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Procedural Response to Unexpected Deaths in Childhood (PRUDiC) 2023

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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 His 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 the PRUDiC minutes following each meeting (which may need to be redacted at the discretion of the Chair of the meeting). 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 in addition to Rapid Reviews to issues of concern.

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 2Wish 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 National Reportable 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'.*[1]
>
> 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'.*[2]

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 18th 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 (This is a birth on or after a gestation of 24 weeks (168 days), where the baby **does not breathe or show any other signs of life**)
- 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**. (See section 7).
- Those with a life-limiting condition known to the Palliative Care Team **and where death was expected**. (See section 3).

[1] Fleming et al.
[2] American Academy of Paediatrics

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 (029 2074 7747) at any time.

3.3 If a child who has a life limiting condition dies in an unexpected way, then PRUDIC **will** apply.

3.4 The definitions of unexpected deaths of children with a life limiting condition are the same as referenced in 2.1.

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, Scotland or Northern Ireland, but is normally resident in Wales, the PRUDiC process should usually be followed in the area where the child normally resides and relevant information shared by the Welsh Police Force with the equivalent for England, Scotland and Northern Ireland.

5.2.1 Notification should be made by the relevant Child Death Review Team in England (https://www.gov.uk/government/publications/child-death-overview-panels-contacts), Scottish National Hub for Reviewing and Learning from the Deaths of Children and Young People and Northern Ireland National Hub for Reviewing and Learning from the Deaths of Children and Young People (once established) to the Head of Safeguarding in the Welsh Health Board where the child resides who will connect with relevant colleagues in the police and local authority to determine whether the PRUDiC should occur.

5.2.2 If a decision is made for PRUDiC not to occur then this conversation should also include what support is needed for the family and wider community and referrals for support made.

5.2.3 Minutes of the PRUDiC meeting (redacted if necessary at the discretion of the chair) should be shared with the relevant child death review programme where the child died and likewise the minutes from the English, Scottish and Northern Ireland Review Process shared with the Wales CDRP.

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.

5.3.1 Notification should be made to the relevant Child Death Review Team in England[3] (https://www.gov.uk/government/publications/child-death-overview-panels-contacts), Scottish National Hub for Reviewing and Learning from the Deaths of Children and Young People and Northern Ireland National Hub for Reviewing and Learning from the Deaths of Children and Young People (once established) by the Head of Safeguarding in the Welsh Health Board where the child died.

5.3.2 Minutes of the PRUDiC meeting (redacted if necessary at the discretion of the chair) should be shared with the relevant child death review programme where the child died and likewise the minutes from the English, Scottish and Northern Ireland Review Process shared with the Wales CDRP.

[3] https://www.gov.uk/government/publications/child-death-overview-panels-contacts

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 abroad, 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.

5.5.1 If a decision is made for PRUDiC not to occur then this conversation should also include what support is needed for the family and wider community and referrals for support made.

6. Organ and Tissue Donation

6.1 Organ and tissue donation is a routine part of end-of-life care.

In **all** cases – the assessing doctor should contact the 24-hour Organ Donation Referral Line to discuss: 03000 203040

7. Unexpected Neonatal Deaths

7.1 In those neonates where the death was not expected 24 hours before the death and the death was not from a recognised neonatal complication, then a discussion between the Consultant Neonatologist/ Paediatrician (or doctor with appropriate training) and the Head of Safeguarding/Named Midwife for Safeguarding (and Police/Social Services as necessary) should be held, to decide whether the PRUDiC process should be followed. Although it is important to not duplicate other mortality processes which run in parallel, it is important to be able to identify those unexplained unexpected deaths where harm may have occurred.

Sometimes a death may be from a recognised neonatal complication, but this was not expected in this particular child. Conversely, a death may be expected 24 hours before the death, but the underlying cause/ event may have happened some days or even weeks earlier and may have been unexpected. In such cases consideration should be given to initiation of the PRUDiC process through discussion with the Consultant Neonatologist/Paediatrician (or doctor with appropriate training) and the Head of Safeguarding/Named Midwife for Safeguarding (and Police/ Social Services as necessary).

7.2 The Head of Safeguarding will be the initial point of contact for liaison with the appropriate multiagency partners as they have the working knowledge of the PRUDiC process and most appropriate contacts within other agencies.

8. Unexpected Deaths on Paediatric Critical Care Unit (PCCU)

8.1 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".
>
> "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".

8.2 If there are concerns that a PRUDiC meeting is not needed for any patient on PCCU then there needs to be a discussion between the Head of Safeguarding, Police, Social Care and PCCU to discuss any issues to enable them to cease the process for this child. If there are any concerns around the cause of death, then PRUDiC processes should be commenced.

8.3 Section 2.1 on the PRUDiC guidance will be considered in all cases. If a child has been receiving care in PCCU for longer than 24 hours this will need to be discussed further as above.

9. 16 & 17 Year Olds Who are Cared for in Adult Areas of the Health Board

9.1 PRUDiC applies to all unexpected deaths in children under the age of 18 years. If a child is admitted or is receiving care in an adult area and dies, then the PRUDiC procedure should be implemented. If the team are not familiar with the process, then the Head of Safeguarding (or Children's Social Services/the Police) should be contacted for advice.

10. Suicide

10.1 Where a child is thought to have died of suspected suicide the PRUDiC process should be followed as usual. However, when notification is made to the CDRP, this will automatically be transferred to the Real Time Suspected Suicide Surveillance programme (RTSSS) in Public Health Wales. There is no need to submit to the RTSSS in addition.

10.2 Where a child is found with a mechanism of suspected suicide still in place and it is not possible to remove this, WAST should ensure that the receiving emergency department are aware of the situation.

10.3 On examination of the body, it is important that the examining doctor does not make descriptions outside their realm of expertise such as describing marks as "ligature marks", but simply describe what is seen.

Appropriate support and bereavement services should be initiated as with all PRUDiC cases.

10.4 The 'Help is at Hand' resource was developed specifically for those affected by death by suspected suicide: Help is at Hand Pages - NHS SSHP

11. Disagreement on Initiation of PRUDiC Process

11.1 If there is disagreement over whether the PRUDiC process should be initiated following the death of a child then there needs to be a discussion between the Head of Safeguarding, Police, Paediatrician (or doctor with appropriate training) and Social Care to discuss any issues surrounding the death. If there are any concerns around the cause of death, then PRUDiC processes should be commenced.

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

12.1 The Emergency Services will follow their own protocols. For WAST Trust please see Appendix 7.

12.2 Even if the child is obviously dead and resuscitation is not attempted the body should be transported by WAST to the nearest appropriate Emergency Department.

12.3 Where a parent gives birth in the community 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.

12.4 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, incineration or decomposition (this decision will need to be shared with all relevant departments and agencies). However, all other deceased children should be taken to the Emergency Department to be examined by a Paediatrician (or doctor with appropriate training and competence).

12.5 If the child is obviously deceased **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).

12.6 Welsh Ambulance Services NHS Trust personnel will consider the need to report (as a National Reportable Incident) to Welsh Government in accordance with the 'Putting Things Right' Guidance'.

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

13.1 The Emergency Services will follow their own protocols. For the Police see Appendices 3, 4 and 8.

13.2 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 deaths the Senior Investigating Officer responsibilities will be performed by a Road Death Senior Investigating Officer.

13.3 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 has been removed to Hospital. (Refer to Appendix 4: Scene Examination Checklist). It is the decision of the police if the body is to remain at the scene for further examination rather than immediate transfer to hospital.

13.4 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.

13.5 A uniformed police officer will rarely be the right person to be a part of the joint history/examination unless they have recent relevant experience.

The police officer attending the joint exam should be at least a PIP2 qualified Detective Officer with relevant experience and/or training; or be someone delegated to undertake that task by the appointed SIO (Senior Investigating Officer).

13.6 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 **may** allocate a Family Liaison Officer (FLO) whenever the Senior Investigating Officer deems it appropriate. A FLO is not necessarily allocated in all unexpected deaths.

13.7 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.

13.8 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.

13.9 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.

14. The Role of Children's Social Care

14.1 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.

14.2 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.

15. The Role of Health Professionals

15.1 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.

15.2 Consultant Paediatrician (or doctor with appropriate training and competence)

On arrival at the Emergency Department the child will be attended by a doctor, usually the Consultant Paediatrician but this **may** be a doctor with appropriate training and competence. 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 (however, in this situation re-examination with the Police is likely to be necessary once in attendance).
- Post-mortem examination of the eyes:
  - Examination of the eyes of infants should be attempted as per the joint Royal College position statement (January 2022)[4] with the understanding that the lack of identification of retinal haemorrhages does not mean that they are not present, simply not seen.
    - It is of extreme importance that the child's eyes are examined as soon as possible after any unexplained death and therefore can be carried out by any senior clinician, which would most likely be a Paediatrician (or doctor with appropriate training and competence).
    - When practicable and where swift examination can occur, the senior clinician can contact an ophthalmologist, **following locally agreed protocols**.
    - The expectation is that the clinician records what it is possible to see, including the presence or absence of retinal haemorrhages in each eye, with an accompanying proviso about their degree of expertise and that they are unable to make any comment on the interpretation of significance. Other professionals will use this information to help inform the most appropriate next steps in the investigation process of the child's death

[4] https://www.rcpch.ac.uk/news-events/news/joint-statement-eye-examination-sudden-unexpected-death-children

    - The detection of retinal haemorrhages immediately post-mortem, particularly where there are no other immediately obvious concerning features of unnatural death, may lead to a formal forensic post-mortem process. Importantly, this will include the engagement of a forensic pathologist to perform the autopsy and the initiation of the process that adequately protects any living siblings.

- 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 (elements may need to be repeated once police are in attendance). (See Appendix 3).

- **Organ and tissue donation** is a routine part of end-of-life care. In **all** cases – the assessing doctor should contact the 24-hour Organ Donation Referral Line to discuss: 03000 203040

- 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). Genetic/metabolic diseases may be more easily identified where an early skin biopsy is taken, this should be discussed with the Pathologist.

- 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 (or doctor with appropriate training and competence) **may** 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. This will either be the Consultant Paediatrician (or doctor with appropriate training and competence) in attendance or the child's usual clinical team.

16. 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.
- Will liaise with other agencies and lead the coordination of information gathering within Health to be shared throughout the PRUDiC.
- Will be part of the decision-making process where there is disagreement on whether a PRUDiC should occur in conjunction with Police and Social Services.
- 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 National Reportable 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.

16.1 The Named Midwife for Safeguarding Children

- The Named Midwife for Safeguarding is a registered midwife who has had specific safeguarding training and who leads on safeguarding issues within maternity settings.
- They will be informed, and contribute to the PRUDiC process, if a child dies unexpectedly before the age of 28 days.[5]

16.2 The General Practitioner

- Will be fully informed of the unexpected death of a child registered with their practice by the Consultant Paediatrician (or doctor with appropriate training and competence) 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.

[5] Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff: Intercollegiate Document. Jan 2019

- 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 National Reportable 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.

16.3 The Independent Medical Examiner

The Medical Examiner Service is hosted by NHS Wales Shared Service Partnership (NWSSP) and will provide an independent scrutiny of all deaths that are not investigated by the coroner. Scrutiny will be undertaken by a Medical Examiner, who is an experienced doctor with additional training in death certification and the review of documented circumstances of death. They will ensure that an accurate cause of death of recorded, identify any concerns surrounding the death itself which can then be further investigated if required, and take the views of the bereaved into consideration. They may therefore have an interest or contribute to the PRUDiC process.[6]

16.4 **The Pathologist** (see 17.8)

[6] https://nwssp.nhs.wales/ourservices/medical-examiner-service/

17. The Role of the Regional Safeguarding Children Board

17.1 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.

17.2 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.

18. PRUDiC Timeline

18.1 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 (usually 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 (usually within 12 months): The management of information sharing, including the **Case Review Meeting**, when the final post-mortem Report is available.

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

18.3 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.

18.4 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.

18.5 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 with a copy (redacted if necessary) sent to the CDRP.

18.6 In some areas, an Immediate Response Group (IRG) may be held, but these **cannot** take the place of the PRUDiC meeting however may run immediately afterwards according to local multi-agency preference.

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

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

18.7.2 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.

18.7.3 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. In specific circumstances (e.g. neonatal deaths) input or guidance may be needed from the Consultant Paediatrician (or doctor with appropriate training and competence), Head of Safeguarding or Neonatologist.

- As a minimum the Senior Police Officer (as defined above), Health Board Head of Safeguarding, Consultant Paediatrician (or doctor with appropriate training and competence) 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, Health Visitor, School Nurse) whilst keeping numbers to a minimum and on a need to be there basis.

- Education representatives at the meeting should be at a sufficiently senior level such as the Designated Child Protection Teacher/Head Teacher.

Individuals who do not usually attend PRUDiC meetings should be prepared beforehand to ensure that there is a level of awareness of the likely content and PRUDiC meeting process.

Consideration should be given to the sensitive nature of some of the information which may be distressing, in particular to those who knew the child. A warning should be issued at the beginning of the meeting and a decision made whether to add information in writing to the minutes, or whether some participants may wish to leave for this part of the meeting.

Minutes should be drafted and circulated to all invitees within 5 working days of the meeting.

18.7.4 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 safeguarding 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.

- An offer for any professionals to be referred and receive support from 2Wish is recommended to be a standing agenda item at every Information Sharing and Planning meeting.

- 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.

- 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 with a copy (redacted if necessary) sent to the CDRP.

18.7.5 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 by Children's Social Care, according to timescales and processes defined within the Wales Safeguarding Procedures.[7]

[7] https://www.safeguarding.wales/en/

18.8 Phase 1: The Pathologist and the Post-mortem Examination

18.8.1 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.

18.8.2 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.

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

18.8.4 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.

18.8.5 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 (or doctor with appropriate training and competence), and the findings of the death scene investigation by the Police Senior Investigating Officer.

18.8.6 Any photographs or video recordings of the child or the scene will be made available to HM Coroner and the Pathologist.

18.8.7 If appropriate radiological investigations[8] 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.

18.8.8 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.

18.8.9 If the Consultant Paediatrician (or doctor with appropriate training and competence) 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.

18.8.10 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 (or doctor with appropriate training and competence). 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).

[8] 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.

18.8.11 Where the possibility of sexual abuse of a child is raised the Pathologist should consult a clinician skilled in the assessment and examination of children for alleged sexual abuse. The contact will be through local children's SARC provision. (See Appendix 10).

18.8.12 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.

18.8.13 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.

18.8.14 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.

18.8.15 A copy of the final post-mortem report will be sent by the Pathologist to HM Coroner, who will share with appropriate professionals at their discretion.

18.8.16 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.

18.8.17 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.

18.8.18 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.

18.8.19 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.

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

18.9.1 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.

18.9.2 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 (or doctor with appropriate training and competence) 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 **may** be made available.

18.9.3 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. An offer for referral to 2Wish (or other local support groups) for any professionals to be included is recommended to be a standing agenda item for PRUDiC meetings.
- 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.

18.9.4 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 with a copy (redacted if necessary) sent to the CDRP.

18.9.5 The Chair (or their delegate) will provide available information to the RSB Business Manager and the Child Death Review Programme using the Child Death Notification Form. (Appendix 5)

18.9.6 With the agreement of the Chair and depending on circumstances and on the course of any criminal investigation, the Consultant Paediatrician (or doctor with appropriate training and competence) will write a letter to the parents (if appropriate) 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.

18.9.7 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.

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

18.10.1 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.

18.10.2 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.

18.10.3 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.

18.10.4 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.

18.10.5 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.

18.10.6 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.

18.10.7 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.

19. Supporting Bereaved Families

19.1 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.[9]

19.2 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).

19.3 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, with consideration of their religious beliefs and cultural differences.

19.4 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 2Wish or other support organisation as deemed appropriate by staff.

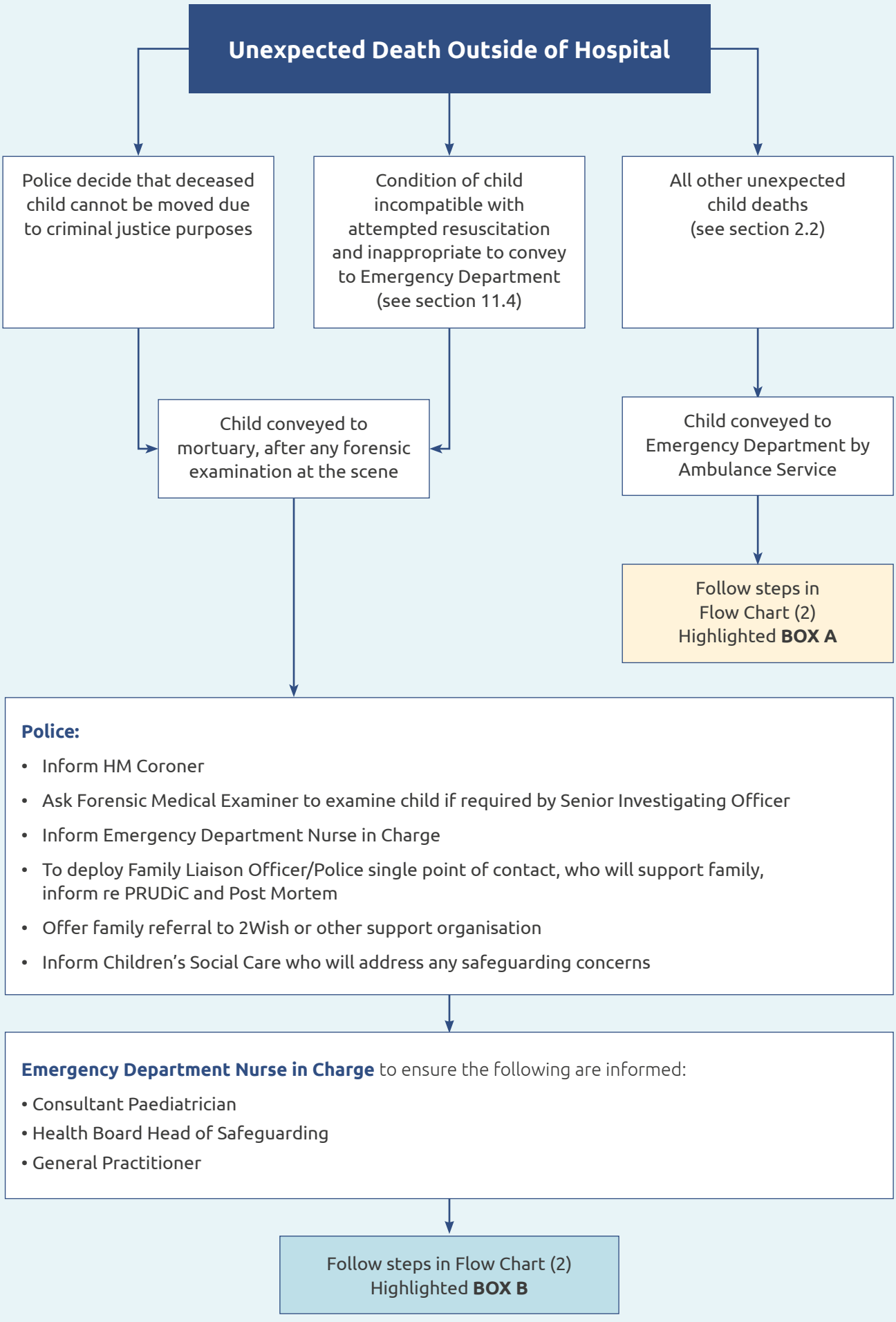
[9] Child Death Review Statutory Guidance, HM Government October 2017

20. Supporting Staff

20.1 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. 2Wish will also offer independent support to professionals if needed.

21. Flowchart of PRUDiC Process

21.1 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 (or doctor with appropriate training and competence) on call.


Unexpected Death Outside of Hospital
Police decide that deceased child cannot be moved due to criminal justice purposes
Condition of child incompatible with attempted resuscitation and inappropriate to convey to Emergency Department (see section 11.4)
All other unexpected child deaths (see section 2.2)
Child conveyed to mortuary, after any forensic examination at the scene
Child conveyed to Emergency Department by Ambulance Service
Follow steps in Flow Chart (2) Highlighted BOX A
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 2Wish 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

BOX A
(death out of hospital - continued from page 37)

Unexpected Death as a Hospital Inpatient

Consultant Paediatrician:

- Take history from parents/carers with Police
- Examine child (Police should be present)
- Advise family about PRUDiC and Post Mortem Examination
- Ensure Emergency Department Keyworker has been allocated, to provide trauma support in Department and offer a Memory Box and referral to 2Wish or other support organisation as appropriate.

Emergency Department or Ward Nurse in charge must ensure the following are aware:

- HM Coroner
- Police
- General Practitioner
- Health Board Head of Safeguarding
- Children's Social Care
- **Consider** the need to report to Welsh Government as Serious Incident or No Surprises Incident under 'Putting Things Right'

BOX B
Information Sharing & Planning Meeting within 2 working days
See Section 11.6

Must include as minimum:

- Senior PVPU/PPU Officer
- Health Board Head of Safeguarding (or delegate)
- Children's Social Care representative
- Consultant Paediatrician who attended the child

Post Mortem:
See Section 11.7

- Pathologist to report to HM Coroner
- Investigating Officer where appropriate, to advise what information can be shared with others including Police, Family, Consultant Paediatrician and other Professionals

Case Discussion Meeting within 5-28 days:
See Section 11.8

Police to inform family about Case Discussion Meeting outcomes and preliminary Post Mortem results as appropriate

Case Review Meeting within 12 months:
See Section 11.9

Case Summary to be completed by the Chair (or delegate) and sent to the Regional Safeguarding Children Board Business Unit and Child Death Review Programme

Appendix

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', 'scene' 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

2Wish

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
Monday - Friday: 09.30 - 16.30

Email: info@2wish.org.uk

www.2wish.org.uk

Child Bereavement UK

Support for parents and children who have been bereaved.

Helpline: 0800 02 888 40
Monday - Friday: 09.00 - 17.00,

Email: support@childbereavementuk.org

www.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:

Every evening: 19.00 - 22.00
Monday - Friday: 10.00 - 13.00
Tuesday - Wednesday: 13.00 - 16.00

www.childdeathhelpline.org.uk

The Compassionate Friends

Support for bereaved parents and their families.

Helpline: 0345 123 2304
Every day: 10.00 - 16.00 / 19.00 - 22.00

Email: helpline@tcf.org.uk

www.tcf.org.uk

Cruse Bereavement Care

Support for anyone who is bereaved.

Helpline: 0808 808 1677
Monday - Friday: 09.30 - 17.00

Email: info@cruse.org.uk

www.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
Monday - Friday: 10.00 - 23.00
Weekends & Bank Holidays: 18.00 - 23.00

Email: support@lullabytrust.org.uk

www.lullabytrust.org.uk

Survivors of Bereavement by Suicide

Support for those bereaved by suicide.

Helpline: 0300 111 5065
Every day: 09.00 - 21.00

Email: sobs.support@hotmail.com

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
Monday - Friday: 09.00 - 17.00

Email: info@winstonswish.org.uk

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, 2nd edition, November 2016'.

To be completed by the Consultant Paediatrician (or doctor with appropriate training and competence) examining the child and retained as part of the health record.

History Proforma

Name of Child

Male or Female

Ethnicity

Date of Birth

DAY MONTH YEAR

Date of Death

DAY MONTH YEAR

Address

Postcode

Name of Father

Date of Birth of Father

DAY MONTH YEAR

Address of Father
(If different from child)

Name of Mother

Date of Birth Mother

DAY MONTH YEAR

Address of Mother
(If different from child)

Name of Partner
(If relevant)

Date of Birth of Partner

DAY MONTH YEAR

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 ☐ NO

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 ☐☐ DAY ☐☐ MONTH ☐☐☐☐ YEAR

History

Taken in Emergency Department by?	
Taken at Home Visit by?	
History given by?	
Relationship to child:	

Events Surrounding Death

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?	

Detailed Narrative Account of Last 24 to 48 hours

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:

Family History

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:

Past Medical History

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:

Social History

Type and nature of housing?

Any major life events?

Any travel abroad?

Wider family support networks?

Any other Relevant History
May vary according to the age of the child and nature of death

Information Retrieved From Record

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 (or doctor with appropriate training and competence).

(Police Investigator should be present).

Name of Child

Male or Female

Ethnicity

Date of Birth DAY MONTH YEAR

Date of Death DAY MONTH YEAR

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 DAY MONTH YEAR

Time of Physical Examination :

Interval since death

For infants and children under 24 months include full growth measurements

Centile				
Length (cm)	cm:		Centile:	
Head circumference (cm)	cm:		Centile:	
Weight (g)	cm:		Centile:	

For all children 0-18 years

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?	

Further details, observations and comments

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: DAY MONTH YEAR **Time:** :

Signature of person who undertook the physical examination

Date: DAY MONTH YEAR **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, 2nd 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

DAY MONTH YEAR

Date of Death

DAY MONTH YEAR

Address

Postcode

Date of Scene Visit

DAY MONTH YEAR

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 ^{0}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?

Position of Child

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:

Diagram of Scene

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.

NB. Please fill in as much detail as possible, however, not all sections may be relevant – if this is the case leave blank.

A. REPORTING DETAILS: (Your Details)

Date of Completion	☐☐ DAY ☐☐ MONTH ☐☐☐☐ YEAR
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	☐☐ DAY ☐☐ MONTH ☐☐☐☐ YEAR
NHS No.	

Home address
(normal residence of child)

Postcode

Sex ☐ MALE ☐ FEMALE

Ethnic Group

Was the child on the Child Protection Register?

☐ At the time of death ☐ Previously ☐ Not at all

Was the child a "Looked after Child"?

☐ At the time of death ☐ Previously ☐ Not at all

If yes, what local authority?

Was the child in receipt of any of additional services?

Team around the Family (TAF)

☐ At the time of death ☐ Previously ☐ Not at all

Integrated Family Support Service (IFSS)

☐ At the time of death ☐ Previously ☐ Not at all

Flying Start

☐ At the time of death ☐ Previously ☐ Not at all

Families First

☐ At the time of death ☐ Previously ☐ Not at all

C. DETAILS OF THE DEATH

Date of death ☐☐ DAY ☐☐ MONTH ☐☐☐☐ YEAR

Time of death ☐☐ : ☐☐

Where did the event which led to the death occur? ☐ Home ☐ Hospital ☐ Other

Address of event (if hospital or other)?

Where was death confirmed? ☐ Home ☐ Hospital ☐ Other

Has this death been referred for any other type of review?

☐ Child practice review ☐ Hospital morbidity/mortality

☐ Domestic homicide review ☐ Criminal investigation

Has the death been reported to Welsh Government as a serious incident? (as defined in section 9.2 of Putting Things Right) ☐ YES ☐ NO

Medical certificate for the cause of death issued? ☐ YES ☐ NO

If yes, please state cause of death

If no, what is your understanding of the cause of death?

Death expected? ☐ YES ☐ NO

Was an advance (end of life) care plan in place? ☐ YES ☐ NO ☐ NOT KNOWN

Has a PRUDiC been implemented? ☐ YES ☐ NO

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.

Was the death referred to HM Coroner? ☐ YES ☐ NO

If yes, state date reported and name of HM Coroner?

☐☐ DAY ☐☐ MONTH ☐☐☐☐ YEAR

Post mortem date and venue

☐☐ DAY ☐☐ MONTH ☐☐☐☐ YEAR

Has an inquest been held? ☐ YES ☐ NO

D. ADVERSE CHILDHOOD EXPERIENCES

Please select all that you are aware of in relation to the social background of the child

- ☐ verbal abuse
- ☐ physical abuse
- ☐ sexual abuse
- ☐ parental separation
- ☐ household domestic violence
- ☐ household mental illness
- ☐ household alcohol abuse
- ☐ household drug use
- ☐ household member incarcerated
- ☐ household physical health issues
- ☐ household disability (including learning disability)
- ☐ neglect

Did the child perform any caring duties? ☐ YES ☐ NO

If yes, who for? ☐ PARENT ☐ SIBLING ☐ OTHER

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

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

Sudden Unexpected Death in Infancy (under 2 years old)

Co-sleeping at time of death	☐ YES	☐ NO	☐ NOT KNOWN
Sofa sleeping at time of death	☐ YES	☐ NO	☐ NOT KNOWN
Parental smoking	☐ YES	☐ NO	☐ NOT KNOWN
Illness in child in week prior to death	☐ YES	☐ NO	☐ NOT KNOWN
Parental history of drug use	☐ YES	☐ NO	☐ NOT KNOWN
Parental alcohol use at time of death or past history of concern	☐ YES	☐ NO	☐ NOT KNOWN

Drowning

Ability to swim	☐ YES	☐ NO	☐ NOT KNOWN
Possible alcohol consumption	☐ YES	☐ NO	☐ NOT KNOWN
Lack of active supervision	☐ YES	☐ NO	☐ NOT KNOWN

Deaths in Motor Vehicles

Seatbelt use (or appropriate car seat)	☐ YES	☐ NO	☐ NOT KNOWN
Driving at night	☐ YES	☐ NO	☐ NOT KNOWN
Driving over legal blood alcohol limit	☐ YES	☐ NO	☐ NOT KNOWN

Apparent Suicide

Known to CAMHS	☐	YES	☐	NO	☐ NOT KNOWN
Known to youth offending services	☐	YES	☐	NO	☐ NOT KNOWN
History of alcohol abuse	☐	YES	☐	NO	☐ NOT KNOWN
History of drug misuse	☐	YES	☐	NO	☐ NOT KNOWN
Bullying	☐	YES	☐	NO	☐ NOT KNOWN

Fire

Working smoke alarm in house	☐	YES	☐	NO	☐ NOT KNOWN

NEXT STEPS

Please send the completed form password protected 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

Post: Child Death Review Programme Team
Public Health Wales
5th Floor Capital Quarter 2
Tyndall street
Cardiff
CF10 4BQ

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.

Child's Name:

Date of Birth: DAY MONTH YEAR

Date of Death: DAY MONTH YEAR

Address:

NHS Number:

Cause Death

Details:

Case Summary

Details:

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 Clinical Contact Centre (CCC) must immediately notify the Police when a call is received indicating a possible unexpected child death.

Attending Emergency Medical Staff should:

a) Assess patient as per JRCALC Clinical Guidelines and WAST Policies

b) Provide all clinical interventions as indicated

c) Pre-alert the Emergency Department giving an estimated time of arrival and patient's condition.

d) Transport the child to the nearest appropriate Emergency Department.

e) Note position and location of the baby or child when found.

f) Note any injury and any explanation offered.

g) Handover all relevant information to the receiving clinicians at the Emergency Department and ensure Police are also informed of any suspicious circumstances.

h) Complete the Patient Clinical Record in full as a record of attendance, clinical management and observations of the scene.

- Even if death has been determined at the incident location, ambulance staff should convey the child/young person to the Emergency Department rather than to the mortuary, unless the child is obviously dead **AND** there are suspicious circumstances where removing the body from the scene could cause loss of evidence.
- Conveyance to the mortuary may occur in exceptional circumstances that are unequivocally associated with death and deemed inappropriate to convey to Emergency Department, such as decapitation, decomposition, incineration etc.
- Best practice would recommend ambulance staff gain confirmation that 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 (or doctor with appropriate training and competence) and parents/carers can talk with the Paediatrician (or doctor with appropriate training and competence) and be provided with bereavement support.

- If suspicious circumstances around the child's death exist Police will determine next steps and advise ambulance crew (this decision should be captured on the Patient Clinical Record (PCR).

- If scene examination suggests a protracted timeframe before the child is released from scene, seek confirmation from Police Senior Investigating Officer (SIO) as to whether ambulance conveyance to Emergency Department is still required or an alternative plan exists? (WAST staff to record the discussion, decision and identify police officer(s) involved on the PCR).

- 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.

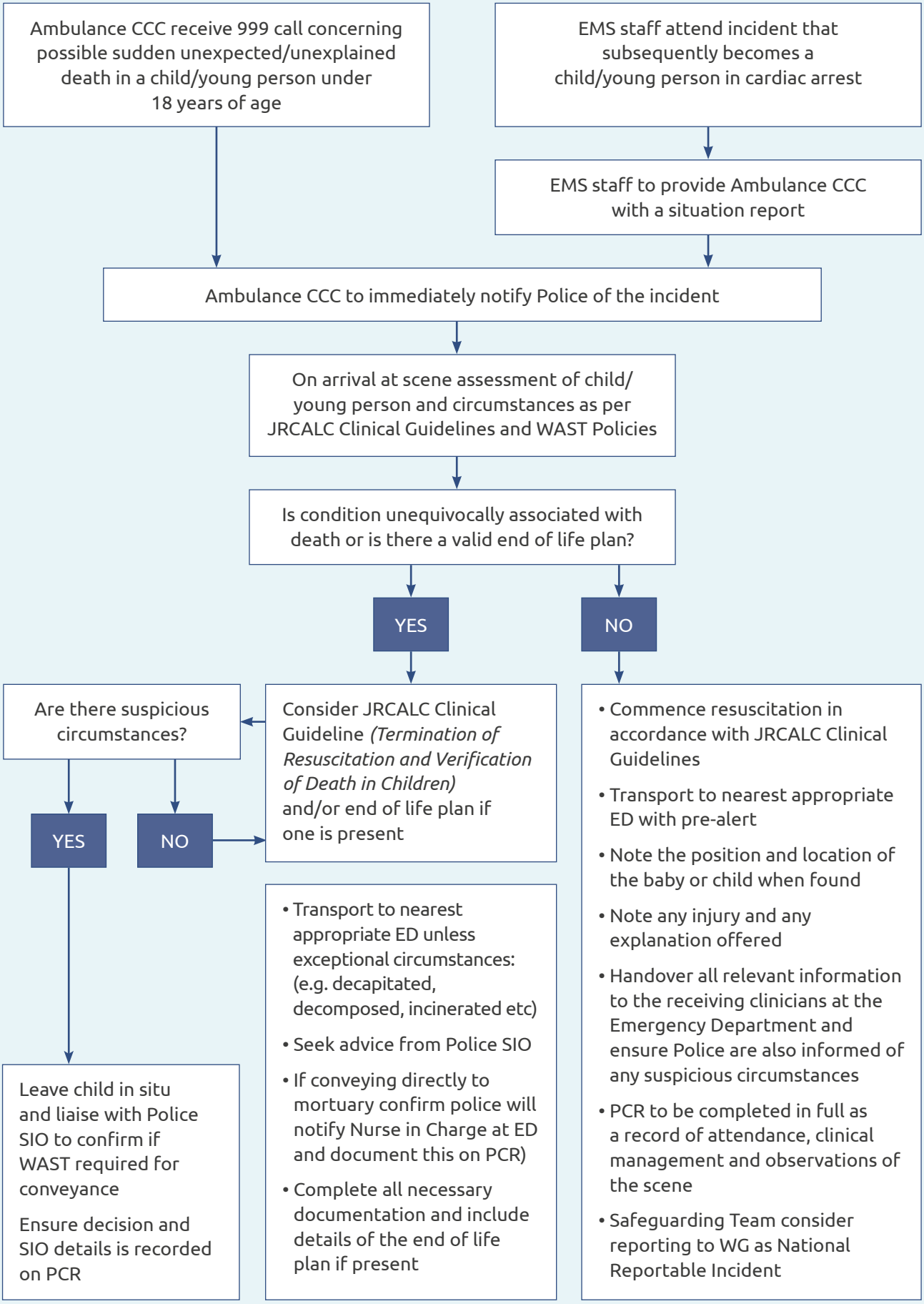
- If the circumstances allow, note any comments made by the carers, any background history, any possible drug misuse and the conditions of the living accommodation.

- Any such information or concerns must be passed on to the receiving doctor, the Police and the Consultant Paediatrician (or doctor with appropriate training and competence).

- Any safeguarding concerns for children and/or adults at risk associated with incident should be reported to the Police and Local Authority via WAST safeguarding process

- WAST Safeguarding team will consider the need to report a National Reportable 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[10]

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.

[10] Sudden unexpected death in infancy and childhood: multi-agency guidelines for care and investigation. 2nd edition, November 2016

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

Wales Safeguarding Procedures
https://www.safeguarding.wales/en/

All Wales PAC-Plan
https://www.paedpallcarewales.com/pac-planning

Child Death Review Programme
http://www.wales.nhs.uk/sitesplus/888/page/84337

Guidance for professionals | Human Tissue Authority (hta.gov.uk)
https://www.hta.gov.uk/guidance-professionals

Sudden unexpected death in infancy and childhood: multi-agency guidelines for care and investigation. 2nd 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

The radiological investigation of suspected physical abuse in children | The Royal College of Radiologists (rcr.ac.uk)
https://www.rcr.ac.uk/publication/radiological-investigation-suspected-physical-abuse-children

Joint Statement on Eye Examination in Sudden Unexpected Death in Children
https://www.rcpch.ac.uk/news-events/news/joint-statement-eye-examination-sudden-unexpected-death-children

SARC (Sexual Abuse Referral Centre) contacts

- **South Wales: Ynys Saff Sexual Assault Referral Centre**
  https://cavuhb.nhs.wales/our-services/sexual-health/services-provided/ynys-saff-sexual-assault-referral-centre/
  Tel: 029 2033 5533

- **North Wales: North Wales: Queries should be directed to the Named Doctor for Safeguarding Children, who will disseminate to the appropriate Paediatrician**

Child Death Review Review Teams (England)
https://www.gov.uk/government/publications/child-death-overview-panels-contacts

National Hub for Reviewing and Learning from the Deaths of Children and Young People (Scotland): his.cdrnationalhub@nhs.scot

Northern Ireland
Public Health Agency Child Death Review Team sinead.magill@hscni.net

WAG Bereavement Pathway for Sudden and Unexpected Death in Children and Young Adults:

https://www.gov.wales/sites/default/files/pdf-versions/2022/8/5/1660308229/sudden-and-unexpected-death-children-and-young-people-25-years-age-support-pathway.pdf