Title:	***Protocol for the Management of an Unexpected Child Death in the Falkland Islands.***
Author:	***Chief Medical Officer***
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Contents

Appendices:

1 Introduction

The death of a child is always a tragedy. It is the right of every family to have their child's death properly investigated. Families desperately need to know what has happened, how the event occurred, what the cause of death was and whether it could have been prevented. The investigation must be as uncomplicated as possible and carried out in a compassionate, professional way through a coherent multi-disciplinary and multi-agency approach. Professionals need to strike a balance between ensuring that a proper investigation is carried out and protecting the interests and safety of children and providing sensitive support for the bereaved family.

This protocol is issued by the Falkland Islands Safeguarding Children Board and provides a framework for a co-ordinated multi-disciplinary and multi-agency response in the Falkland Islands to any sudden, unexpected or unexplained death of a child. It is based on the report of a working group convened by the Royal College of Pathologists and the Royal College of Paediatrics and Child Health chaired by Baroness Helena Kennedy QC (2004) 'Sudden Unexpected Death in Infancy' otherwise known as the 'Kennedy Protocol', updated to a second edition November 2016 along with A Guide to investigating Child Deaths; Association of Chief Police Officers 2014 and the London Rapid Response Procedure; London Safeguarding Children Board 2017. It reflects United Kingdom best practice guidance for the investigation and care of families after child death and allows for the special circumstances of the Falkland Islands. It takes into account the guidance contained in the document 'Working Together to Safeguard Children 2015', adopted by the Falkland Islands Safeguarding Children Board.

In any sudden and unexplained death, the lead lies with Her Majesty's Coroner and the Royal Falkland Islands Police. This protocol sets out how ALL the agencies must work together when a child dies and gives insight into the priorities of all the professionals involved along with their roles and responsibilities.

Children who die unexpectedly but from an evident medical or surgical cause in hospital (eg; overwhelming sepsis) will be under the care of the CMO, Surgeon or Anaesthetist. The appropriate Registered Medical Practitioner is responsible for discussing with HM Coroner and sharing information with the pathologist, if appropriate, and, if, agreed with the Coroner signing the medical cause of death certificate.

The health services will be responsible for support for the family with a designated professional.

2 Principles

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

1. A sensitive, open-minded and balanced approach

2. An inter-agency response

3. Sharing of information

4. An appropriate response to the circumstances

5. Preservation of evidence

3 Definitions

Chief Medical Officer (CMO)

Registered medical practitioner appointed as Chief Medical Officer of the Falkland Islands or, in his or her absence, the person designated to fulfil this role.

Chief Nursing Officer (CNO)

A Registered Nurse who is responsible for the provision of nursing services in the Falkland Islands or, in his or her absence, the person designated to fulfil this role.

Child

According to Section 3(1) of the Children Ordinance 2014 a child means 'a person under the age of eighteen'. This includes new born, baby, infant, toddler, child and teenager. While it is recognised that a teenager may be living independently, part of the work force and indeed a parent and/or married, their death is recognised as requiring the multi-agency approach.

Consultant Pathologist

A Medical Practitioner who specialises in medical diagnosis by examining body organs, tissues and fluids and chosen by HM Coroner to examine the person who has died, with a view to establishing a statutory cause of death. In the case of a child the pathologist will have specialist training.

Consultant Paediatric Advisor

A Medical Practitioner who specialises in Paediatrics. This person will vary depending on the nature of the death, the age of the child and other circumstances. CMO will arrange contact.

Coroner's Officer

The Coroner's Officer works under the direction of Her Majesty's Coroner to assist in the investigation of an unexpected death, to make inquiries at the direction and on behalf of HM Coroner and to liaise with the bereaved family. The Coroner's Officer must consider whether a crime may have been committed and inform the Coroner accordingly

Falkland Islands Safeguarding Children Board (FISCB)

The Falkland Islands Safeguarding Children Board is a statutory board under the Children Ordinance 2014. The objectives of the FISCB are:

"(a) to co-ordinate what is done by (and on behalf of) the Crown under its various functions (both statutory and non-statutory) for the purposes of safeguarding and promoting the welfare of children; and
(b) to ensure the effectiveness of what is done by (or on behalf of) the Crown for those purposes." (s83(1) Children Ordinance 2014).

The FISCB has the additional function of collecting and analysing information about all child deaths, whether expected or unexpected. Every death of a child must be notified to the FISCB for this purpose.

The FISCB has the authority to request information from any person or body to assist it in meeting its objectives.

Health Visitor (HV)

A registered nurse or midwife who specialises in the care of children and young people or in his or her absence the person designated to fulfil this role.

Her Majesty's Coroner (HM Coroner)

This is the person appointed to carry out coronial duties to investigate unexpected deaths. The Coroner must investigate all violent or unnatural deaths, all sudden deaths of unknown cause, all deaths of those who have died in prison or in the care of the state but only where the body of the deceased is lying within the coroner's district. As soon as death has been pronounced, HM Coroner has control of the body. HM Coroner usually orders a post mortem examination as soon as possible and opens an inquest.

Registered Medical Practitioner

A registered doctor who is on the list of doctors approved to work in the Falkland Islands.

Senior Investigating Officer

A police officer appointed to oversee an investigation.

School Nurse

A registered nurse or midwife who specialises in the care of children and young people or in his or her absence the person designated to fulfil this role.

Team Leader Social Services (TLSS)

A social worker who is responsible for the provision of social services in the Falkland Islands or in his or her absence the person designated to fulfil this role.

Unexpected death

An unexpected death is defined as the death of an infant or child (under 18) that is not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse or incident leading to or precipitating the events that led to the death.

The CMO should be consulted where professionals are uncertain about whether the death is unexpected. Where there is doubt the processes for unexpected child deaths should be followed until the available evidence enables a different decision to be made.

The definition includes all accidental deaths from whatever cause and deaths following suicide. It excludes situations where treatment is withdrawn or replaced with palliative care in a child with a long-standing medical condition.

4 The response pathway

Notification of the death of a child, whether expected or unexpected

To ensure that a response process is initiated where appropriate; Registered Medical Practitioners in the Falkland Islands are to notify promptly all deaths of children under their care, whether expected or unexpected, to the CMO who will inform Her Majesty's Coroner. The decision as to whether the medical cause of death certificate can be signed off by the Registered Medical Practitioner or not will be discussed and agreed with HM Coroner. Where there is a need to investigate further see Appendix 3.

Where the death has happened in Camp it is recognised that strict compliance with the protocol may not be met and reasoning for not complying must be recorded. For instance, early access to the scene may not be feasible.

In addition; in the case of unexpected death, or in cases where professionals are uncertain about whether it is unexpected, a number of other professionals will be notified by the CMO including:

- Police
- Chief Nursing Officer
- Health Visitor and or School Nurse
- Linked Consultant Paediatrician/Neonatologist

  Team Leader Social Services

Notification will include:

- Date and time of notification
- Name of child
- Date of Birth
- Ethnicity of child
- Sex of child
- Home Address
- Names of persons with parental responsibility (ie; mother, father or other by court order)
- Other children in household or affected by the death
- Carer of child at time of death
- Place/locality of death
- Time found
- Who found the child
- Senior medical practitioner present at time of death
- Case known to Social Services?
- Is this death unexpected?
- Is a post mortem required?
- Summary description of the circumstances of the death (if known; include immediate medical history, possible cause)
- Signature of registered medical practitioner and print name

(see Appendix 2 for the form)

Route of response process

If a child dies suddenly or unexpectedly, this information may be reported through several routes including:

1 Resuscitation is carried out by family or members of the public and the child is brought to the hospital and resuscitation continued by the health services staff. The jurisdiction of the police would commence once the child has been declared dead by the registered medical practitioner unless staff or family had reported a concern on the arrival of the child.

2 Resuscitation may have been commenced and continued into the hospital by emergency services. If the police were involved with the call out, or are informed of the incident, the Senior Investigating Officer must secure the scene so that the property is protected and evidence preserved so that an appropriate investigation can be commenced once the child has been declared dead. All adjuncts to the resuscitation would remain in place or are photographed in situ and fully documented as to their placement.

3 The child may be found and then declared dead by a registered medical practitioner at the scene. He or she must inform the CMO who must inform HM Coroner and the Police who will commence their investigations. In general, the child would be taken by ambulance to the hospital once permission is given by HM Coroner and the police, who first have a duty to secure and preserve evidence at the scene before the child is moved. At the hospital the child may be taken to casualty but more usually would be cared for in the chapel of rest.

In any of these situations when the child has been declared dead it is important that the care pathway is followed (see Appendix 1a ,b & c) and that family, friends and colleagues are treated sensitively. Do not be afraid to seek more assistance, through your line manager, at an early stage.

Where the child is initially transferred to within the KEMH

If investigations and tests are required, these can be carried out in casualty or most likely in the chapel of rest. The Falkland Islands have limited resources and locally available investigations and tests are listed at Appendix 5. The decision as to where the paediatric post-mortem examination is to be held, will be made by the CMO and coroner after discussion with the consultant pathologist. There may be circumstances where it is reasonable to undertake a specialist post-mortem in the Islands, eg; after a death from a fire, road traffic collision, drowning etc but an unexpected death, or death from criminal activity will most likely require transfer of the body overseas for post mortem.

Child dying overseas

A child from the Falkland Islands who dies overseas comes under the repatriation protocol available from HM Coroner.

A child death review would take place whether the child died in the Falkland Islands or overseas.

Initial enquiries

The child should be examined as soon as possible by the appropriate doctor as decided by the CMO. A detailed history should be taken from the parents, or carers, ideally but not absolutely by Coroner's Officer, CMO and Health Visitor/School Nurse.

The Kennedy Protocol and the Investigation into the Death of a Child by the Association of Chief Police Officers, recommend that those family members involved should be interviewed at an early stage. The questions are laid out in Appendix 4. *The appendix is intended to be printed out in booklet form.*

Multi-Agency approach to the enquiry

It is noted that a multi-agency approach to the investigation provides the best evidence in order that homicide or death where abuse or neglect is a factor can be excluded and a cause of death identified. The multi-agency approach causes the least distress to parents and carers and yet obtains the information needed by all the agencies. To this end the family are questioned once but with all or some of the multi-agency group present. The family is generally able to describe what has happened even at this early stage most effectively. If all professionals hear at one time, then the family does not feel that they are continually re questioned over the death of their child. Otherwise, they may repeat what has happened many times. Evidence shows (from Foundation of Sudden Infant Deaths for instance) that they are frustrated by having to start all over again with each service, however, when treated sensitively, are content for a detailed review of their child's death to be carried out.

The multi-agency group should meet prior to the initial meeting with the family to ensure that they are prepared and have agreed their roles and responsibilities.

In the event of the death being suspicious, the Coroner's Officer will alert the Coroner who will inform the Senior Investigating Officer, who will decide upon the appropriate course of action, which may or may not include the arrest of a suspect. There are strict legal requirements placed upon the Police when conducting a criminal investigation that govern the way in which people are questioned and evidence secured/preserved.

Multi-agency group

The core multi-agency group will be:

- CMO (most likely lead questioner)
- Coroner's Officer (most likely the recorder)
- Health Visitor/School Nurse

Consideration may be given to include:

- Team Leader Social Work
- Nurse

Once information has been collected staff are identified to remain with the family while the Coroner's Officer, CMO and Health Visitor/School Nurse see the house.

Tasks for each professional in the multi-agency team are at Appendix 6.

5 Scene of death examination

If a child has died at home or in the community, it is essential that the Coroner's Officer, the Chief Medical Officer and Health Visitor visit the place where the child died in order to gather information to inform the Multi Agency team and HM Coroner. The visit needs to be made as soon as possible. In cases where the death is suspicious the, Senior Investigating Police Officer, whose duty it is to manage any potential crime scene and to avoid contamination of forensic evidence, may exclude persons from it until all forensic work at the scene has been completed.

6 Support for parents and family

If possible, and wanted, the family may wish to be with the child.

It may be that the family will wish a faith leader to be present.

Appropriate support for the family will be initiated at the time and continued throughout. Consideration needs to be given to:

- Siblings and other close family members
- Identifying a close relative or friend who may be able to act in a liaison supportive role
- Wider family and friends
- Referral to appropriate professionals such as General Practitioner (GP), Community Psychiatric Nurse (CPN) and Social Services
- Identify where the family are going to return to, bearing in mind that the home may have been secured by the Coroner's Officer for preservation of evidence
- Ongoing professional support
- Obtaining contact details

7 Initial debrief and information sharing

The CMO will arrange for key professionals to meet as soon as possible. The purpose of the meeting will be sharing and reviewing of information and identifying and planning for any immediate safeguarding issues. Professionals involved will be invited and these may include:

- Chief Medical Officer
- Chief Nursing Officer
- Health Visitor/School Nurse
- Coroner's Officer
- Senior Investigating Police Officer, where applicable Emergency Responders
- HM Coroner
- Social Services Team Leader
- Nurses and Doctors involved

If there are any suspected safeguarding issues, these will be actioned in accordance with the Falkland Islands Safeguarding Children and Young People Procedures. A strategy meeting under those procedures may be required.

8 Strategy meeting

The CMO will set up a multi-agency strategy meeting to take place within three working days of the child's death. The purpose of the meeting is to; share information about events leading to the child's death, to provide background history for the pathologist, to ensure a coordinated bereavement plan for the family and consider any past or ongoing safeguarding issues. The professionals attending will present reports and these are taken to the meeting.

Those invited may include the Registered Medical Practitioners, Health Visitor, Team Leader Social Services, CNO, Senior Investigating Police Officer, Coroner's Officer, education staff and other health professionals. The meeting is chaired by the CMO. Specialist opinion will be sought from the Consultant Paediatric Advisor.

9 Multi agency discussion following the post mortem

While it is impossible to estimate the time of the results for the post mortem these will be released as soon as practicable by HM Coroner. This may take several months and the parents should be made aware of this. In certain circumstances confidentiality or legal issues may delay the release of the information.

The Coroner's Rules limits who has the right to see the post-mortem report which has been commissioned by the Coroner. If the report is shared by the Coroner, a multi-agency discussion will take place to review the information available and to decide if any further action or inquiries are required. The meeting may be attended by the CMO, CNO, the Coroner's Officer, Team Leader Social Services and the Health Visitor/School Nurse.

Feedback from the primary care team and others in the community such as faith leaders are sought prior to the meeting and, if appropriate, they are invited.

At the meeting, relevant information about the unexpected child death is collected and a review of any safeguarding, modifiable factors, improvement or training needs will be identified. Consideration may be made of any representations and to whom they should be addressed. The information is forwarded to Her Majesty's Coroner to inform the inquest.

The case discussion should agree how detailed information about the cause of the child's death will be shared, and by whom, with the parents or carers, and who will offer the parents on-going support.

10 Child death review

As soon as is practicable, and once the results of all relevant investigations have been obtained, a child death review is to be undertaken. A review should be held for all child deaths, even when a child from the Falkland Islands dies overseas. The review meeting is to be chaired by the Chief Medical Officer and should involve all relevant professionals, including the Health Visitor/School Nurse, Team Leader Social Services, Chief Nursing Officer, Coroner's Officer and may also include a Police Senior Investigating Officer and Medical Practitioner. All relevant information concerning the circumstances of the death, the child's

history, family history and subsequent investigations should be reviewed and the information and discussions documented. Written reports by those providing information need to be prepared and circulated three working days before the meeting. The main purpose of the meeting is to share information and for future planning for the family. Formal classification of the cause of the child's death should be agreed. Families will not normally be invited, as the discussion is about the technical and medical information. The family must however be fully informed of the outcome and the review will decide and document who this information will be provided by. It is likely to be the CMO or Health Visitor/School Nurse.

During the child death review meeting it is important that there is explicit discussion of the possibility of neglect or abuse as a contributory factor to the child's death. If there is no evidence, this should also be documented. The quality of medical and social care should be discussed and any shortcomings and appropriate measures identified for improved future care. If the death has been found to be from natural causes, a review is still of value.

The results of the child death review should be communicated as a report to HM Coroner and information will be provided for the FISCB.

11 FISCB child death review

All child deaths, whether unexpected or not, are reviewed by the FISCB. The purpose of this review is to:

- Collate information from all agencies
- Classify the cause of death
- Identify modifiable factors
- Decide on preventability of the death
- Consider whether to make recommendations and to whom they should be addressed

12 References:

- Sudden Unexpected Death in Infancy Chair Baroness Helena Kennedy 2004 (incl 2nd edition November 2016)
- A Guide to investigating Child Deaths Association of Chief Police Officers 2014
- London Rapid Response Procedure London Safeguarding Children Board 2009
- Working Together to Safeguard Children 2015

Consulted with:

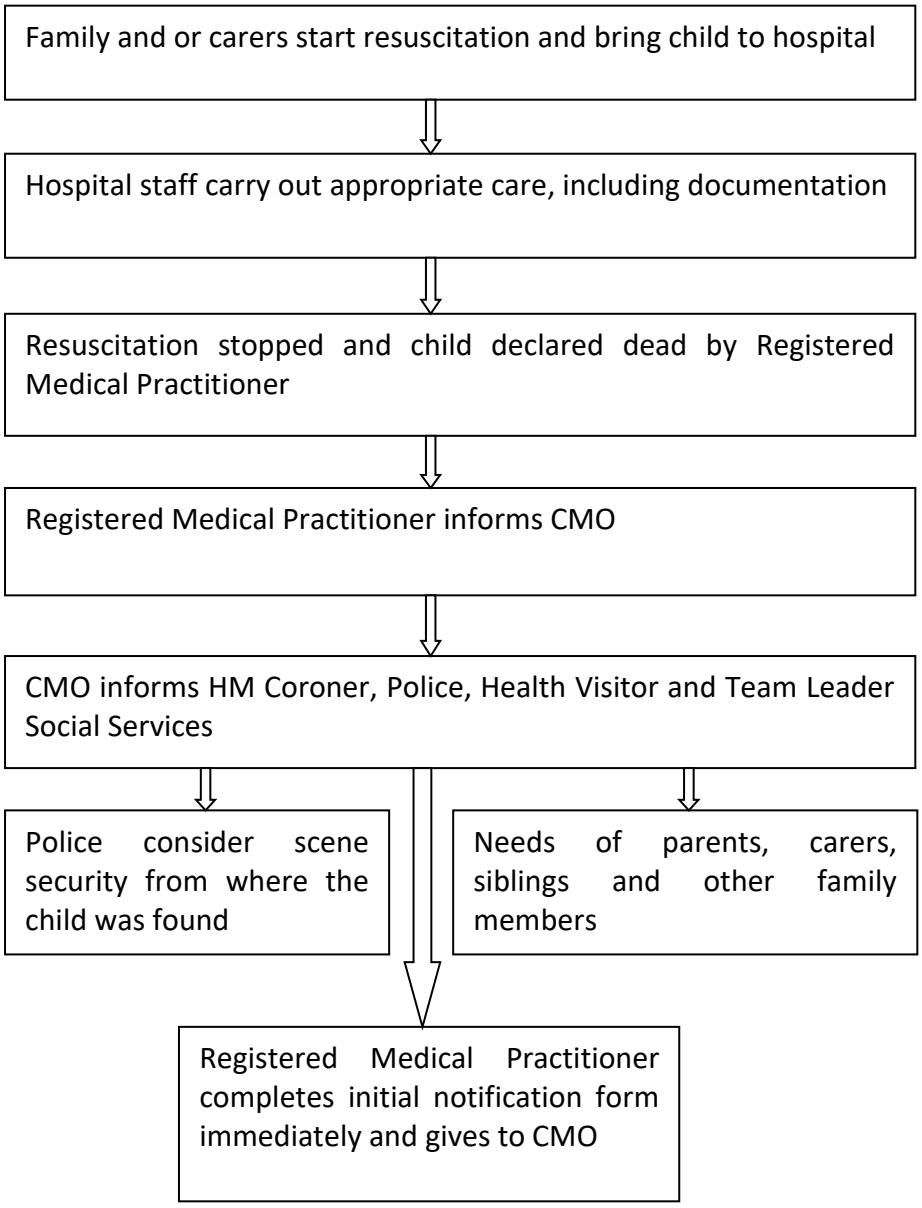
Chief Medical Officer	Dr R Edwards
Health Visitor	Ms S Linnell
School Nurse	Ms Westerman
Chief Police Officer	CPO Dave Street
HM Coroner	Mrs M Kuschner
Chief Nursing Officer	Mrs M Heathman
Court's Administrator	Mr J Brooks
Courts Clerk	Miss L Street
Consultant Pathologist	Dr J Clark
Crown Counsel	Ms E Price

2019 Review undertaken by Mrs M Heathman (CNO), Dr R Edwards (CMO) and Mrs S Whitby (Senior Crown Counsel Safeguarding)

2020 review undertaken by Mrs M Heathman (CNO) & Dr R Edwards (CMO)

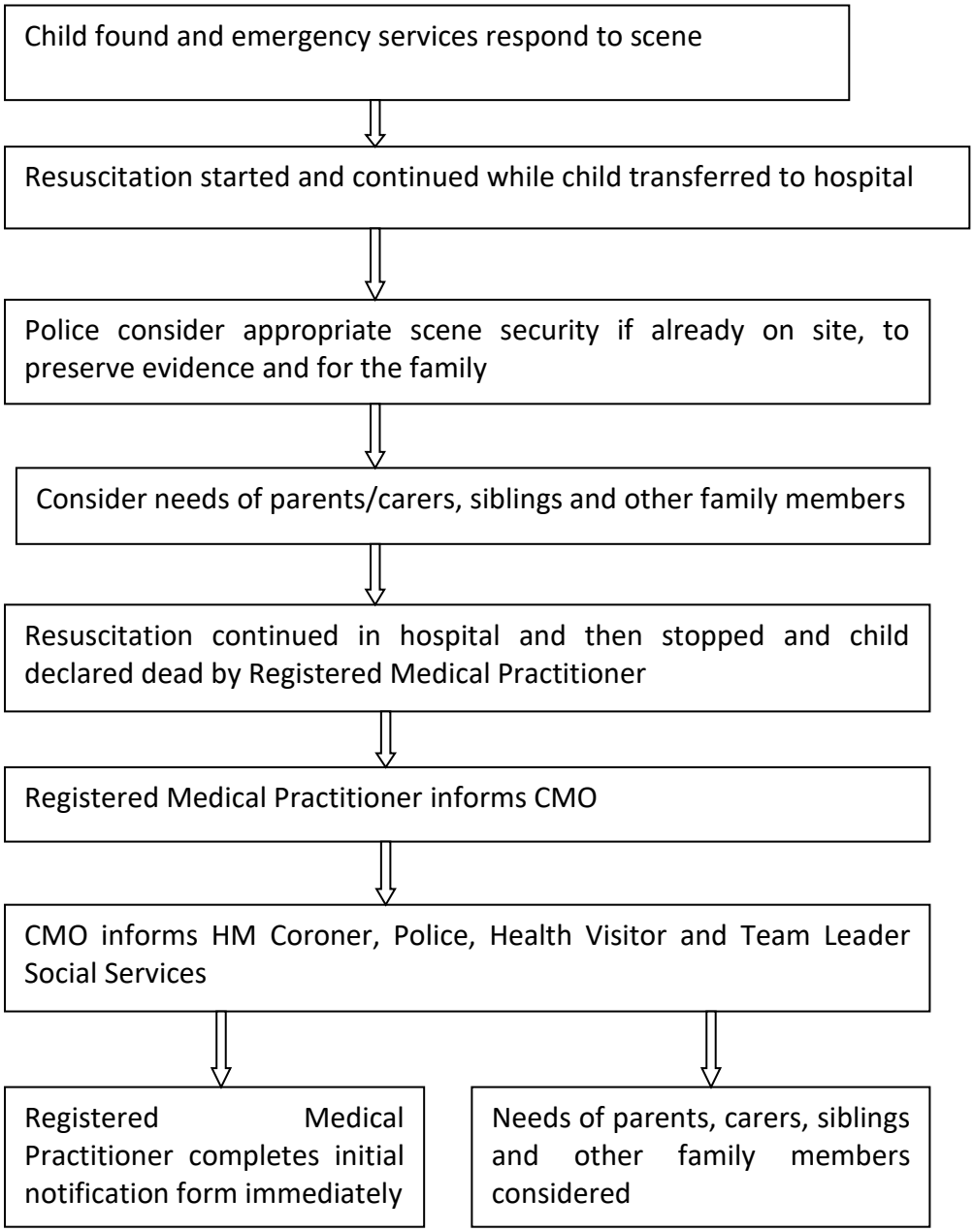
Appendix 1a

Care Pathway following Unexpected Death of a Child brought to hospital by family and or carers



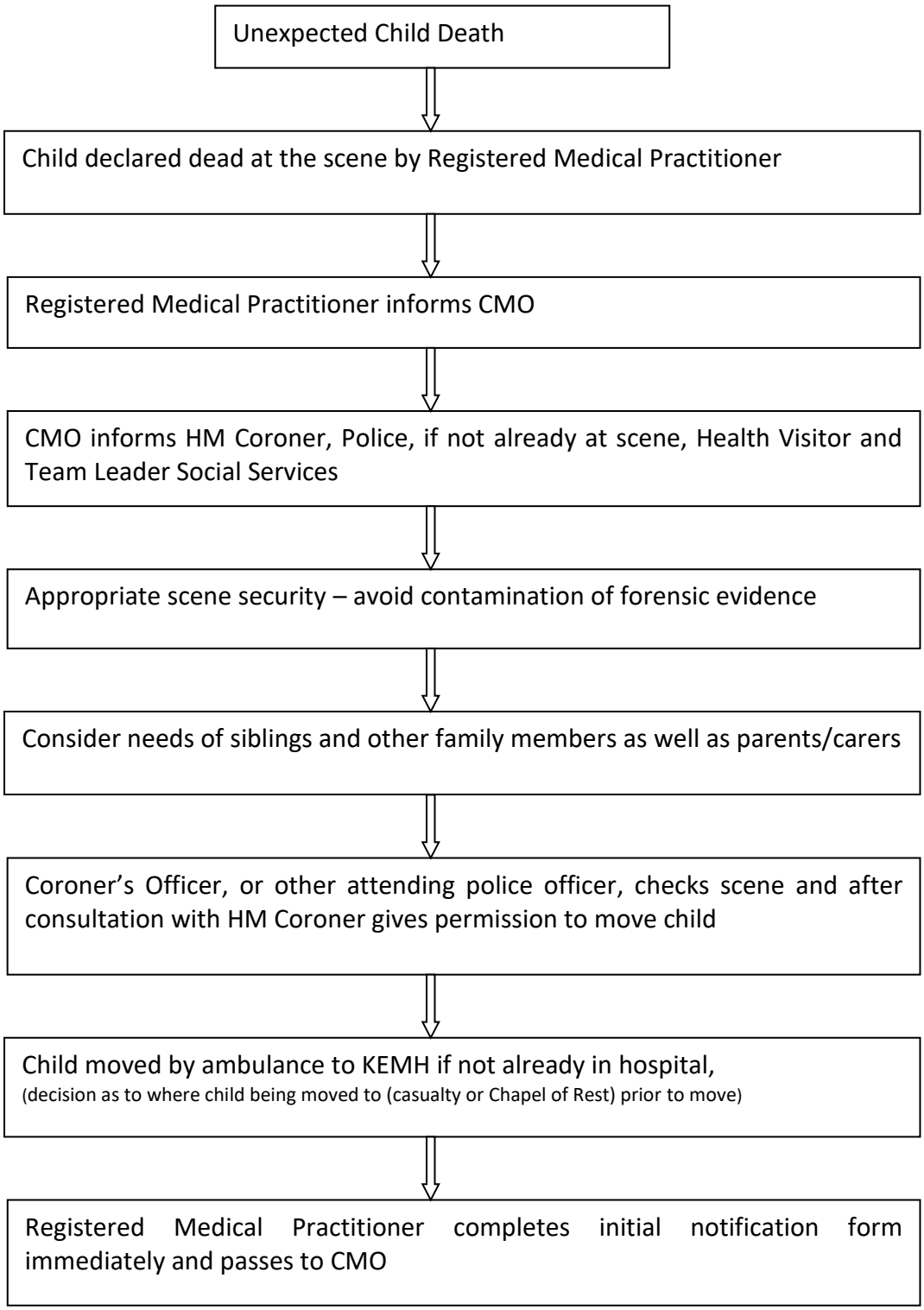
Appendix 1b

Care Pathway following Unexpected Death of a Child transferred to KEMH during resuscitation



Appendix 1c

Care Pathway following Unexpected Death of a Child with Registered Medical Practitioner at scene



Appendix 2

Initial Notification of the Death of a Child
To be completed and submitted as soon as possible by Registered Medical Practitioner
Please complete in BLOCK CAPITALS
Do not delay

Family Name of Child (include all other names used and known by)				First and other names of child	
Date and time of death				Date of birth of child	
Ethnicity of child		Sex of child		Carer of child at time of death	
Name/s of persons with parental responsibility ie; mother, father or other (state relationship)					
Home address of child					
Other children in household or affected by death (please complete with any available information)	Names (if known)			Ages/DOB (if known)	
Place/locality of death				Contact number	
Senior Medical Practitioner present at time of death				Contact number	
Is this an unexpected death? IE; not expected in the previous 24 hours	YES NO	Has this been confirmed by the designated Medical Practitioner? YES NO		Is a post mortem required	YES NO
Summary description of the circumstances of the death					
Is the child or are other children in the household known to Social Services?					
Print Name				Date and Time of notification	
Sign Name					

Please send form to CMO who will be sending onwards to: HM Coroner, Health Visitor

Appendix 3

Care Pathway following Unexpected Death of a Child

Notification to CMO who will notify HM Coroner of death of child and decision that this is an Unexpected Death of a Child

Brief Meeting instituted by CMO to outline plan of action

Consider logistics – space, tissues water/tea/coffee. Ensure adequate time. Care of siblings and other family members

Initial History and Narrative to be taken from parents and/or carers of child at time of finding the child

This is a multi-agency meeting including:
CMO
Health Visitor/School Nurse
Coroner's Officer
Team Leader Social Services
Initial decision taken on who is the questioner and who is to be the scribe (another may act as scribe)

It is entirely natural for parent/carers to want to hold or touch their dead child. Providing this is done with a professional, such as police officer, nurse or social worker present, it should be allowed in most cases as it is highly unlikely that forensic evidence will be lost. If, however, the death is considered suspicious, HM Coroner should, where possible, be consulted before a parent/carer is allowed to hold the child.

Multi-agency scene visit
Consider family and child and who will remain as support

On the death of a child it is normal to offer parents/carers a lock of hair and or foot and hand prints. Ensure feasibility of this by consulting with HM Coroner and Police prior to discussing with parent/carer. Some parents/carers will prefer for these to be taken and stored by the hospital until they are ready for them

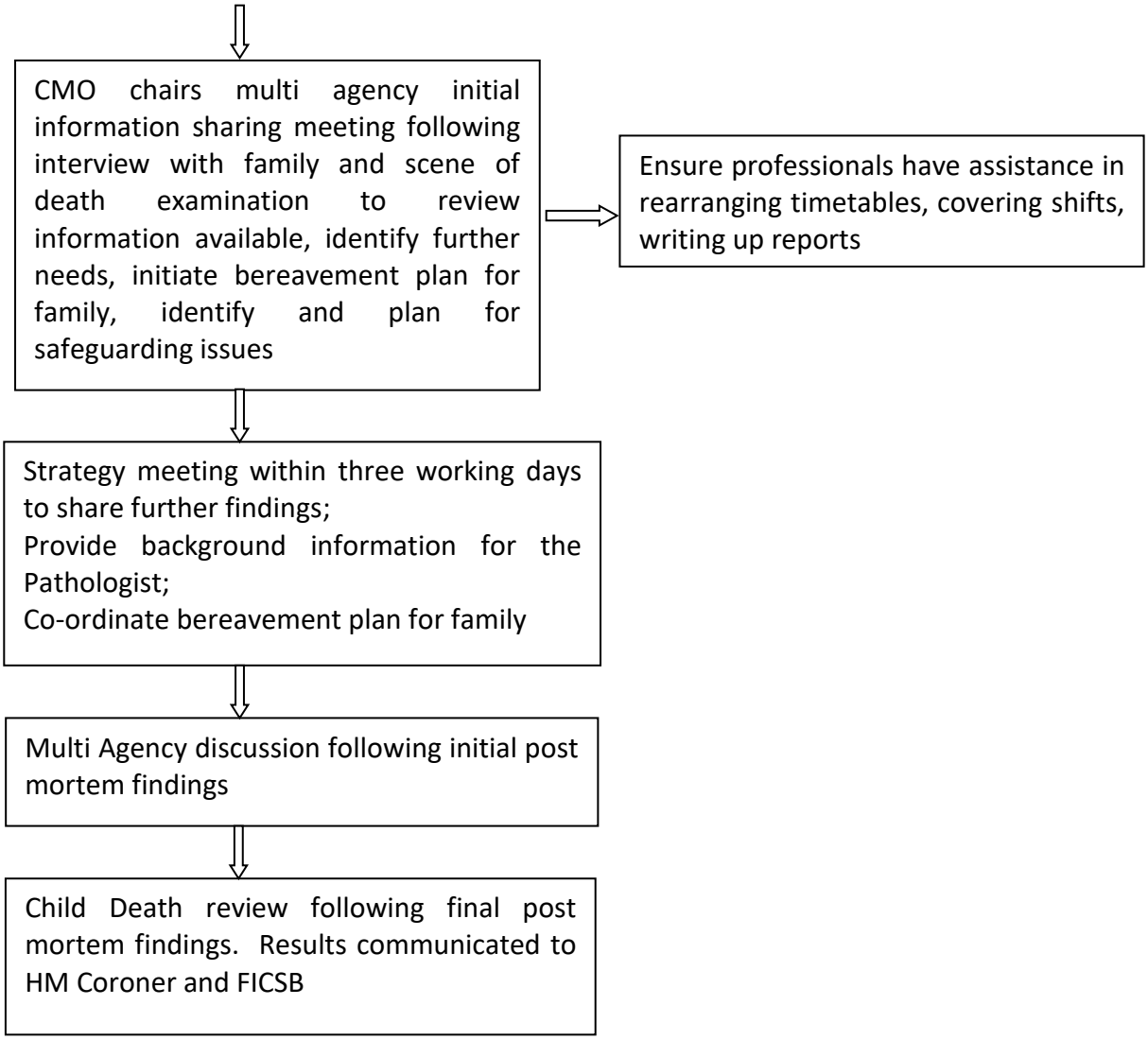
Areas covered in questions
(see Appendix 4 for full details

- The Child
- Mother
- Mother's partner and/or father of the baby
- Other members of the household present and in the recent past
- Family medical history
- Social and Family history
- Detailed medical history of mother
- Detailed medical and developmental history of the child who has died
- Detailed narrative account of child's feeding sleeping activity and health over the two week period prior to the death
- Detailed hour by hour narrative account of events within the 48 hours prior to the child dying
- The final sleep (child under 2)
- Action after child was found
- Further specific questions

While house visit undertaken, professional support remains with family. If appropriate start to identify family arrangements, support within family/close friend, contact details, where staying, any medical needs, a brief outline of what to expect next and exactly who to contact for support and information from the multi-agency team

Appendix 3

Care Pathway following Unexpected Death of a Child (*continued*)



Appendix 4 ***(it is intended that the pages in Appendix 4 are collated in a booklet)***

Page 1 – INITIAL ENQUIRIES

Name of Child_____

Date of Birth_____ Date and Time of Death_____

Date of Initial Review_____

Details of Child			
Family Name of Child		First Name(s) of Child (and any other names used)	
Date of Birth		Hospital No	
Place of Birth			

Details of Mother			
Last Name of Mother		First Name(s) of Mother (and any other names used)	
Address		Hospital No	
Date of Birth		Home/Mobile Number	
Address	(where going to stay)	Contact Details	

Details of Mother's Partner and / or Father of Child			
Last Name of Father		First Name(s) of Father (and any other names used)	
Address		Hospital No	
Date of Birth		Home/Mobile Number	
Address	(where going to stay)	Contact Details	

Other members of the household (present and in the recent past)			
1 Last Name		First Name	
Date of Birth		Contact details	
Relationship to child		When in household	
2 Last Name		First Name	
Date of Birth		Contact details	
Relationship to child		When in household	
3 Last Name		First Name	
Date of Birth		Contact details	
Relationship to child		When in household	
Use extra sheets as required			

Appendix 4

Page 2 - INITIAL ENQUIRIES

Name of Child _____

Date of Birth_____ Date of Initial Review_____

Family Medical History – a detailed account of past medical and social history of all members of immediate family and household		
Child who has died Name	Medical:	Social:
Mother Name Tobacco use? Y/N Number per day ☐ Alcohol use? Units per day ☐ Prescription Medication Non-prescription Meds	Medical:	Social:
Mother's Partner and or Father of Child Name Tobacco use? Y/N Number per day ☐ Alcohol use? Units per day ☐ Prescription Medication Non-prescription Meds	Medical:	Social:
Other members of household Name Tobacco use? Y/N Number per day ☐ Alcohol use? Units per day ☐ Prescription Medication Non-prescription Meds	Medical:	Social:
Other members of household Name Tobacco use? Y/N Number per day ☐ Alcohol use? Units per day ☐ Prescription Medication Non-prescription Meds	Medical:	Social:

Appendix 4

Page 3 - INITIAL ENQUIRIES

Name of Child _____

Date of Birth_____ Date of Initial Review_____

Other members of household Name Tobacco use? Y/N Number per day Alcohol use? Units per day Prescription Medication Non-prescription Meds	Medical:	Social:
Other members of household Name Tobacco use? Y/N Number per day Alcohol use? Units per day Prescription Medication Non-prescription Meds	Medical:	Social:
Previous children oldest first Name Date of Birth Place of Birth	Medical	Social
Sibling number Name Date of Birth Place of Birth	Medical	Social
Sibling number Name Date of Birth Place of Birth	Medical	Social

Where appropriate information on any deaths in infancy or childhood in family including close relatives		
Relationship Name Date of Birth Place of Birth	Medical	Social
Relationship Name Date of Birth Place of Birth	Medical	Social
Relationship Name Date of Birth Place of Birth	Medical	Social

Appendix 4

Page 4 - INITIAL ENQUIRIES

Name of Child _____

Date of Birth_____ Date of Initial Review_____

Draw a family tree:

Provide information on any recent changes in household:

Detailed History of Mother – name of mother			
Detailed Medical History	Detailed Surgical History	Detailed Obstetric History	Detailed Social History

Detailed Medical and Developmental History of the Child who has died. Name:			
Gestation	Birth weight	Perinatal problems	Neonatal problems
☐ weeks	☐ Kg		
Type of feeding (including date and reason for change)	Growth – link to centile	Developmental assessments	Past assessments
Immunisations			
Any known contact with infection (include; what is suspected)			
Medication – prescribed and over the counter			
Parent held child record		Copy out for record and return to parent	

Appendix 4

Page 5 - INITIAL ENQUIRIES

Name of Child _____

Date of Birth_____ Date of Initial Review_____

A detailed narrative account of child's: Feeding Sleeping Activity Health Over the two weeks prior to the child's death	
Feeding (include any changes in pattern)	
Sleeping (include any changes in child's sleeping habits, or for a child under two, patterns or place of sleep)	
Activity	
Health	
Changes in individuals responsible for providing care to the child	
Social/ Family/ Health related changes to routine practices over the last two weeks	
Illness Accident or other Major Event affecting other family members in the past two weeks	

Appendix 4

Page 6 - INITIAL ENQUIRIES

Name of Child _____

Date of Birth_____ Date of Initial Review_____

A detailed hour by hour narrative account of events within the 48 hours prior to the child's death
Where appropriate: detailed description of: **(Child under two)** Precisely where the baby was placed to sleep Duration of sleeping period Position at the end of the sleeping periods **(Older Child)** Any changes in Child's routine care or routine activity levels Any disruptions to normal patterns Information on the activity and location of all significant members of the household **Information on:** Alcohol intake Recreational drug use During the last 48 hours, of parent/carer or older child

Appendix 4

Page 7 – INITIAL ENQUIRIES

Name of Child _____

Date of Birth_____ Date of Initial Review_____

Specific to infant death (child under two)

The Final Sleep: A very careful description of when and where the child was placed to sleep including:	
The nature of the surface (bed or sofa for instance)	
Bedding	
Arrangement of bedding	
Clothing	
Precise sleeping position	
Who was sharing the surface on which child was sleeping?	
How often the child was checked?	
When he or she was last seen or heard?	
The times at which the child awoke for feeds	
Whether feeds were given	
Whether the feeds were taken well	
Who else was in the room at each stage	
What were the activities of others in the room?	
Were the others awake?	
Where, when and by whom was the child found?	
What was the appearance of the child when found?	

Appendix 4

Page 8 - INITIAL ENQUIRIES

Name of Child _____

Date of Birth_____ Date of Initial Review_____

What was the position of the child when found?	
Where was the bedding?	
Were there any covers over the child?	
Had the covers and the position of the covers moved?	
Were there other objects in the cot or bed adjacent or close to the baby (eg; teddies, dollies, pillows)?	
Was the heating on?	
What type of heating was there?	
Were the windows and or doors open?	
All further details and narrative	

Appendix 4

Page 9 - INITIAL ENQUIRIES

Name of Child _____

Date of Birth_____ Date of Initial Review_____

Specific Questions – in addition to the information already gathered information should be obtained on the parents' perception of:	
Whether the baby was feeding as well as or less well than usual in the previous 24 - 48 hours	
Any vomiting	
Any respiratory difficulty, noisy breathing, in drawing of ribs, wheezing or stridor	
Excessive sweating	
Unusual activity	
Unusual behaviour	
Level of alertness	
Difficulty sleeping	
Difficulty waking the baby	
Passage of stool and urine (how often and how much)	
And for child of any age:	
Were any healthcare professionals consulted within the last two weeks, the past 48 hours or the past 24 hours?	
If so who was contacted?	
What was the problem described to the healthcare professional?	
What advice was given?	
Was the child seen and assessed by any healthcare professional during the past two weeks?	

Appendix 4

Page 10 - INITIAL ENQUIRIES

Name of Child _____

Date of Birth_____ Date of Initial Review_____

Action after the child found: A detailed narrative account of events that followed the discovery of the child collapsed or apparently dead including:	
When, how and by whom the emergency services were called?	
Who was with the child at each stage?	
Was resuscitation attempted and if so by whom?	
Were any responses obtained from the child?	
When did the emergency services arrive or arrival at hospital?	
All further details and narrative	

Appendix 4

Page 11 - INITIAL ENQUIRIES

Name of Child _____

Date of Birth_____ Date of Initial Review_____

Scene Examination

Child's name

Date of Birth

Date of Death

Address

Date and Time of Scene visit

Who was present?

Room: (Description of room; including, noting size; orientation (compass))
Contents, 'clutter'
Ventilation; windows and doors – which way they face. Were they open or closed?
Heating; including times switched on/off; measure drawer temperature ……˚C - do this by putting thermometer in a drawer in the room which has clothes in and leave for 10 minutes, record the result.

Sleep environment
Note location, position of bed/cot in relation to other objects in room
Mattress, bedding, objects

Position of child
When put down; when found

Any evidence of over-wrapping or over-heating?	Yes/No
Any restriction to ventilation or breathing?	Yes/No
Any risk of smothering?	Yes/No
Any potential hazards?	Yes/No
Any evidence of neglectful care?	Yes/No

Appendix 4

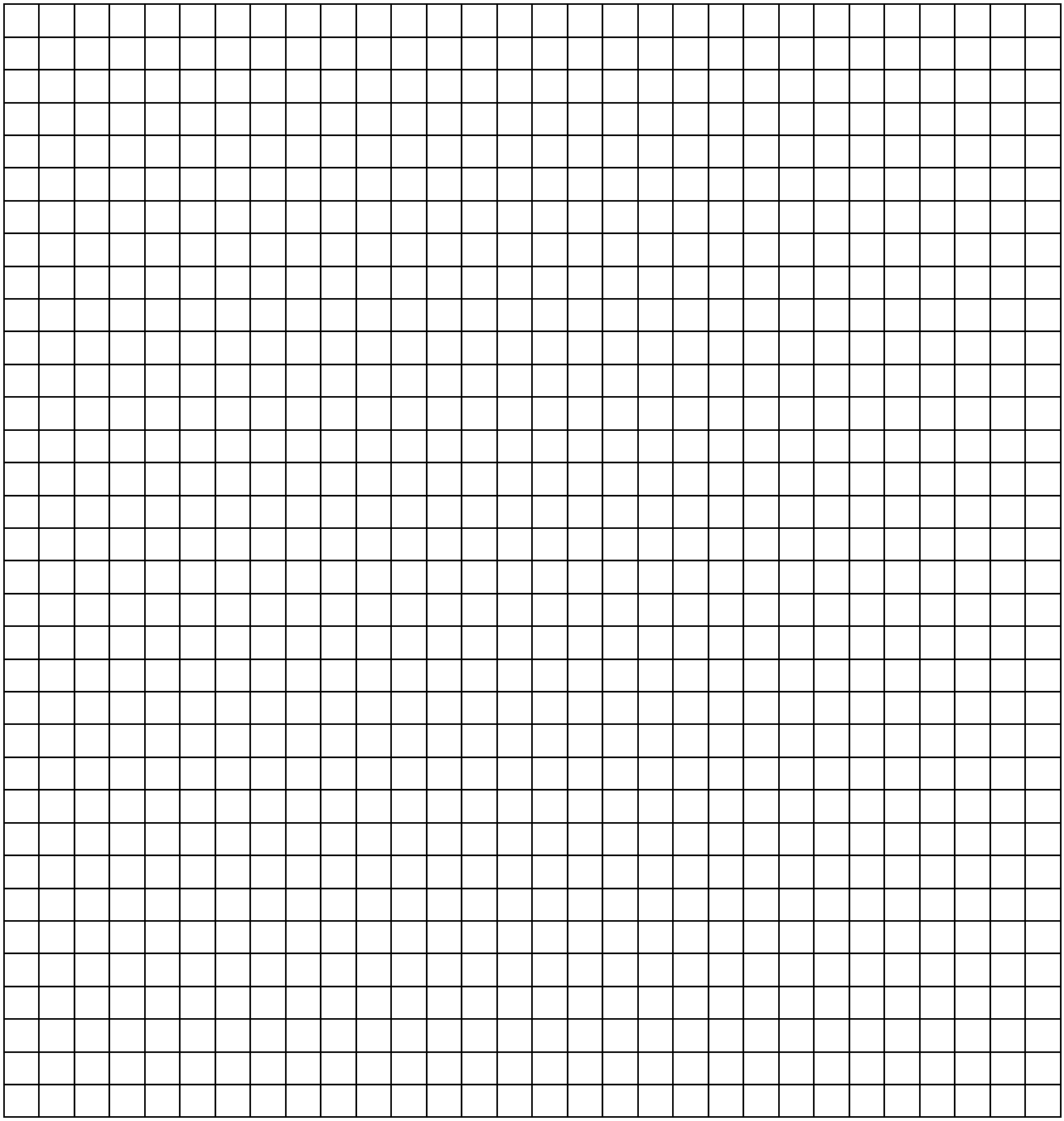
Page 12 - INITIAL ENQUIRIES

Name of Child _____

Date of Birth_____ Date of Initial Review_____

Scene Examination (continued)

Diagram of scene
Note: North/South orientation; room measurements
Location of doors, windows, heating, amount of clutter, sunshine etc
Any furniture and objects in the room



Appendix 4

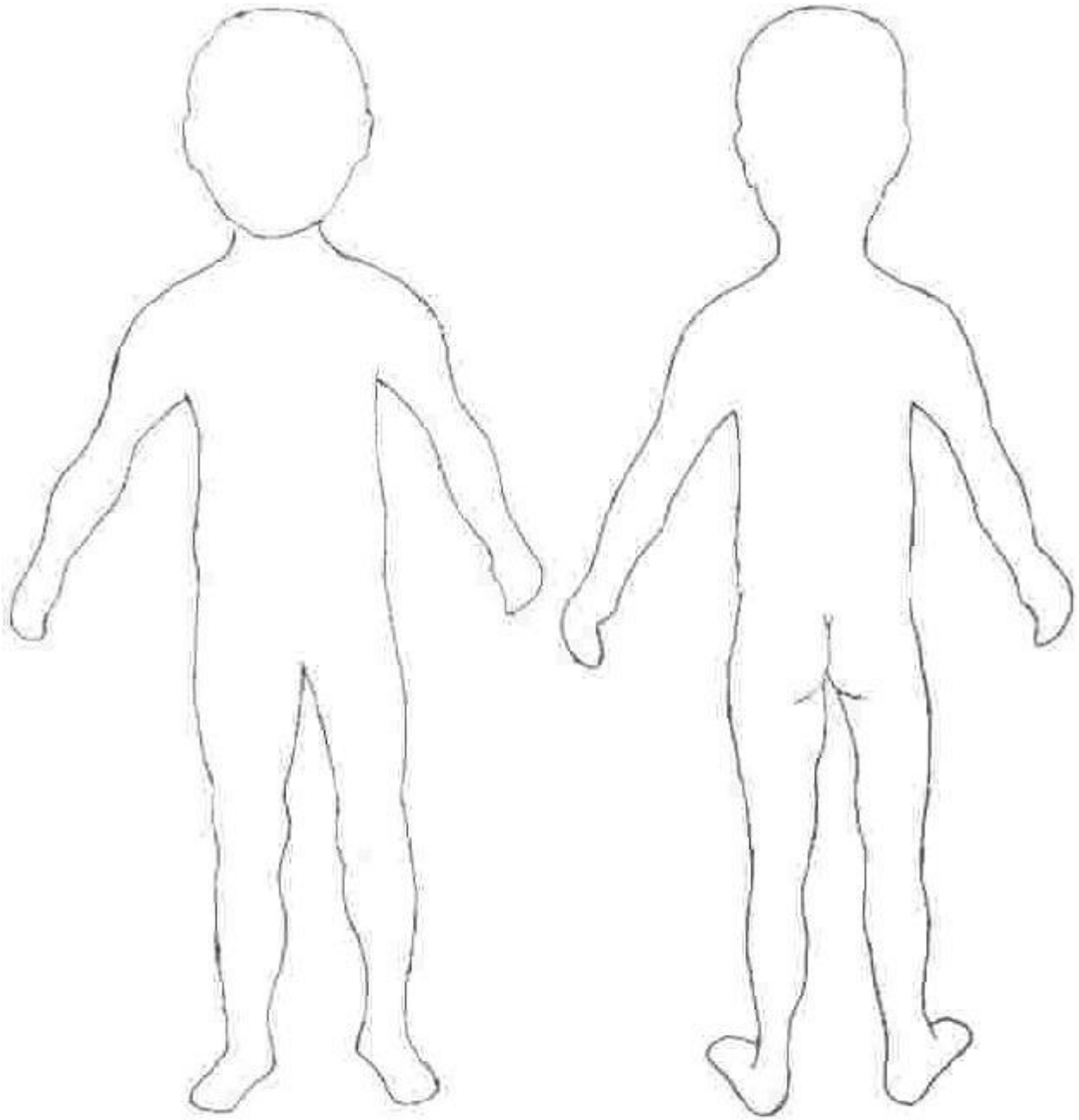
Page 13 - INITIAL ENQUIRIES

Name of Child _____

Date of Birth_____ Date of Initial Review_____

PHYSICAL EXAMINATION

BODY CHART



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Appendix 4

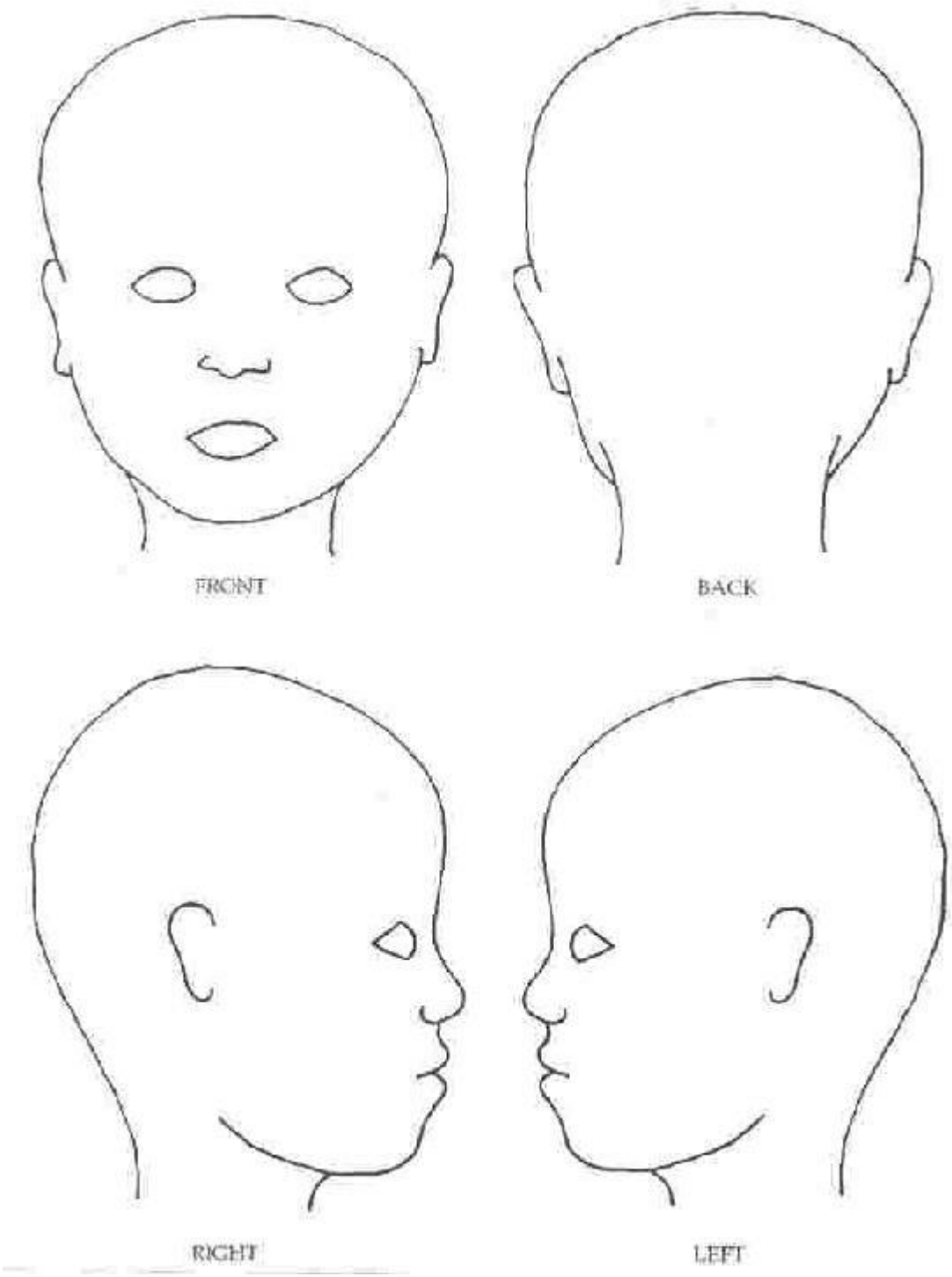
Page 14 - INITIAL ENQUIRIES

Name of Child _____

Date of Birth_____

Date of Initial Review_____

PHYSICAL EXAMINATION
BODY CHART - HEAD



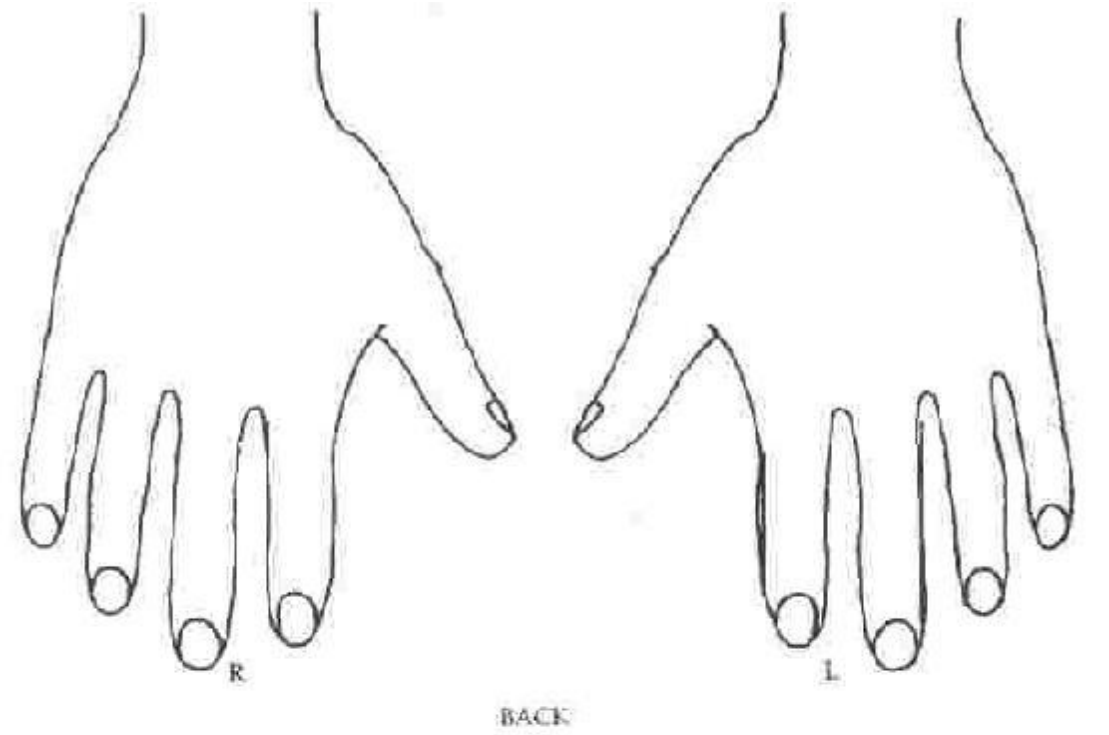
Appendix 4

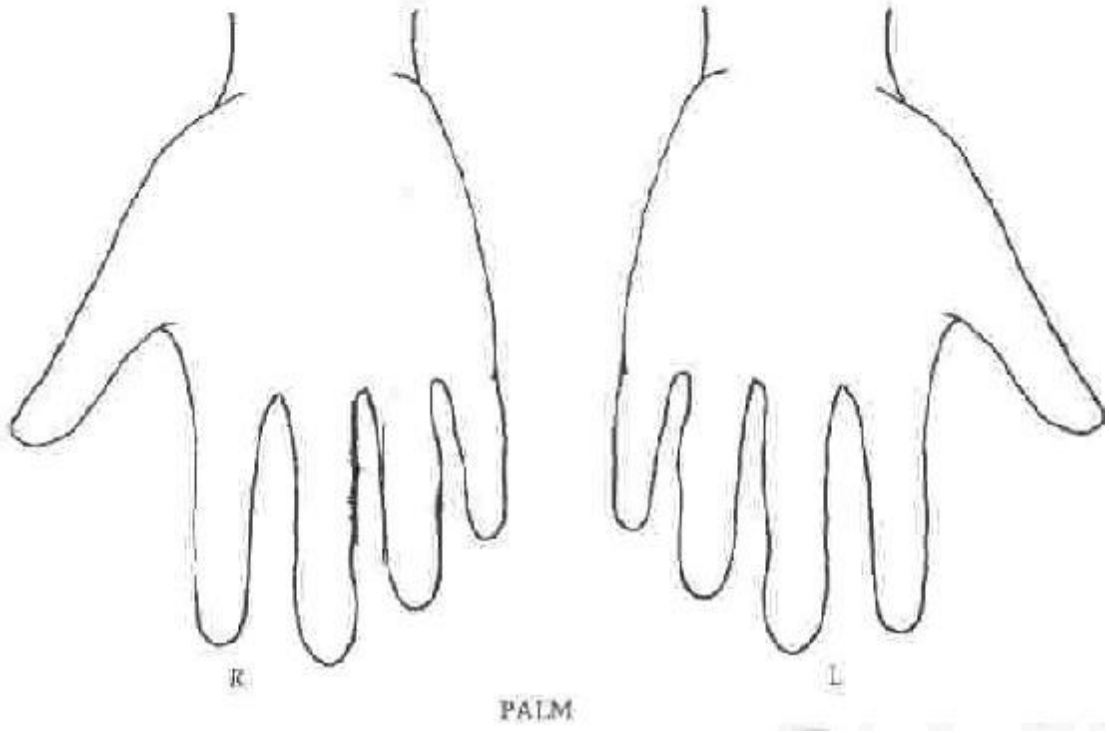
Page 15 - INITIAL ENQUIRIES

Name of Child _____

Date of Birth_____ Date of Initial Review_____

PHYSICAL EXAMINATION
BODY CHART - HANDS





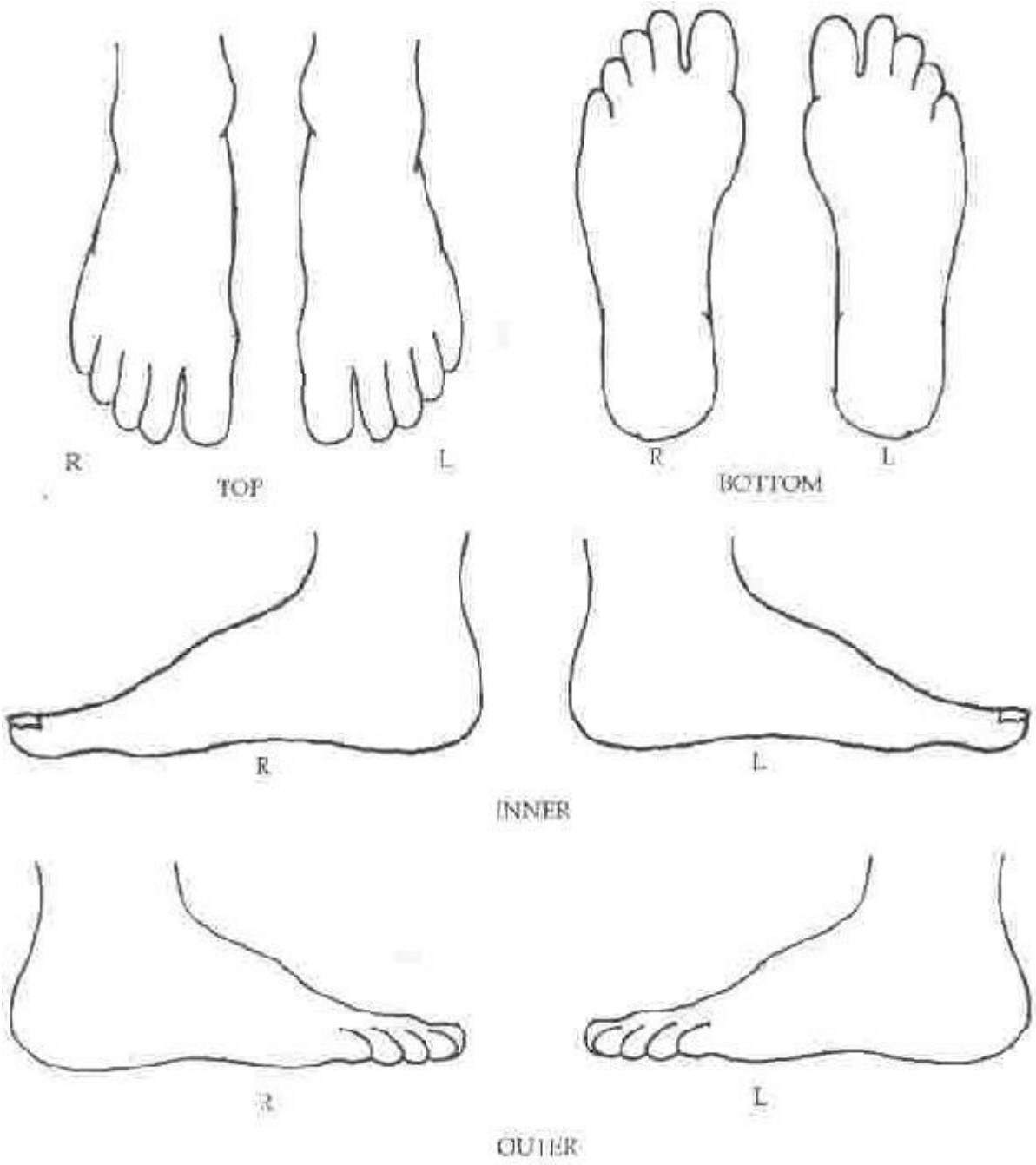
Appendix 4

Page 16 - INITIAL ENQUIRIES

Name of Child _____

Date of Birth_____ Date of Initial Review_____

PHYSICAL EXAMINATION
BODY CHART - FEET



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Appendix 5

KEMH Pathology Post-Mortem Capabilities

The following specialist tests are unavailable as post mortem tests due to the listed complications:

1. Viral cultures of nasopharyngeal aspirate and other tissues are currently not processed locally but can be sent to the UK.
2. Histopathology sections are not possible due to the lack of equipment and technical expertise. The lab can freeze tissue/organs to -70°C, or can preserve them with formalin. Transport of specimens at -70°C cannot be maintained.
3. Skin samples for fibroblast culture are not possible. The laboratory cannot maintain fibroblast culture medium, or transport samples under the required conditions to maintain viability.

Table 1 shows the availability of routine tests for post-mortem examination that the KEMH Pathology laboratory can carry out either in-house or as a referred test.

Table 1: Routine Post-Mortem Test Availability

Sample	Send to	Handling	Test	Available	Additional
Blood (serum)	Biochemistry	Spin, separate - 20°C	Toxicology	UK for processing	Chain of custody required
Blood Culture	Microbiology	Normal	Culture and Sensitivity	KEMH	
Blood (Guthrie Card)	Biochemistry	Normal	Inherited metabolic disease	UK for processing	
Blood Li Heparin	Cytogenetics	Do NOT separate	Chromosomes	UK for processing	
CSF	Microbiology	Normal	Culture and Sensitivity	KEMH	
Nasopharyngeal Aspirate	Virology	Normal	Viral Culture, DNA Amplification, Immunofluorescence	UK for processing	
Nasopharyngeal Aspirate	Microbiology	Normal	Culture and Sensitivity	KEMH	
Swabs	Microbiology	Normal	Culture and Sensitivity	KEMH	
Urine (white Universal)	Biochemistry	Normal	Toxicology	UK for processing	Chain of custody
Blood/Bile Spots (Guthrie Card)	Biochemistry	Normal	Acyl carmitines	UK for processing	

Appendix 6

Summary of tasks

<u>Emergency staff:</u>

1. Familiarise yourself with this document

2. Attempt resuscitation, unless it is clear that it cannot be successful

3. Discontinue resuscitation after discussion and decision with Registered Medical Practitioner

4. Keep careful records, including:
    - The history given to you by the parents
    - Notes on initial findings
    - Notes on initial physical examination
    - Detailed records on all interventions and procedures carried out (including attempts at a procedure before success)

5. As soon as death confirmed, Registered Medical Practitioner to inform CMO who will inform HM Coroner and police

6. Ensure any further action is taken with HM Coroner's and police approval

7. Care for parents' sensitively

8. Identify further close family/siblings who may be affected

Appendix 6

Summary of tasks

Ambulance Staff:

1. Familiarise yourself with this document
2. Attempt resuscitation, unless it is clear that it cannot be successful
3. Call for the Registered Medical Practitioner who will call the police if not already present
4. Care for the parents/carers' sensitively, keeping them informed as you know information
5. Take the child to the hospital if resuscitating
6. If not resuscitating, await the Registered Medical Practitioner and police instructions and follow their directions
7. Transfer the child to the hospital as requested, check whether this will be to casualty or the chapel of rest

Appendix 6

Summary of tasks

Her Majesty's Coroner:

1. Familiarise yourself with this document

2. Ensure that the investigation of unexpected death of child has a proper balance between medical and forensic requirements

3. Ask to be provided with a full history as obtained at the home visit

4. Maintain good communication with CMO and Police and Coroner's Officers

5. Ensure that the post mortem is carried out by a pathologist with the most appropriate and recent paediatric training and expertise, (working with a forensic pathologist when maltreatment is suspected), if necessary ensuring that the child is transported to an appropriate specialist centre

6. Make a copy of the post mortem report available to the CMO and (if there are no suspicious circumstances) give permission for them to discuss with the parents

7. Authorise and ensure that the parents/carers are informed that tissue is to be taken at post mortem examination and could be retained indefinitely as part of the medical record if the family consent

8. Ensure that parents are informed about any further bodily material that has been retained after the initial post mortem examination, for how long it is likely to be required and the purpose of this retention in line with obtained family consent as per point 7

9. Within the scope of the Coroner's Rules, stipulate and authorise the period for which such further bodily material should be retained

10. Ensure the body is released for burial or cremation as soon as possible

11. Save those where there are clear natural causes immediately recognisable at post mortem (and a certificate of the cause of death can therefore be issued immediately) hold an inquest following every child's unexpected death and schedule the inquest as expeditiously as possible

12. At inquest take account of the report of the Multi-agency Discussion following Post Mortem meeting; summon all relevant local professionals to attend the inquest if no multi-agency meeting was held

13. Avoid the term 'unascertained' as the final registered cause of death; if the death meets the international criteria for sudden infant death syndrome (SIDS) that is the term that should be the registered cause of death

14. Be prepared to share information with the FISCB for the purposes of a Child Death Review

Appendix 6

Summary of tasks

Coroner's Officer:

1. Familiarise yourself with this document

2. Attend the scene. Avoid attendance in uniform at the home if possible

3. Maintain a sympathetic and sensitive approach to the family regardless of the cause of the child's death

4. Maintain a careful balance between consideration for the bereaved family and recognising the potential of a crime having been committed. If suspicious of the circumstances, inform the Coroner

5. Be alert to any factors which may cause concern

6. Consider the possibility that the death may have been unnatural or that abuse or neglect may have been a factor

7. Consider securing the scene and arranging for it to be fully recorded. Give directions to other professionals accordingly

8. Act as part of a multi-agency approach to recording a detailed history from parents/carers and consider whether to instruct others that this cannot happen if immediate circumstances dictate that this should be an interview under caution

9. Give a co-ordinated and timely inter-agency response including around information sharing. Attend Initial Debrief, Strategy meeting and Multi-agency Discussion following Post Mortem

10. Visit the family as necessary treating them with sensitivity and keeping them fully informed about all procedures that are taking place and helping them with practical arrangements

11. Explain to the parents what takes place in an inquest and let them know that they can take a friend and ask questions at the inquest

12. Provide information for the FISCB Child Death Review

Appendix 6

Summary of tasks

Registered Medical Practitioner:

1. Familiarise yourself with this document

2. If called to the scene of death, once the police agree, arrange for the child's body to be sent to the hospital. Arrange whether this is to casualty or the chapel of rest

3. If called to the emergency, support the resuscitation and transfer to hospital

4. Attempt resuscitation until it is clear that it cannot be successful

5. Discontinue resuscitation after discussion and decision taken

6. Keep careful records, including:
    a. The history given to you by the parents
    b. Notes on initial findings
    c. Notes on initial physical examination
    d. Detailed records on all interventions and procedures carried out (including attempts at a procedure before success)

7. As soon as death confirmed, inform CMO who will inform HM Coroner and police

8. Ensure any further action is taken with HM Coroner's and police approval

9. Complete the Initial Notification of the Death of a Child (Appendix 2) and pass **immediately** to the CMO

10. Visit the parents at home as support once initial enquiries have been completed

11. Make the medical notes available

12. Attend multi-agency meetings as advised by the CMO

13. With the Health Visitor/School Nurse and other relevant agencies, ensure that the family receives adequate support

14. Ensure that there is a good record visible in the parents/carers' notes

Appendix 6

Summary of tasks

Health Visitor/School Nurse:

1. Familiarise yourself with this document
2. Visit the family at home as soon as possible, especially if you are already known to the family, subject to police instructions regarding scene security and preservation of evidence
3. Act as part of the multi-agency approach to obtaining a detailed history (see Appendix 4)
4. Facilitate the visit of the CMO
5. Support the facilitation of the multi-agency discussion meeting
6. Make the health visiting and school nurse notes available
7. Attend the multi-agency Initial Debrief, Strategy Meeting and Multi-Agency Discussion following Post Mortem meetings as appropriate
8. With the Registered Medical Practitioner, ensure the family receives adequate support

Appendix 6

Summary of tasks

<u>Chief Nursing Officer:</u>

1. Familiarise yourself with this document
2. Support the family and ensure ongoing support is organised and available
3. Facilitate and support the response of professionals
4. Support the facilitation of the multi-agency meetings as appropriate
5. Take the notes as required

Appendix 6

Summary of tasks

Midwife: (if still providing care)

1. Familiarise yourself with this document
2. Visit the family at home as soon as possible, subject to the instruction of the CMO
3. Advise on suppression of lactation if necessary
4. Make the notes available
5. Attend multi-agency meetings as appropriate

Appendix 6

Summary of tasks

Chief Medical Officer:

1. Familiarise yourself with this document

2. Whenever possible, be available in the hospital when a child has an unexpected death

3. Upon notification of the death, inform HM Coroner and the police and consult with them on the approach to the investigation

4. Ensure that the family are treated sensitively, are as fully informed as possible and given support. Offer to speak to them as needed

5. Be alert to any factors which may cause concern

6. Ensure that the family are interviewed by the multi-agency team (unless police need to interview them as suspects) and that the environment is visited while the family remain supported elsewhere as soon as possible

7. Ensure that appropriate investigations are conducted and samples taken in a timely manner following consultation with the Consultant Pathologist and where relevant the Consultant Paediatric Advisor:
   - Post nasal swabs or nasopharyngeal aspirate
   - Stool and urine
   - Cerebrospinal fluid – only take sample if indicated to do so by consultant pathologist
   - Bloods, including toxicology
   - Skeletal radiological survey

8. Consider (in liaison with police and HM Coroner) the collection of hand and or foot prints and locks of hair. It may be that parents wish for these at the time or may wish these to be stored by the hospital

9. Take the medical lead in:
   - The instigation and running of the multi-agency approach to care and investigation
   - Communication with health professionals
   - Communication with other agencies, notably HM Coroner, police and social services
   - Ensuring the multi-agency debrief, strategy meeting and discussion following post mortem takes place

10. Collate all relevant medical and social records for HM Coroner and the multi-agency case discussion

11. Notify the designated person for the FISCB that a death has occurred

12. Prepare a report for the pathologist prior to the post mortem including information on the details of the resuscitation procedures

13. Maintain good communication with HM Coroner and the Coroner's Officer

14. Co-ordinate, organise and chair the Multi-agency Discussion as soon as the full results of the post mortem have been made available by HM Coroner

15. Prepare a written summary of the Multi-agency Discussion and ensure it is distributed to all relevant professionals including HM Coroner and the FISCB

16. If agreed at the Multi-agency Discussion, offer to meet with the family to explain the cause of the child's death and send the family a full written report in accessible language

17. Liaise with HM Coroner whenever necessary in the organisation and conduct of the inquest

18. Provide information to the FISCB for a Child Death Review

Appendix 6

Summary of tasks

Pathologist:

1. Familiarise yourself with this document

2. Only undertake post mortem examinations on Sudden Infant Death or Child Death cases if you have appropriate and recent expertise and training in the field

3. If you are instructed as a forensic pathologist and are without appropriate expertise in paediatric pathology, ensure that a pathologist with appropriate and recent paediatric training and expertise is involved

4. Ensure that an adequate history (preferably including a detailed account of the precise circumstances of the death from the home or site visit) is available before starting the post mortem

5. Ensure that a full skeletal survey is carried out before starting the post mortem. This should then be reported by a radiologist with recent experience and training in paediatric radiology (preferably before the post mortem examination is conducted)

6. If SUDI is suspected, follow recommended protocol

7. The phrase 'unexplained pending further investigation' should be used initially unless a clear and sufficient natural or unnatural cause for the death has been identified

8. Inform HM Coroner (and ensure the family is informed) about what bodily material has been retained

9. Inform HM Coroner (and ensure the family is informed) if retention of whole organs is necessary for further investigation and whether the organ (eg; the brain) can be returned to the body in a week or so after fixation and sampling

10. When criminal proceedings are likely, ensure that retention of adequate tissue of organ samples (eg; the whole brain) is discussed with HM Coroner and that, if such retention is considered necessary, the sample is made an exhibit so that its retention is covered by the Criminal Procedure and Evidence Ordinance 2014

11. Agree to the release of the body for the funeral as soon as possible, consistent with conducting an appropriate and thorough examination

12. Ensure that your findings are explained to the parents with HM Coroner's permission, usually via the CMO

13. Attend or contribute to the Multi-agency Discussion following Post Mortem meeting

14. Provide information for a FISCB Child Death Review

Appendix 6

Summary of tasks

Police:

1. Familiarise yourself with this document
2. Investigate the possibility that the death may have been unnatural
3. Avoid the attendance of uniformed officers at the home if possible
4. Ensure that the officer involved has specialist training and appropriate experience
5. Liaise with the CMO and other agencies from the outset and confer about possible causes of death
6. Always treat the family with sensitivity and ensure that their Rights under Chapter 2 of the Criminal Procedure and Evidence Ordinance are respected.

Appendix 6

Summary of tasks

Social Services Team Leader:

1. Familiarise yourself with this document

2. Review the child protection register and any other records relating to the child who has died and or other members of the family and household

3. Take part in a multi-agency approach to questioning (Appendix 4) if appropriate

4. Provide a family and social history and make any relevant records available for the Strategy Meeting and subsequent multi-agency meetings. Attend meetings as appropriate

5. Call a Strategy Meeting under the Falkland Islands Safeguarding Children and Young Persons' Procedures if safeguarding concerns emerge regarding other children

6. Conduct an investigation under Section 69, Children Ordinance 2014, as appropriate, taking whatever action may be necessary according to the Procedures

7. Treat the family sensitively

8. Support the family if they have no access to their home for a length of time