ensure every clinical area has staff with further training and enhanced skills in bereavement care, to include knowledge of cultural sensitivities, the coronial service, post-mortem examinations and funeral arrangements.
- Have a Bereavement Care Pathway to ensure parents and siblings are supported from arrival in the Emergency Department onwards.
- Have arrangements in place to ensure that the Bereavement Care Pathway is followed.
- Offer parents a Memory Box containing bereavement support information and mementoes of their child, as well as offering a referral to '2 Wish Upon A Star' or other support organisation as deemed appropriate by staff.

### 13. Supporting Staff

All child deaths will impact to varying degrees on members of staff who come into contact with the child and family. Agencies should have arrangements in place to support staff who may be affected by the events surrounding the death. 2 Wish Upon A Star can also offer independent support to professionals.

### 14. Flowchart of PRUDiC process

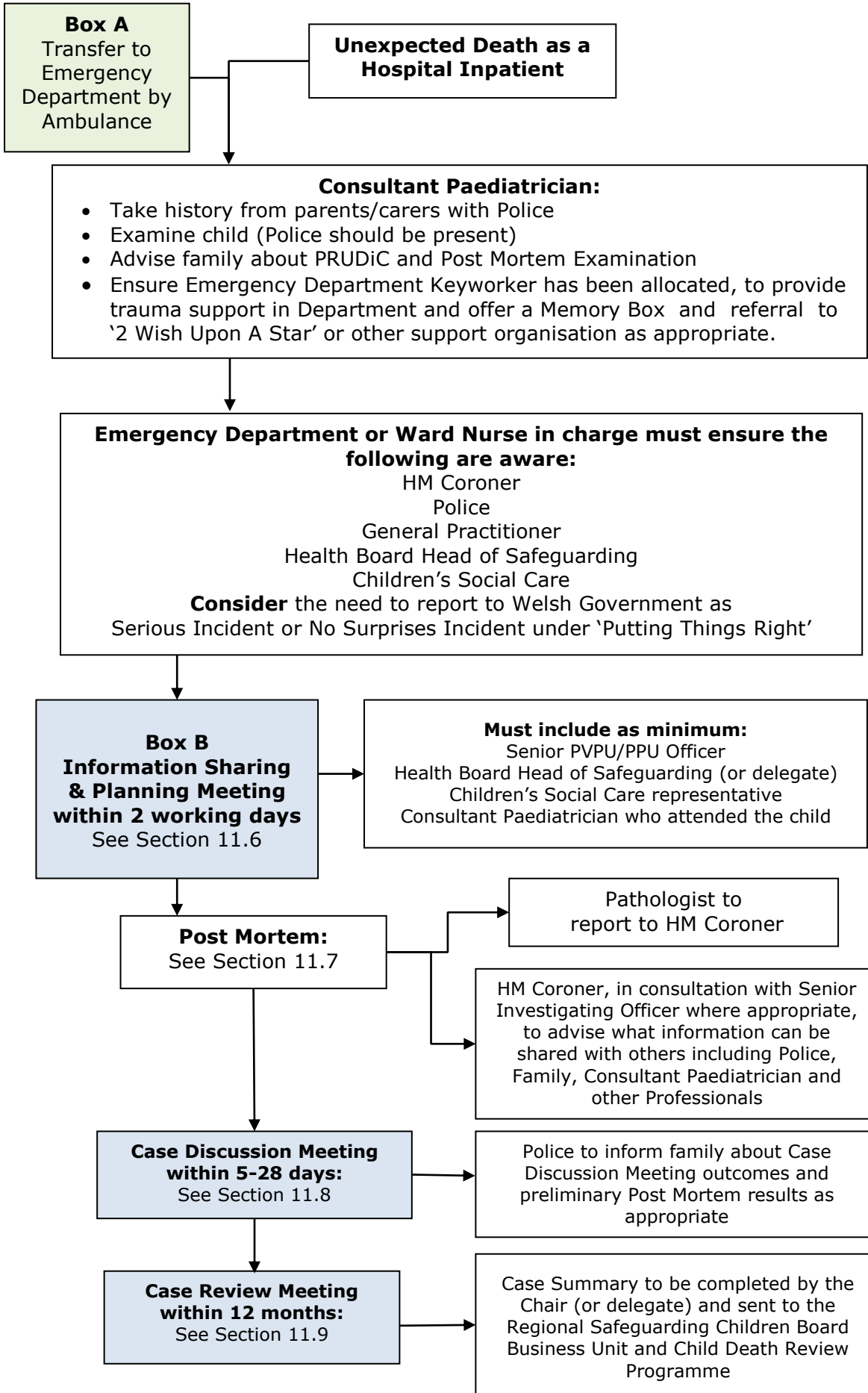
This flowchart should be followed depending on the circumstances of each case. Variance should be recorded along with the rationale. It is emphasised that only in exceptional circumstances should the child be taken directly to the mortuary. In most cases the child should be taken to the Emergency Department and examined by the Consultant Paediatrician on call.



- Police:**
- Inform HM Coroner
  - Ask Forensic Medical Examiner to examine child if required by Senior Investigating Officer
  - Inform Emergency Department Nurse in Charge
  - To deploy Family Liaison Officer/Police single point of contact, who will support family, inform re PRUDiC and Post Mortem
  - Offer family referral to 2 Wish Upon A Star or other support organisation
  - Inform Children’s Social Care who will address any safeguarding concerns

- Emergency Department Nurse in Charge** to ensure the following are informed:
- Consultant Paediatrician
  - Health Board Head of Safeguarding
  - General Practitioner

Follow steps in Flow Chart (2) Highlighted Box B



**Appendix 1: Talking with Bereaved Parents**

*(Adapted from advice given by the Lullaby Trust)*

- 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 distress. 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.
- Consideration should be given to when the body can be released for burial. Parents should be kept fully informed if there is going to be a delay.
- Be sensitive to non-traditional family structures, e.g. same sex relationships, stepfamilies, foster parents and grandparents as guardians.
- If English is 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.
- 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 2: Sources of Family Support

### 2 Wish Upon A Star

Provides immediate support, counselling and support groups for parents who lose a child or young adult under 25 years of age suddenly and traumatically.

Tel: 01443 853125

09.30 – 16.30, Monday - Friday

Email: [support@2wishuponastar.org](mailto:support@2wishuponastar.org)

[2wishuponastar.org](http://2wishuponastar.org)

### Child Bereavement UK

Support for parents and children who have been bereaved.

Helpline: 0800 02 888 40

09.00 - 17.00, Monday – Friday

Email: [support@childbereavementuk.org](mailto:support@childbereavementuk.org)

[childbereavementuk.org](http://childbereavementuk.org)

### The Child Death Helpline

The Child Death Helpline is a helpline for anyone affected by the death of a child of any age, 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 (Free phone): 0800 282 986

Additional Free phone number for ALL mobiles: 0808 800 6019

The Helpline is open every day of the year from:

19.00 - 22.00, every evening

10.00 - 13.00, Monday - Friday

13.00 - 16.00, Tuesday - Wednesday

[childdeathhelpline.org.uk](http://childdeathhelpline.org.uk)

### The Compassionate Friends

Support for bereaved parents and their families.

Helpline: 0345 123 2304

10.00 - 16.00/19.00 - 22.00, every day

Email: [helpline@tcf.org.uk](mailto:helpline@tcf.org.uk)

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

### Cruse Bereavement Care

Support for anyone who is bereaved.

Helpline: 0808 808 1677

09.30 - 17.00, Monday – Friday

Email: [info@cruse.org.uk](mailto:info@cruse.org.uk)

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

### The Lullaby Trust

Specialist support for bereaved families and anyone who has suffered the sudden death of an infant.

Helpline (Free phone): 0808 802 6868

10.00 - 23.00, Monday - Friday

18.00 - 23.00, Weekends & Bank Holidays

Email: [support@lullabytrust.org.uk](mailto:support@lullabytrust.org.uk)

[lullabytrust.org.uk](http://lullabytrust.org.uk)

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**Survivors of Bereavement by Suicide**

Support for those bereaved by suicide.

Helpline: 0300 111 5065

09.00 - 21.00, every day

Email: [sobs.support@hotmail.com](mailto:sobs.support@hotmail.com)

[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: 08452 03 04 05

09.00 - 17.00, Monday – Friday

Email: [info@winstonswish.org.uk](mailto:info@winstonswish.org.uk)

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

**Appendix 3: Proforma for History and Physical Examination of the Child**  
*(Adapted from 'Sudden unexpected death in infancy and childhood: multi-agency guidelines for care and investigation. Royal College of Pathologists, 2<sup>nd</sup> edition, November 2016')*

To be completed by the Consultant Paediatrician examining the child and retained as part of the health record

**History Proforma**

Identification Data	Details
Name of Child	
Male or Female	
Ethnicity	
Date of Birth	
Date of Death	
Address	
Postcode	
Name of Father	
Date of Birth of Father	
Address of Father (If different from child)	
Name of Mother	
Date of Birth Mother	
Address of Mother (If different from child)	
Name of Partner (If relevant)	
Date of Birth of Partner	
Address of Partner (If different from child)	
Consanguinity (Degree of relatives)	

General Practitioner	
General Practitioner Address	
Consultant/s	
Police Lead Investigator	
Social Worker	
HM Coroner / HM Coroner's Officer	
Other Professionals (Please provide full details)	

**Details of Transport of Child to Hospital**

Place of Death? Home address as above? Another location? (Please specify) Hospital? (Please specify)	
Time Found?	
Time arrived in Emergency Department?	
Resuscitation carried out? Yes or No (Please specify)	
At scene of death? Ambulance? Emergency Department?	
By whom? (Please specify) Carers? General Practitioner? Ambulance Crew? Hospital Staff? Others?	
Confirmation of Death Time	
Confirmation of Death Date	

**History**

Taken in Emergency Department by?	
Taken at Home Visit by?	
History given by?	



Relationship to child:	
<b>Events Surrounding Death</b>	
Who found the child?	
Where and when?	
Appearance of the child when found?	
Who called the Emergency Services?	
When child was last seen alive and by whom?	
Details of any resuscitation at home, by Ambulance Crew and in Hospital?	
For accidental/traumatic deaths, details of circumstances around the death and witnesses?	
<b>Detailed Narrative Account of Last 24 to 48 hours</b>	
To include details of activities and carers during last 24 to 48 hours.	
Details:	
Any alcohol or drugs consumed by child or carers?	
Details:	
For Sudden Unexpected Death in Infancy (SUDI), include details of last sleep, where and how put down, where and how found, any changes? Details of feeding and care given?	
Details:	
When last seen by a Doctor or other professional and why?	
Details:	
Further details of previous 2 to 4 weeks, including child's health, any changes to routine?	
Details:	
<b>Family History</b>	
Details of all family and household members, including names, dates of birth, health, any previous or current illnesses including mental health, any medications and current occupation?	
Details:	
Maternal parity and obstetric history?	
Details:	

Parental relationships?	
Details:	
Children, including children by previous partners?	
Details:	
Household composition?	
Details:	
Any previous childhood deaths in the family?	
Details:	
<b>Past Medical History</b>	
Of the child, to include pregnancy and delivery, perinatal history, feeding, growth and development?	
Details:	
Health and any previous or current illnesses, hospital admissions and any medication?	
Details:	
Routine checks and immunisation?	
Details:	
Systems Review?	
Details:	
Behavioural and educational history if appropriate?	
Details:	
<b>Social History</b>	
Type and nature of housing?	
Any major life events?	
Any travel abroad?	
Wider family support networks?	
<b>Any other Relevant History</b>	
May vary according to the age of the child and nature of death	
Details:	
<b>Information Retrieved From Record</b>	
Hospital, GP, Health Visitor, NHS Direct, etc. (Include family-held records such as the Personal Child Health Record (Red Book)	
Ambulance Crew	
Social Services, Databases, Case Records, Child Protection Register, etc.	

Police Intelligence, Police ASSIST, Police National Computer, Domestic Violence, etc.	
Any other information?	
Details:	

## Physical Examination Proforma

Examination to be carried out by the Consultant Paediatrician  
(Police Investigator should be present)

Identification Data	Details	
Name of Child		
Male or Female		
Ethnicity		
Date of Birth		
Date of Death		
Address		
Postcode		
Physical Examination carried out by: (Please print full name and title)		
Others present at the Examination? (Please print full name/s and title/s)		
Date of Physical Examination		
Time of Physical Examination		
Interval since death		
<b>For infants and children under 24 months include full growth measurements</b>		
Centile		
Length (cm)	cm:	Centile:
Head circumference (cm)	cm:	Centile:
Weight (g)	cm:	Centile:
<b>For all children 0-18 years</b>		
Retinal examination		
Rectal temperature		
State of nutrition		
State of hygiene		
Marks, livido, bruises or evidence of injury. Include any medical		

puncture sites and failed attempts (should be drawn on body chart)	
Note: Check genitalia	
Note: Check back	
Note: Check mouth Is the fraenum of lips/tongue intact?	
<b>Further details, observations and comments</b>	
List all drugs given at the Hospital and any interventions carried out at resuscitation.	
Document direct observations of the position of the endotracheal tube prior to removal.	
Document any cannulae, nasogastric tubes and any other medical intervention prior to removal.	
Date:	
Time:	
Signature of person who undertook the physical examination	
Date:	
Time:	
Signature/s of others present at the examination.	

Insert Body Chart

## Appendix 4: Scene Examination Checklist for Infants and Children Under 24 Months

(Adapted from 'Sudden unexpected death in infancy and childhood: multi-agency guidelines for care and investigation. Royal College of Pathologists, 2<sup>nd</sup> edition, November 2016')

To be completed by the police and retained as part of their record

### Scene Examination Proforma

Child's Name	
Date of Birth	
Date of Death	
Address	
Date of Scene Visit	
Persons Present	

Room	
Please Note: Size Orientation (compass) Contents Any 'clutter'?	
Ventilation: Windows and Doors (open or shut)	
Heating: (Including times switched on/off)	
Measure Drawer Temperature °C	
Sleep Environment	
Note: Location position of bed/cot in relation to other objects in room	
Was the child sleeping on a sofa, floor or elsewhere?	
Mattress/Bedding/Objects?	

--	--

<b>Position of Child</b>		
--------------------------	--	--

When put down?		
----------------	--	--

When found?		
-------------	--	--

Any evidence of over-wrapping or over-heating?	Yes:	No:
--	------	-----

Comments:		

Any Restriction to ventilation or breathing?	Yes:	No:
--	------	-----

Comments:		

Any risk of smothering?	Yes:	No:
-------------------------	------	-----

Comments:		

Any potential hazards?	Yes:	No:
------------------------	------	-----

Comments:		

Any evidence of neglectful care?	Yes:	No:
----------------------------------	------	-----

Comments:		

<b>Diagram of Scene</b>
-------------------------

Please draw diagram of scene including North/South orientation, room measurements, location of doors, windows, heating, any furniture and objects in the room

--

**Appendix 5: Child Death Notification Form**

**UNEXPECTED DEATHS:** To be completed by the Chair (or their delegate) of the Case Discussion Meeting and a copy submitted to the Child Death Review Programme and the Business Manager of the Regional Safeguarding Children Board.

**EXPECTED DEATHS:** To be completed by the doctor who confirms the fact of death and a copy submitted to the Wales Child Death Review Programme.

**A. REPORTING DETAILS: (Your Details)**

Date of Completion		Welsh Paediatric Surveillance number (if applicable)	
Full name and role			
Organisation			
E-mail address			

**B. CHILD'S DETAILS**

Full name of child			
Date of birth		NHS No.	
Home address (normal residence of child)			
Postcode	Sex	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Was the child on the Child Protection Register?	At the time of death <input type="checkbox"/> Previously <input type="checkbox"/> Not at all <input type="checkbox"/>		
Was the child a "Looked after Child"	At the time of death <input type="checkbox"/> Previously <input type="checkbox"/> Not at all <input type="checkbox"/> If yes, what local authority?		
Was the child in receipt of any of additional services?	<p><b>Team around the Family (TAF)</b> At the time of death <input type="checkbox"/> Previously <input type="checkbox"/> Not at all <input type="checkbox"/></p> <p><b>Integrated Family Support Service (IFSS)</b> At the time of death <input type="checkbox"/> Previously <input type="checkbox"/> Not at all <input type="checkbox"/></p> <p><b>Flying Start</b> At the time of death <input type="checkbox"/> Previously <input type="checkbox"/> Not at all <input type="checkbox"/></p> <p><b>Families First</b> At the time of death <input type="checkbox"/> Previously <input type="checkbox"/> Not at all <input type="checkbox"/></p>		

### C. DETAILS OF THE DEATH

Date of death		Time of death	
Where did the event which led to the death occur?	Home <input type="checkbox"/> Hospital <input type="checkbox"/> Other <input type="checkbox"/>		
Address of event (if hospital or other)?			
Where was death confirmed?	Home <input type="checkbox"/> Hospital <input type="checkbox"/> Other <input type="checkbox"/>		
Has this death been referred for any other type of review?	Child practice review <input type="checkbox"/> Hospital morbidity/mortality <input type="checkbox"/> Domestic homicide review <input type="checkbox"/> Criminal investigation <input type="checkbox"/>		
Has the death been reported to Welsh Government as a serious incident? (as defined in section 9.2 of Putting Things Right)	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Medical certificate for the cause of death issued?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, please state cause of death		If no, what is your understanding of the cause of death?	
Death expected?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Was an advance (end of life) care plan in place?	Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>
Has a PRUDiC been implemented?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>An unexpected death is defined as the death of a child which is a 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</b>			
Was the death referred to the HM Coroner?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes state date reported and name of HM Coroner?			
Post mortem date and venue		Has an inquest been held?	

### D. ADVERSE CHILDHOOD EXPERIENCES

Please select all that you are aware of in relation to the social background of the child			
<input type="checkbox"/> verbal abuse	<input type="checkbox"/> physical abuse	<input type="checkbox"/> sexual abuse	<input type="checkbox"/> parental separation
<input type="checkbox"/> household domestic violence	<input type="checkbox"/> household mental illness	<input type="checkbox"/> household alcohol abuse	<input type="checkbox"/> household drug use
<input type="checkbox"/> household member incarcerated	<input type="checkbox"/> household physical health issues	<input type="checkbox"/> household disability (including learning disability)	<input type="checkbox"/> neglect
Did the child perform any caring duties?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
	If yes, who for? Parent <input type="checkbox"/> sibling <input type="checkbox"/> other <input type="checkbox"/>		



## E. NARRATIVE OF CIRCUMSTANCES AND HISTORY

### Please record:

**Circumstances leading to death:**

**Relevant past history:**

**Relevant social and family circumstances:**

**Any other relevant information:**

**Please complete the relevant section on the next page for:**

- **Sudden unexpected deaths in infancy**
- **Deaths from drowning**
- **Deaths from apparent suicide**
- **Deaths in motor vehicles**
- **Deaths from fire**

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## F. MODIFIABLE FACTORS – please record if any of the following factors were present

<b>Sudden Unexpected Death in Infancy (under 2 years old)</b>			
Co-sleeping at time of death	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>
Sofa sleeping at time of death	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>
Parental smoking	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>
Illness in child in week prior to death	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>
Parental history of drug use	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>
Parental alcohol use at time of death or past history of concern	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>
<b>Drowning</b>			
Ability to swim	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>
Possible alcohol consumption	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>
Lack of active supervision	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>
<b>Deaths in Motor Vehicles</b>			
Seatbelt use (or appropriate car seat)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>
Driving at night	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>
Driving over legal blood alcohol limit	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>
<b>Apparent Suicide</b>			
Known to CAMHS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>
Known to youth offending services	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>
History of alcohol abuse	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>
History of drug misuse	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>
Bullying	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>
<b>Fire</b>			
Working smoke alarm in house	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>

## NEXT STEPS

Please send the completed form to the Regional Safeguarding Children Board Business Manager and the Child Death Review Programme:

**Email:** An e-mail attachment to [ChildDeath.Review@wales.nhs.uk](mailto:ChildDeath.Review@wales.nhs.uk)

**Post:** Child Death Review Programme Team, Public Health Wales, 1<sup>st</sup> Floor Matrix House, Northern Boulevard, Swansea Enterprise Park, Swansea, SA6 8DP.

**Tel:** 01792 940938 or 01792 940939

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Authors: Dr Lorna Price - Designated Doctor Safeguarding and Debbie Pachu - Designated Nurse Safeguarding National Safeguarding Team (NHS Wales)	Page: Page <b>34</b> of <b>43</b>	

**Appendix 6: Case Summary Template**

To be completed by the Chair (or delegate) at the Case Review Meeting and forwarded to the Regional Safeguarding Children Board Business Manager and the Child Death Review Programme.

<b>Child's Name:</b>	
<b>Date of Birth:</b>	
<b>Date of Death:</b>	
<b>Address:</b>	
<b>NHS Number:</b>	

**Cause Death**

<b>Details:</b>
-----------------

**Case Summary**

<b>Details:</b>
-----------------

### Contributory Factors

**Factors intrinsic to the child:** Include any known health needs; factors influencing health; development/educational issues; behavioural issues; social relationships; identity and independence; abuse of drugs or alcohol; note strengths and difficulties.

**Please enter relevant information:**

**Social environment including family and parenting capacity:** Include family structure and functioning: provision of basic care; health care (including antenatal care where relevant); safety; any evidence of current or previous abuse or neglect; emotional warmth; stimulation; guidance and boundaries; stability; parental abuse of drugs or alcohol; wider family relationships; employment and income; social integration/ support; nursery/pre-school or school environment

**Please enter relevant information:**

**Physical environment:** Include known hazards relating to the external environment in relation to common childhood injuries of burns and/or falls; road traffic accidents; issues relating to housing and home safety measures.

**Please enter relevant information:**

**Service Provision:** Include any identified services (either required or provided); any gaps between child’s or family member’s needs and service provision; any issues in relation to service provision, access or uptake

**Please enter relevant information:**

**Please enter any other relevant information which you wish to share:**

**Appendix 7: Welsh Ambulance Services NHS Trust**

**WAST Procedural Response to Unexpected Deaths in Childhood (PRUDiC)**

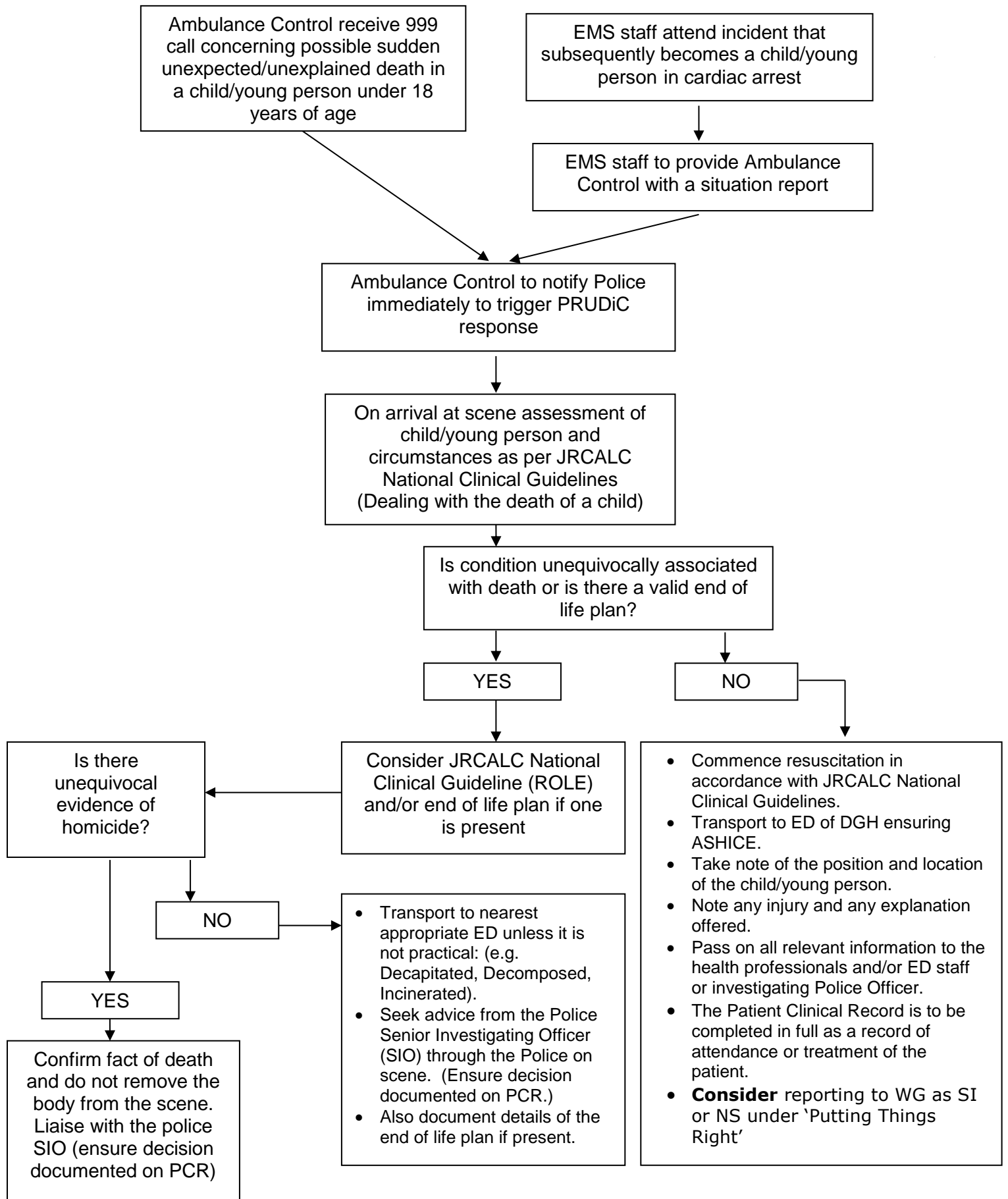
Ambulance Control must immediately notify the Police when a call is received for an unexplained child death in order that PRUDiC may be triggered.

The attending Emergency Medical Staff should:

- a) Not automatically assume that the death has occurred.
- b) Clear the airway and if in any doubt about death, apply full Cardiopulmonary Resuscitation.
- c) Inform the Emergency Department giving an estimated time of arrival and patient’s condition.
- d) Transport the child to an Emergency Department at one of the District General Hospital.
- e) Take note of the position and location of the baby or child.
- f) Note any injury and any explanation offered.
- g) Pass on all relevant information to the health professionals and/or Emergency Department staff or investigating Police Officer.
- h) The Patient Clinical Record is to be completed in full as a record of attendance or treatment of the patient.

- Ambulance staff should remove the child/young person to the Emergency Department of the local District General Hospital rather than to the mortuary, even if the death has been determined at home unless the child is obviously dead **AND** there are suspicious circumstances where removing the body from the scene could cause loss of evidence.
- Exceptions to this would include situations that are unequivocally associated with death as a result of decapitation, decomposition, incineration where removal is not practical.
- Seek advice from the Police Senior Investigating Officer (SIO) through the Police on scene (ensure decision documented on Patient Clinical Record).
- Best practice would recommend that the crew gain confirmation that the Police will be informing the Emergency Department Nurse in Charge if the child is being taken directly to the mortuary to ensure the correct procedures are triggered.
- The main reason for taking the child/young person to the Emergency Department rather than the mortuary are that an immediate examination can be made by the Paediatrician and parents/carers can talk with the Paediatrician and be provided with bereavement support.
- In circumstances of a suspicious death the first Police Officer on scene should make this decision, seeking advice from a Police Senior Investigating Officer (SIO) as appropriate. (This decision should be captured on the Patient Clinical Record.)
- The first professional on scene (e.g. Ambulance, General Practitioner) should note the position of the child, the clothing worn and the circumstances of how the child was found.
- If the circumstances allow, note any comments made by the carers, any background history, any possible drug misuse and the conditions of the living accommodation.
- Any such information or concerns must be passed on to the receiving doctor, the Police and the Consultant Paediatrician.
- Any safeguarding concerns for other children present should be reported directly to the Police and to Children’s Social Care as soon as possible.
- Consider the need to report (as a Serious Incident (SI) or No Surprises (NS) incident) to Welsh Government in accordance with the ‘Putting Things Right’ guidance.

## WAST Procedural Response to Unexpected Deaths in Childhood (PRUDiC)





**Appendix 8: Role of Police**

The relevant guidance for the Police is the National Police Chiefs’ Council (NPCC) 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 2016 (supplementary reading CD-ROM).

**Road Traffic Collision**

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

**Sudden Unexpected Death in Infancy and Childhood<sup>5</sup>**

As Chair of a working group into the care and investigation of sudden unexpected death in infancy and childhood Baroness Kennedy stated that:

*‘Parents suffering a terrible tragedy need sensitive support to help deal with their loss. It is every family’s right to have their baby’s death properly investigated. Families desperately want to know what happened, how the event could have occurred, what the cause of death was and whether it could have been prevented.*

*This is important in terms of grieving but is also relevant to a family’s high anxiety about future pregnancies and may identify some hidden underlying cause, such as a genetic problem. And if there happens to be another sudden infant death in the family, carefully conducted investigations of an earlier death also help prevent miscarriages of justice.’*

These guidelines provide a useful resource for Police and includes appendices to support the Police in their investigative processes.

<sup>5</sup> Sudden unexpected death in infancy and childhood: multi-agency guidelines for care and investigation. 2<sup>nd</sup> edition, November 2016

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Authors: Dr Lorna Price - Designated Doctor Safeguarding and Debbie Pachu - Designated Nurse Safeguarding National Safeguarding Team (NHS Wales)	Page: Page <b>41</b> of <b>43</b>	

## Appendix 9: Role of HM Coroner in the PRUDiC

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 death is pronounced, HM Coroner has control of the body until s/he releases it. If an investigation is to be opened, then it is usually at this point that the body is released by the HM Coroner.

The HM 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 HM Coroner has signed release paperwork for the child at the opening of the inquest. It is important this information is shared only by the HM 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, HM Coroner must be kept informed of all significant information obtained from the multi-agency communications and interviews with parents.

HM Coroner, usually via a HM 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 HM Coroner.

The PRUDiC will be implemented in all cases of unexpected death in childhood in addition to any coronial investigation. The chair of all PRUDiC meetings will inform HM Coroner of any relevant information shared and in some instances the HM Coroner's Officer will choose to be present at the meeting(s).

## Appendix 10: Resources

- **National Police Chiefs' Council (NPCC) 2016 Guidelines on Infant Death: Murder Investigation Manual**
- **All Wales Child Protection Procedures** <http://www.awcpp.org.uk>
- **All Wales PAC-Plan**  
Together for short lives  
[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)
- **Child Death Review Programme**  
<http://www.wales.nhs.uk/sitesplus/888/page/84337>
- **Human Tissue Authority Guidelines**  
<http://www.hta.gov.uk/licensingandinspections/sectorspecificinformation/postmortem.cfm>
- **Sudden unexpected death in infancy and childhood: multi-agency guidelines for care and investigation. 2<sup>nd</sup> edition, November 2016** (the Kennedy Report)  
<https://www.rcpath.org/resourceLibrary/sudden-unexpected-death-in-infancy-and-childhood-report.html>
- **Putting Things Right** Welsh Government guidance on dealing with concerns about the NHS from 1 April 2011, Version 3 November 2013  
<http://www.wales.nhs.uk/sites3/home.cfm?orgid=932>
- **Standards for Radiological Investigations of Suspected Non-accidental Injury RCR September 2017**  
[https://www.rcr.ac.uk/system/files/publication/field\\_publication\\_files/bfcr17\\_suspected\\_physical\\_abuse.pdf](https://www.rcr.ac.uk/system/files/publication/field_publication_files/bfcr17_suspected_physical_abuse.pdf)