Practice Advice on Child Death Investigation

The National Police Chiefs' Council (NPCC) with the College of Policing has agreed to these guidelines being circulated to, and adopted by, Police Forces in England, Wales, Scotland and Northern Ireland.

It is marked as Official under the Government Security Classification scheme and any referrals for advice and rationale in relation to Freedom of Information Act disclosure should be made to the NPCC Central Referral Unit at npcc.request@foi.pnn.police.uk.

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Preface

This new Practice Advice has been developed by the NPCC Homicide Working Group (Child Death Sub-Group) and replaces the *ACPO (2014) A Guide to Investigating Child Deaths*. Since that time much has changed in policing and investigative practice and this guidance will help investigating officers to conduct an effective and compassionate investigation following the death of a child.

The NPCC would like to express its thanks to all those involved in the development of this guidance, including members of the NPCC Homicide Working Group (Child Death Sub-Group), the College of Policing, the National Crime Agency, the Metropolitan Police Service and all those individuals who generously gave their time and shared their professional expertise to contribute to this guidance. Particular thanks are extended to the lead authors Chief Superintendent Liz Hughes (Avon and Somerset), Detective Superintendent Jon Holmes (Lancashire), Detective Chief Superintendent David Ashton (Durham), Chief Superintendent Fiona Bitters (Hampshire and Isle of Wight), Sonya Baylis (National Crime Agency) and Detective Sergeant Robert Simmons (Suffolk).

The NPCC Homicide Working Group (Child Death Sub-Group) continues to welcome feedback about this Practice Advice from individuals, academics, medical professionals, safeguarding partners and police forces and will take this into account when undertaking future updates to the guidance.

Any queries relating to this document should be directed to either the Chair of the NPCC Homicide Working Group (Child Death Sub-Group) or the NPCC Business Support Office.

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1 Introduction

Investigating the death of a child is extremely complex, and emotionally demanding. Children are not meant to die prematurely, and the police investigation into a sudden unexpected death of a child must be guided by this fact. This means that even where there are no apparent suspicious factors, the police investigation must be detailed and thorough.

In the United Kingdom, Article 2 of the *Human Rights Act 1998* requires that everyone's right to life shall be protected by law. In England and Wales, the *Coroners and Justice Act 2009* places a legal duty on coroners to investigate certain deaths, including those where the cause of death is unknown. In Northern Ireland, the *Coroners Act (Northern Ireland) 1959* provides similar provisions in relation to unexpected or unexplained deaths. In Scotland, the *Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016* provides the Lord Advocate with discretion to inquire into sudden, suspicious or unexplained deaths. These investigations ensure that, wherever possible, the cause of death is established, and whether the death was the result of homicide or natural causes.

When a child dies, public authorities must seek to establish the cause of death. Knowing the correct cause may help the parents and relatives of the child to grieve. It may also enable medical professionals to understand the cause of death and, where necessary, allow for steps to be taken to prevent future deaths. Where it is suspected a crime may have been committed, this guidance should be used in conjunction with the NPCC (2021) *Major Crime Investigation Manual (MCIM)* as well as College of Policing Authorised Professional Practice.

The primary responsibility of the police investigation is to the child who has died, their siblings and any future children who may be born to the parents. It may not be immediately possible to identify a cause of death and it may take time to determine whether the death is suspicious or due to natural causes. This guidance will help investigating officers to conduct an effective investigation into all cases of sudden unexpected death in children whether or not there are suspicious factors.

In the early 2000s there were a series of high-profile miscarriages of justice involving the prosecution of mothers accused of causing the deaths of their babies. Baroness Helena Kennedy KC chaired a working group which identified best practice for handling sudden unexpected death in infancy and childhood. In 2004 the working group published a multi-agency protocol for care and investigation and the second edition, published in 2016 by the Royal College of Pathologists, remains widely known as the '*Kennedy guidelines*'. Police child death investigators must be familiar with these guidelines.

A multi-agency approach is the best way to investigate child deaths, determine the cause of death, identify any natural processes that may have led to death and, where appropriate, to support any future prosecution. When dealing with SUDICs all agencies need to follow five common principles:

- a balanced approach which incorporates both sensitivity and the investigative mindset;
- a multi-agency response;
- the sharing of information;
- an appropriate response to the circumstances;
- the preservation of material and evidence.

1.1 Use of language

This document is primarily intended for a professional readership, and consequently it uses legal, medical, and policing terminology which it is acknowledged, with sincere regret, may be distressing for some readers, particularly those with first-hand personal experience of the death of a child. For ease of reading, the term 'child' is used throughout, but this could mean baby, infant or child. Similarly, the term 'parents' is used throughout as shorthand for parents, legal guardians and/or primary carers.

1.2 National guidance

Investigators are reminded of the need to read this Practice Advice in conjunction with relevant national guidance from the four nations of the United Kingdom. These documents provide overarching guidance for the police and partner agencies on how they should collectively investigate child deaths.

For investigators in England, the national guidance includes the statutory guidance HM Government (2023) *Working Together to Safeguard Children* (chapter 6) and the HM Government (2018) *Child Death Review: Statutory and Operational Guidance (England)*.

For investigators in Wales, the national guidance includes the NHS Wales (2023) *Procedural Response to Unexpected Deaths in Childhood (PRUDiC)*.

For investigators in Northern Ireland, national guidance includes the *Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse (April 2021)*.

For investigators in Scotland, national guidance includes the Scottish Government (2021) *National Guidance for Child Protection in Scotland* (chapter 4) and the Healthcare Improvement Scotland (2021) *National Guidance when a Child or Young Person Dies*.

Please note that in Scotland the Crown Office and Procurator Fiscal Service (COPFS) have responsibility for the investigation of deaths on behalf of the Lord Advocate. Where this document refers to a coroner it should be read as referring to the COPFS in relation to a child death occurring in Scotland.

See also:

Human Rights Act 1998 https://www.legislation.gov.uk/ukpga/1998/42/contents

Coroners and Justice Act 2009 https://www.legislation.gov.uk/ukpga/2009/25/contents

Coroners Act (Northern Ireland) 1959 https://www.legislation.gov.uk/apni/1959/15/contents

Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016
https://www.legislation.gov.uk/asp/2016/2/contents

Crown Office and Procurator Fiscal Service
https://www.copfs.gov.uk/about-copfs/our-role-in-investigating-deaths/

NPCC (2021) *Major Crime Investigation Manual*
https://library.college.police.uk/docs/NPCC/Major-Crime-Investigation-Manual-Nov-2021.pdf

College of Policing Authorised Professional Practice (APP) https://www.college.police.uk/app

Royal College of Pathologists (2016) *Sudden unexpected death in infancy and childhood: Multi-agency guidelines for care and investigation – second edition* (often referred to as the '*Kennedy guidelines*')
https://www.rcpath.org/resourceLibrary/sudden-unexpected-death-in-infancy-and-childhood-report.html

HM Government (2023) *Working Together to Safeguard Children*
https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

HM Government (2018) *Child Death Review Statutory and Operational Guidance (England)*
https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

NHS Wales (2023) *Procedural Response to Unexpected Deaths in Childhood (PRUDiC)*
https://phw.nhs.wales/services-and-teams/national-safeguarding-service/safeguarding-latest-guidance/prudic-procedural-response-to-unexpected-death-in-childhood/

Health and Social Care Board (2021) *Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland*
https://proceduresonline.com/sbni/files/joint_invest_protocol.pdf

Scottish Government (2021) *National Guidance for Child Protection in Scotland*
https://www.gov.scot/publications/national-guidance-child-protection-scotland-2021-updated-2023/

Healthcare Improvement Scotland (2021) *National Guidance when a Child or Young Person Dies*
https://www.healthcareimprovementscotland.scot/publications/national-guidance-when-a-child-or-young-person-dies/

2 Relevant offences

In addition to the offences of murder and manslaughter (or culpable homicide in Scots law) there are many other offences that may be relevant considerations in child death investigations. Please note there are differences in offences across the distinct legal jurisdictions of England and Wales [E+W], Scotland [S] and Northern Ireland [NI].

2.1 Offences where a death has occurred

Infanticide – woman kills her child under 12 months old while her mind was disturbed *Infanticide Act 1938, section 1* ***[E+W]*** *Infanticide Act (Northern Ireland) 1939, section 1* ***[NI]***
Child destruction – wilful act causing a child to die before it has an existence independent of its mother, with intent to destroy the life of a child capable of being born alive *Infant Life (Preservation) Act 1929, section 1* ***[E+W]*** *Criminal Justice Act (Northern Ireland) 1945, section 25* ***[NI]***
Causing or allowing a child or vulnerable adult to die or suffer serious physical harm *Domestic Violence, Crime and Victims Act 2004, section 5* ***[E+W, NI]***
Criminal overlay – death of child under three years caused by suffocation while lying next to someone over the age of sixteen years under the influence of drink or drugs *Children and Young Persons Act 1933, section 1(2)* ***[E+W]*** *Children and Young Persons (Scotland) Act 1937, section 12(2)* ***[S]*** *Children and Young Persons Act (Northern Ireland) 1968, section 20(2)* ***[NI]*** See **7.8 Co-sleeping and overlay** for further details on these offences.

2.2 Offences relating to termination of pregnancy

Administering drugs or using instruments to procure an abortion *Offences Against the Person Act 1861, section 58* ***[E+W]***
Supplying or procuring poison, noxious thing or any instrument to cause an abortion *Offences Against the Person Act 1861, section 59* ***[E+W]***
Maliciously administering poison or noxious thing so as to endanger life or inflict GBH *Offences Against the Person Act 1861, section 23* ***[E+W, NI]***
Terminate a pregnancy otherwise than in accordance with regulations *The Abortion (Northern Ireland) (No. 2) Regulations 2020, regulation 11* ***[NI]***

2.3 Offences relating to concealment of birth

Concealing the birth of a child – secret disposition of dead body of a child to conceal birth *Offences Against the Person Act 1861, section 60* ***[E+W, NI]***
Concealing pregnancy and child later found dead or missing *Concealment of Birth (Scotland) Act 1809, section 2* ***[S]***
Preventing lawful and decent burial of a dead body *Common law*
Obstructing the Coroner – disposal of a corpse with intent to obstruct or prevent an inquest *Common law*

2.4 Offences relating to child neglect/endangerment

Cruelty or neglect to persons under sixteen *Children and Young Persons Act 1933, section 1(1)* ***[E+W]*** *Children and Young Persons (Scotland) Act 1937, section 12(1)* ***[S]*** *Children and Young Persons Act (Northern Ireland) 1968, section 20(1)* ***[NI]***
Death or serious injury of child having been exposed to open fire grate or heating appliance by person over the age of sixteen years with responsibility for child *Children and Young Persons Act 1933, section 11* ***[E+W]*** *Children and Young Persons (Scotland) Act 1937, section 22* ***[S]*** *Children and Young Persons Act (Northern Ireland) 1968, section 29* ***[NI]***
Exposing child under two years whereby life is endangered or health injured *Offences Against the Person Act 1861, section 27* ***[E+W, NI]***

Where the same offence is listed above under different legislation for England and Wales, Scotland, and Northern Ireland there exist some slight variations between some offences. Investigators are advised to familiarise themselves with the relevant offence in their jurisdiction using either https://www.legislation.gov.uk or the Police National Legal Database (PNLD) https://www.pnld.co.uk.

3 Standards for child death investigations

The same standard of investigation should apply to the death of a child as for any other type of death.

Over the past 40 years infant mortality rates have reduced significantly in the United Kingdom[1]. Safer sleeping advice and medical advances are seen as major contributors to this decline. Sadly, several thousand children still die each year, with most childhood deaths occurring during the first year of life. About 19% of child deaths are sudden and unexpected with no immediately apparent cause[2]. The number of child deaths identified as homicide, although small in total number (29 per million population), remains relatively stable year on year, and children under the age of one are the most likely age group to be killed by another person[3].

Following the death of a child, sometimes the likely cause is immediately obvious (for example, a road traffic collision, drowning or fatal injury). On other occasions the death is both sudden, unexpected and without obvious cause. This can create unique investigative challenges. At the point of reporting, the presenting circumstances of a child death arising from natural causes, could be identical to the presenting circumstances of a child death resulting from homicide.

Factors raising suspicion may only become known later in the investigation, such as when the results from a post-mortem examination become available. When a child dies at home in their bed, it could be a crime scene, or it could just be where the parents put their apparently healthy child to bed before later discovering they had died in their sleep. As a result, the police response will require tact and sensitivity from the outset.

The potential influence of genetic factors on vulnerability to sudden unexpected death in children remains the subject of scientific research. More than one child death can, unfortunately, occur in the same family, and equally more than one child in a family can die as the result of abuse. A previous child death in the same family, especially where the cause or means of death is the same or similar, will therefore require a careful examination of potential natural or unnatural contributory factors.

[1] Royal College of Paediatrics and Child Health (2020) *State of Child Health* https://stateofchildhealth.rcpch.ac.uk
[2] NCMD (2022) *Sudden and Unexpected Deaths in Infancy and Childhood* https://www.ncmd.info/publications/sudden-unexpected-death-infant-child/
[3] Office for National Statistics (2022) *Homicide in England and Wales: year ending March 2022* www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/march2022

3.1 Factors which may increase suspicion

These include the following (this is not an exhaustive list):

- previous unusual or unexplained illnesses or admissions to hospital;
- unusual bruises or injuries;
- foreign bodies in the upper airway;
- child is older than 12 months;
- inconsistent accounts from parents;
- delay in seeking help/child appears to have been dead for longer than stated;
- previous unexpected death of a sibling or other child in the family;
- history of alcohol/substance abuse in the family;
- history of domestic abuse in the family;
- history of mental health conditions in parents;
- concerns regarding previous violence, neglect, or failure to thrive;
- deceased or siblings known to social services/subject to Child Protection Plan (or equivalent).

3.2 Key questions

Any childhood death investigation should seek to answer the following four questions[4]:

- Why did this child die?
- What was the cause of death and the circumstances?
- Are any criminal offences disclosed?
- If so – who was / were responsible for committing those offences?

[4] See Marshall, D. (2012) *Effective Investigation of Child Homicide and Suspicious Deaths*. Oxford: Oxford University Press.

4 Key terminology

4.1 Sudden unexpected death

It is recognised that there are many different terms used to describe the death of an infant or child. A sudden unexpected death (or collapse leading to the death) is one which would not have reasonably been expected to occur in the 24 hours previously, and where no pre-existing medical cause of death is apparent. The following terms are often used interchangeably in advice and guidance documents and may be used by other professionals to describe a death:

- **Sudden Unexpected Death in Infancy (SUDI)** – infants up to 24 months of age
- **Sudden Unexpected Death in Childhood (SUDC)** – children 24+ months, but under 18 years
- **Sudden Unexpected Death in Infancy and Childhood (SUDIC)** – an umbrella term that applies to a death occurring from birth to under the age of 18 years.

It is particularly important to note that some agencies define the term 'infant' as describing children between the ages of 0 to 12 months. This is because the term 'Sudden Infant death Syndrome' (SIDS) is used by medical professionals to describe circumstances as follows:

> *SIDS is defined as the sudden unexpected death of an infant <1 year of age, with onset of the fatal episode apparently occurring during sleep, that remains unexplained after a thorough investigation, including performance of a complete autopsy [post-mortem examination] and review of the circumstances of death and the clinical history*[5].

While the *Kennedy guidelines* define an infant as a child between 0 and 24 months, it is not uncommon to also see the alternative 0 to 12 months definition being used. For example, the Lullaby Trust charity focuses primarily on SIDS prevention and so uses the 12 months threshold. The important thing for police lead investigators is that they focus on investigating each death thoroughly whilst also remaining mindful of the differing thresholds for the definition of infancy that may be used by other professionals.

For the purposes of consistency within this guidance, the term SUDIC is used throughout.

[5] Krous, H. et al. (2004) 'Sudden Infant Death Syndrome and Unclassified Sudden Infant Deaths: A Definitional and Diagnostic Approach' *Pediatrics*, 114(1): pp.234-238.

4.2 Suspicious death

A death is considered as suspicious where:

- there are obvious criminal offences related to the death, or
- although there are no direct grounds to suspect a specific criminal act there are, however, factors that raise the **possibility** that a criminal act **may** have contributed to the death and thereby merit a **more detailed investigation** of the **circumstances of the death**.

It is important to remember that although there MAY be factors present that raise the level of concern, their presence is NOT conclusive proof of a criminal offence. The subsequent investigation may uncover criminal wrongdoing but equally may provide evidence of a natural cause of death[6].

4.3 Joint agency response

A joint agency response (JAR) is a coordinated multi-agency response, including an on-call health professional, police investigator and duty social worker[7]. A JAR should be triggered if a child's death:

- is or could be due to external causes;
- is sudden and there is no immediately apparent cause;
- occurs in custody, or where the child was detained under the Mental Health Act;
- where the initial circumstances raise any suspicions that the death may not have been natural;
- in the case of a stillbirth where no healthcare professional was in attendance.

4.4 Lead health professional

The lead health professional will take responsibility for ensuring that all health responses are implemented, and for ongoing liaison with the police and other agencies[8]. The lead health professional will normally be the designated paediatrician for unexpected deaths in childhood, or another health professional with appropriate training and expertise in responding to child deaths.

Where no out-of-hours rota for responding to unexpected infant deaths exists, the role of lead health professional should be taken by the senior attending paediatrician. Responsibility should then be handed over to the appropriate health professional at the earliest opportunity. Where the role of lead health professional is taken by a specialist nurse or someone other than the designated paediatrician, they must be supported in the role by the designated paediatrician with adequate case supervision.

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[6] Marshall, D. (2012) *Effective Investigation of Child Homicide and Suspicious Deaths*. Oxford: Oxford University Press.
[7] HM Government (2018) *Child Death Review Statutory and Operational Guidance (England)*.
[8] Royal College of Pathologists (2016*) Sudden unexpected death in infancy and childhood: multi-agency guidelines for care and investigation – second edition*.

4.5 Lead investigator

The police lead investigator should be appropriately trained and experienced. Due to the often challenging and complex nature of child death investigations it is strongly recommended that the police lead investigator is an accredited PIP2 or PIP3 investigator[9] who has received specialist child death investigation training. It is recommended that lead investigators have attended the College of Policing Investigating Sudden Unexpected Death in Childhood course (or equivalent).

Regular continued professional development activities, including the effective use of mentoring, will ensure that police lead investigators remain operationally competent and continually develop their approach in response to learning experiences, and their knowledge of evolving good practice.

Robust out of hours/on call arrangements will ensure that there is sufficient resilience to provide an effective and professional response by the police to child deaths at any time of day or night.

[9] College of Policing (2023) *Professionalising Investigations Programme Policy*.

5 Categories of childhood death

5.1 Expected death

Where the death is expected, and a doctor has issued a medical certificate of cause of death (MCCD), a police investigation is unlikely to be required. The circumstances in which a MCCD can be completed differ across the United Kingdom. In England and Wales, in the case of the death of any person who has been attended during their last illness by a registered medical practitioner, that practitioner shall complete a MCCD[10]. If the attending doctor has not seen the deceased within the 28 days preceding death, and has not seen the body after death either, the death must be referred to the coroner[11].

In Scotland, any registered medical practitioner who was in attendance on the deceased during their last illness shall complete a MCCD[12]. In Northern Ireland, where any person dies as a result of any natural illness for which they had been treated by a registered medical practitioner within twenty-eight days prior to the date of his death, that practitioner shall complete a MCCD[13].

Where death was expected but a MCCD has not been completed, the lead investigator should liaise with the relevant coroner or the Crown Office and Procurator Fiscal Service (COPFS).

Children with life-limiting conditions can still die unexpectedly. Where this happens, the police should discuss with the lead health professional to determine the appropriate course of action. Even though death was expected a child can still die from other causes and their death may be unexpected at the time it occurs. The lead investigator should establish whether there are any unusual or suspicious circumstances or risk factors that raise concern.

Where the expected death of a child occurs at their home address, or outside a hospital or hospice setting, consider the following objectives for any investigation:

- ensure a child-focused approach;
- ensure information sharing takes place at the earliest opportunity;
- facilitate co-operation between agencies at an early stage to prevent unnecessary intrusion into the family after a child death. This is particularly relevant as agencies will have time to prepare and share information in advance of the expected death.

[10] Births and Deaths Registration Act 1953, section 22.
[11] Department of Health and Social Care (2024) *Guidance for doctors completing Medical Certificates of Cause of Death in England and Wales* https://www.gov.uk/government/publications/medical-certificate-of-cause-of-death-mccd-guidance-for-medical-practitioners
[12] Registration of Births, Deaths and Marriages (Scotland) Act 1965, section 24.
[13] Births and Deaths Registration (Northern Ireland) Order 1976, article 25.

5.2 Unexpected death

Incidents which will trigger a child death investigation will include:

- accidents
- road traffic collisions
- drowning
- suicide
- homicide
- any unusual circumstances including when children die abroad
- deaths where a doctor raises concerns and the matter is referred to the police for further investigation by the coroner (or COPFS)

A child death investigation could also be instigated where a child is unexpectedly very ill and/or has collapsed at home and dies soon afterwards in hospital and the cause of death is later established as a non-suspicious medical explanation, for example, the child had meningitis. In these cases, a police investigation will be required until the doctor has sufficient information to issue a death certificate, or to inform a coroner (or COPFS) that a natural cause of death has been identified.

In these cases, the police may receive the initial notification of death from health professionals. The police should pay particular attention to any events which happened prior to the child's admission to hospital, and which may have contributed to the death. The results of any medical examinations while the child was being treated should be considered carefully and the investigation adapted accordingly.

Some incidents involving the death of a child will require additional considerations.

5.2.1 Homicides

Where the death is obviously homicide, see the NPCC (2021) *Major Crime Investigation Manual*.

5.2.2 Sudden and unexplained death of a child aged 12 months – 18 years

There will be some differences between an investigation into the death of an infant under 12 months, and those who are older than 12 months, for example, investigating the death of an older child by suicide (where a joint agency response will also be required). As recommended by the *Kennedy guidelines* the same general structure and approach to the investigation should be used, with appropriate modifications, for the deaths of older children.

See also:

College of Policing Authorised Professional Practice – Suicide and Bereavement Response
https://www.college.police.uk/app/mental-health/suicide-and-bereavement-response

5.2.3 In-life referrals due to life-threatening conditions

Where a child has been diagnosed with a life-threatening condition, and their death is anticipated, there may still be suspicious circumstances requiring an investigation. In these cases, the lead investigator should be briefed at the earliest opportunity.

An example may include, where an infant has been admitted to hospital with a suspected brain haemorrhage, possibly caused by trauma, or where a child has been resuscitated after a collapse. A joint agency response should be considered, and arrangements made for an initial information sharing meeting between the relevant agencies even where the child has not died.

Where there are suspicious circumstances identified, a Home Office registered forensic pathologist (HORFP) should be consulted via the lead investigator before the death of the child. The permission of the parent will be required to examine a living child, unless legal proceedings determine that the examination can take place without their consent.

There may be circumstances where a child initially survives a non-accidental injury (NAI), but later dies from those injuries, while still a child. Forces should ensure they have a robust system for recording decisions and retaining investigative material so that a joint agency response and appropriate criminal investigation can be conducted where required. This should include establishing strong communication channels with the relevant hospital and other partner agencies, and an agreed protocol to be enacted in the event of death.

It is recommended that the child's full medical records and the Personal Child Health Record (commonly known as the 'red book') are obtained at the earliest opportunity, i.e. prior to the death, to establish if there are any underlying medical conditions. All subsequent records relating to treatment should be seized post death.

5.2.4 Deaths immediately after birth

Sometimes a baby dies shortly after birth, for example, in the hospital delivery suite, post-natal ward or neo-natal ward, and the cause of death cannot be established by the doctor. Where these deaths are reported to the police the lead investigator should consult with the lead health professional and coroner (or COPFS) for guidance and to determine the extent of the investigation required.

Enquiries at the hospital should be discreet and, where possible, plain clothes should be worn, but these particularly challenging circumstances, and the sensitive environment in which enquiries may be required, should not be allowed to inhibit the effectiveness of any investigation required.

5.2.5 Stillbirth

A baby is considered stillborn if born '*…after the twenty -fourth week of pregnancy and… did not at any time after being completely expelled from its mother breathe or show any other signs of life*'[14]. Where a pregnancy ends without signs of life before 24 weeks this is described as a miscarriage or late foetal loss. In England, a joint agency response is required in the case of a stillbirth where no healthcare professional was in attendance[15]. In cases of stillbirth the relevant child death review processes in England and Scotland are not required (see **13 Child Death Review processes**).

In England and Wales, where there has not been an independent life, there has not legally been a death. Therefore, coroners in England and Wales do not have jurisdiction to conduct an investigation concerning a stillborn child or foetus[16]. Following a 2013 decision of the Court of Appeal in Northern Ireland, the coroner in Northern Ireland does have jurisdiction in relation to a deceased unborn child that had been capable of being born alive[17].

Where it is not clear whether a baby was stillborn or had lived independently from the mother, an investigation should proceed to determine whether the baby was born alive. This will ensure that vital information is not lost if the baby was not stillborn, and their death was not the result of natural causes. The existence of independent life or otherwise would usually be established by a pathologist.

Where incidents of unattended stillbirth with concerns relating to termination of pregnancy are reported to the police see **10.4 Termination of pregnancy** for further guidance.

See also:

Chief Coroner's Guidance No. 45 Stillbirth, and Live Birth Following Termination of Pregnancy
https://www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-no-45-stillbirth-and-live-birth-following-termination-of-pregnancy/ (relevant to England and Wales only)

[14] In England and Wales this is defined by section 41(1) of the Births and Deaths Registration Act 1953, and near identical definitions exist in Scotland by virtue of section 56(1) of the Registration of Births, Deaths and Marriages (Scotland) Act 1965 and in Northern Ireland under Article 2(2) of the Births and Deaths Registration (Northern Ireland) Order 1976.
[15] HM Government (2018) *Child Death Review Statutory and Operational Guidance (England)* and HM Government (2023) *Working Together to Safeguard Children*.
[16] *Chief Coroner's Guidance No. 45 – Stillbirth, and Live Birth Following Termination of Pregnancy*.
[17] Attorney General for Northern Ireland and Siobhan Desmond v The Senior Coroner For Northern Ireland [2013] NICA 68.

5.2.6 Medical negligence

Cases where the death of a child involves any concerns of negligence by medical practitioners should be referred to the police and the coroner (or COPFS) for further investigation.

See also:

NPCC (2015) *An SIO's guide to investigating unexpected death and serious harm in healthcare settings* https://library.college.police.uk/docs/NPCC/2015-SIO-Guide-Investigating-Deaths-and-Serious-Harm-in-Healthcare-Settings-v10-6.pdf

5.2.7 Road traffic collisions

There should be a joint agency response for any child involved in a fatal road traffic collision. In these cases, a Family Liaison Officer may be appointed. The joint agency response should be appropriately tailored to the circumstances of the death, particularly where the cause of death is clear and obvious.

5.2.8 Death of a child abroad

The Foreign, Commonwealth & Development Office (FCDO) can provide advice and guidance when a child who is a British national dies abroad. FCDO guidance states that where a child, ordinarily resident in England or Wales, dies abroad, that multi-agency child safeguarding procedures are required[18].

For a child ordinarily resident in England, the HM Government (2018) *Child Death Review: Statutory and Operational Guidance (England)* advises on the process to be followed. For Wales, the *PRUDiC* states that professionals will consider implementing the *PRUDiC* as far as is practically possible and fully record any decisions made. In Scotland, the Healthcare Improvement Scotland (2021) *National Guidance when a Child or Young Person Dies* sets an expectation that the residing NHS board will conduct a review. A decision-making discussion should take place between appropriate agencies and a joint agency response established in line with the presenting circumstances.

See also:

Foreign, Commonwealth & Development Office (2022) *What to do after a British National Dies Abroad* https://www.gov.uk/guidance/what-to-do-after-a-british-national-dies-abroad

College of Policing Authorised Professional Practice – International Investigations https://www.college.police.uk/app/investigation/international/international

[18] Foreign, Commonwealth & Development Office (2022) *Murder, manslaughter and infanticide of British nationals abroad: memorandum of understanding*.

6 Initial actions following a report of a child death

This section provides practical advice to those attending a report of the death of a child. Where relevant, role-specific actions are indicated. These lists are not exhaustive and should be treated as a guide only. Not every action will be necessary in every case.

Those responding to a report of a child death must demonstrate professional curiosity.

This means exploring and understanding what has happened by asking questions and maintaining an open mind. This involves checking and reflecting on information received, challenging assumptions and not necessarily accepting things at face value.

During the initial stages of a child death investigation actions taken (and equally those not taken) may have significant consequences during the later stages of investigation.

6.1 Engaging with the bereaved family

Your contact with the family may be brief, but it can influence how the family deal with the death long after the initial crisis is over. You cannot take grief away, but you can accept it is a very difficult situation for everyone, including you – thoughtful gestures can be seen as supportive and are often long remembered. Consider the following[19]:

- When speaking to parents explain who you are and your role.
- Remember you are dealing with people who are in the first stages of grief, they may be shocked, numb, withdrawn, possibly hysterical – be patient.
- Acknowledge the parents' situation, they have suffered a tragic loss.
- Avoid saying that you understand or using clichéd expressions of condolence.
- Remember that the child's parents may have already had to explain how their child died to other professionals before you, for example, the 999-call operator and paramedics.
- There is usually no need to rush – a slow, calm approach can give parents time to collect their thoughts – respect their feelings and show them concern.
- If there are time constraints, explain these and, if possible, explain why.
- Ask for the child's name - always use it.
- Avoid insensitive language, for example, 'suspicious death', 'crime scene', 'the body'.
- Some parents will feel guilty about their child's death even though they are not responsible – guilt is common in bereavements – be compassionate and do not reinforce guilt.
- Check that the parents are not going to be left alone, and that they can support any other children in the family – ask if they want anyone contacted.

[19] Adapted from advice provided to professionals by The Lullaby Trust https://www.lullabytrust.org.uk/

6.2 Call handler actions

The call handler taking the initial call should:

- Obtain as much information as possible about the incident. Don't interrupt the caller unnecessarily to obtain this. Type as much information as possible straight onto the screen and review the call to ensure nothing was missed.
- Ask the name and date of birth of the child (refer to the child by name throughout the call).
- Establish where the child is at that moment.
- Find out how the child was found. This should give you an account which you need to record, for example, "I understand this is very difficult, but I need to ask what happened and who found (name of child)".
- Record the call as quickly as possible so that the dispatcher can allocate an immediate response and begin to deploy officers in line with local force policy.
- Ask the caller if medical assistance has been requested. If not contact ambulance control and confirm to the caller that you will do this.

Remember:

- You are dealing with people in the first stages of grief; they may be shocked, numb, withdrawn or hysterical and may not be able to provide the information you need.
- Be patient and take time to ask questions and wait for answers.
- Be sensitive about what has been said, the parents may be questioning their own actions and what they could have done to prevent the death.
- Be prepared to explain some of the questions as they may appear inappropriate to the caller.
- Your role is not to investigate the incident, it is to obtain enough information to prepare the attending officers.

6.3 Dispatcher

The dispatcher should deploy officers as soon as possible as an immediate response incident. This is likely to include deploying officers to:

- where the child died, for example, the home address; and
- where the child is now, for example, the hospital emergency department.

The dispatcher should also:

- Consider the most appropriate deployment – where possible use a discreet presence (plain clothes/unmarked cars) unless this will cause unnecessary delay.

- Inform relevant supervisors (according to force policy), inform them who has been dispatched and request their attendance to the scene.
- Update the incident log at the time you carry out an action as this may later be evidential.
- During office hours, contact the relevant lead investigator (according to force policy), who should attend the incident immediately and take charge of the investigation.
- Out of hours, contact the on-call lead investigator, who should attend the incident immediately and take charge of the investigation.

6.4 First attending officer

The first attending officer should:

- Be sensitive, compassionate and professional (see **6.1 Engaging with the bereaved family**).
- Where possible, attend in an unmarked vehicle and wear plain clothes – unless this would cause unnecessary delay.
- Use body worn video according to local force policy.
- Take steps to preserve life, including administering first aid and requesting the attendance of an ambulance, unless the child has already been taken to hospital for treatment.
- If an officer arrives before the child has been removed to hospital, an officer should accompany the child to hospital.
- If the child is already dead, and has not been taken to hospital, do not allow the child to be washed, or moved (this includes removing traces of vomit or blood, or removing/changing clothes or nappies).
- Do not disturb anything, but note as much information as possible, taking care not to comment on your observations to the parents or others present.

Observations should include:

- The position the child was in when found.
- Whether there was any fluid around the nose and mouth, for example blood-stained froth or gastric contents.
- If found in bed, a cot, crib or Moses basket, or other sleeping surface note the position of the bedding, for example if it was covering the child's face or head.
- Note the presence of other items in the sleeping environment, for example toys, pillows, cot bumpers, sleep monitors.
- The condition of the room the child was found in.
- The temperature in the room and whether the heating is on or off.
- Whether any windows are open and the local weather conditions at the time (if relevant).
- Any unusual or dangerous items in the room and whether any animals are present.
- The presence of any medications or controlled drugs.

Notify a Crime Scene Investigator (CSI)/Crime Scene Manager (CSM) as soon as possible in line with local force policy and ensure that you:

- Preserve the scene sensitively by preventing people from entering the area. Unless it is already clear that a crime has occurred, scene preservation will include balancing the needs of the family and the investigation.
- Prevent any attempt to dispose of or wash any items (e.g. nappies, bottles etc) – explain that these items might be important to find out why their child died.
- Start a scene log according to local force policy. This document must be handed to the lead investigator (or someone acting on their behalf) at the conclusion of the initial response.
- Record personal details, descriptions and demeanour of those present at the scene.
- Record any comments made by those present which may be significant. Parents may disclose important information while searching for answers to what has happened.

Notify social services to ensure that the needs of any siblings or other children left at the scene are met. If children are left in the care of nominated trusted adults, background checks must be made. Consider powers of police protection:

- In England, Wales, and Northern Ireland where there is reasonable cause to believe a child would otherwise be likely to suffer significant harm the child may be removed to safety[20].
- In Scotland a constable may remove a child to a place of safety and keep the child there if they are satisfied that it is necessary to protect the child from harm, and it is not practicable in the circumstances for an application for a child protection order to be made to or considered by the sheriff[21].

Other initial actions include:

- Arranging alternative accommodation for any individuals displaced from the scene by police activity – remember to record temporary addresses and telephone numbers for later contact.
- Obtain the contact details of first responders, paramedics and ambulance staff who attended to the child, including where possible off-duty telephone numbers to allow for follow up witness interviews if required.

Upon their arrival brief the supervisor/lead investigator detailing information you have gathered while at the scene. This could include the scene log and any pocketbook notes.

[20] In England and Wales under section 46 of the Children Act 1989 and in Northern Ireland under article 65 of The Children (Northern Ireland) Order 1995.
[21] Children's Hearings (Scotland) Act 2011, section 56.

6.5 Removal of the body from the scene

Forces should agree arrangements with their local ambulance service so that when their staff attend the death of a child, they understand the policing requirements. Lead investigators should familiarise themselves with these local arrangements. The *Kennedy guidelines* state that:

> *Unless there are clear indications that the [child] has been dead for some time, appropriate resuscitation should be started and continued until the [child] is brought to hospital.*
>
> *Unless there are exceptional reasons not to, the [child] should be brought immediately to an emergency department with paediatric care. Resuscitation should be continued en route to the hospital. The default position should always be to attend the emergency department, but with older children where the cause of death is more apparent (for example, stabbing or a train-related disturbance), a decision may be made to transfer straight to mortuary facilities or to remain in situ at the crime scene to allow other forensic processes to take place under the guidance of the [lead investigator].*

Where life extinct has been declared and the death appears obviously suspicious, the ambulance crew should remain with the body at the scene until a police supervisor arrives. Before the body is moved, the lead investigator and Crime Scene Manager (CSM)/Crime Scene Coordinator (CSC) should be consulted to ensure appropriate decisions are made about forensic recovery and scene management.

6.6 First officer attending the hospital

The first officer attending the hospital should:

- Be sensitive, compassionate and professional (see **6.1 Engaging with the bereaved family**).
- Observe the behaviour/demeanour of, and the dialogue between parents.
- Record any comments which may be relevant to the investigation.

The following requests and investigative actions should be undertaken where possible, but should be secondary considerations where medical staff are continuing attempts to resuscitate a child:

- Do not allow activities such as washing/wiping (unless part of the medical treatment), or other obvious interference with the child in areas (for example, around the mouth), which may provide forensic evidence. If this is unavoidable or has already happened, record details of who has done what, and why.
- Ensure clothing is left on the child and not removed by medical staff unless required for medical treatment. Where clothing is removed, seize each item separately, and package and seal as separate exhibits. Consult a crime scene investigator (CSI) for guidance if unsure.

- Be discreet when securing items which may be required for evidential purposes. Consult medical staff and ask that any disposable lines, tubes, masks or blood-stained bedding be retained. Each item should be seized, packaged and sealed as a separate exhibit.
- Any tubes, intravenous lines, cannulae or similar should only be removed from the body after discussion between the lead investigator and lead health professional. It is of course preferable that parents do not view their child with these items still inserted if possible. However, the decision to remove them will need to be considered in the context of the surrounding circumstances including whether the death is being treated as suspicious at that time – in which case the lead investigator may decide that they are kept in situ until a forensic post-mortem examination is conducted.
- Ensure any relevant items from the ambulance, for example, the drainage bottle is seized, particularly where there is any suspicion that the child may have choked. The drainage bottle may contain an item which has caused an obstruction.

Requests from the parents to hold their deceased child should be referred to the lead investigator. Where an officer arrives at hospital to find that the body is already being handled by family members, ensure this is monitored, noting timings and who has contact with the body.

The officer attending the hospital should brief the lead investigator when they arrive ensuring they relay all of the information they have obtained, and that this information is also communicated to any CSI/CSM in attendance.

6.7 Supervisor of the initial response

The officer supervising the initial response should:

- Take a briefing from the first attending officers.
- Ensure all relevant actions have been carried out (see **6.4 First attending officer** and **6.6 First officer attending the hospital**).
- Ensure unmarked vehicles and non-uniform jackets are used (where available) unless this will cause unnecessary delay.
- Ensure scene logs are in use.
- Record any decisions taken and their rationale according to local force policy.
- Brief the lead investigator and CSM/CSC/CSI as required.
- If the child is already at hospital, ensure officers are deployed to secure the child's location prior to transfer to hospital.
- Debrief attending officers and attend to any welfare/wellbeing issues. Make any relevant referrals for further support where appropriate.

6.8 Lead investigator

The lead investigator should attend the location of the child as soon as practicable. In most cases, this will be the hospital emergency department. The following actions should also be considered.

6.8.1 Golden hour considerations for lead investigators

The College of Policing Authorised Professional Practice on Investigation includes general information about actions that should be taken in the period immediately following the report of an incident. This includes actions to protect, preserve and gather material that may otherwise be concealed, lost, damaged, altered or destroyed. Lead investigators should also be guided by the following suggested actions. This is not an exhaustive or priority ordered list, and the actions taken should be specific to the unique needs and circumstances of each incident.

- Contact and request attendance of the lead health professional.
- Agree with the lead health professional who will tell the family key information during the JAR process, and who will gather a medical/social care history of what has happened. Usually this is best done by the lead health professional, but they and the police should work together where possible. If there are suspicious circumstances the lead investigator will need to brief any officer tasked with this action. It may be appropriate to speak to parents separately.
- Where the deceased child has siblings ask the lead health professional about a physical examination of them. This can offer reassurance for parents who may fear for the health of their other child(ren), and an opportunity to identify any potential signs of abuse or neglect.

- Where the deceased child is a twin (or multiple) aged 0-24 months the Kennedy guidelines specifically recommends that the surviving child(ren) should be admitted to an inpatient paediatric unit for close monitoring for at least 24 hours. This would allow for investigations to exclude infection, inherited metabolic disease or an underlying cardiac condition.
- Arrange a home visit with the lead health professional in accordance with local arrangements (see **7.12 Joint home visits**).

- Request intelligence research (local police systems/PNC/PND/social services records) for:

    - all family members; and
    - any individual who cared for the child in the 48 hours leading to time of death (48 hours is a reasonable time period for gathering initial information, however this may change as the investigation develops).

  Note: during office hours local authority records can be researched via the multi-agency safeguarding hub (or local equivalent) and out of hours via the local emergency duty team arrangements.

- Debrief officers attending the hospital and the scene.
- Confirm life extinct has been declared, this may be carried out by a doctor at the hospital, the family's doctor (GP), qualified ambulance crew or a qualified healthcare professional.
- Identify and secure scenes. If the child is at the hospital, ensure the location of the child at time of death, for example their home address, is secured for examination.
- Review immediate safeguarding arrangements for any other children within the family, considering powers of police protection if required.
- Inform the coroner (or COPFS) in line with local arrangements, including those relating to incidents occurring out-of-hours.
- With the lead health professional, debrief the consultant paediatrician and, if available, the hospital emergency department doctor or consultant who may have been involved in any examination of the child and/or resuscitation process.
- Ensure a police officer is present when a visual examination of the child's body takes place by the lead health professional. Any unusual, unexplained, or suspicious marks/injuries should be discussed with the lead health professional and documented in writing.
- Advice should be sought about forensic photography of marks/injuries to record a high-quality visual record suitable for future interpretation by experts if required. The photographing of marks/injuries using only mobile phones or similar, and without using a calibrated scale, should be a last resort only where forensic photography is unavailable.

- Meet the parents and explain what will happen during the investigation. The following may help in explaining this process:

- the police carry out an investigation on behalf of the coroner (or COFPS) into every case of sudden and unexplained death of a child;
- a detailed investigation, including a post-mortem examination, is carried out jointly by all relevant agencies to find out why their child has died;
- information gathered during the investigation may help to save the lives of other children in the future.

- At an appropriate time, explain to the parents what arrangements may be required to progress the investigation (for example, consent to obtain blood and urine samples from them, statements, home visit, identification procedure and post-mortem examination).
- Co-ordinate initial accounts, joint history-taking (medical/social care) and statements. The lead investigator should review the initial accounts and any history that has already been obtained and decide whether further accounts are required. The timing of and methods used to obtain evidential accounts from the parents is important.
- Brief the duty or on-call Senior Investigating Officer (SIO) according to local force policy.
- Liaise with the on-call CSM/CSC and agree an examination strategy. If the body is still at the scene, liaise with the CSM/CSC before giving consent for removal.
- Establish consent/power of entry to examine and search the home address and any other identified scene(s).
- Consideration should be given to seeking drug and alcohol samples from anyone who had care of the child at the time of death. See **7.9 Drug/alcohol samples from parents** for further guidance and a recommended form of words to make such requests.
- It is important for the lead investigator to record their decision making. They should consider starting a policy file in line with local force policy (see NPCC (2021) *Major Crime Investigation Manual* section 1.6).

6.8.2 Further considerations for lead investigators

Lead investigators should also consider the following. Actions taken should be specific to the unique needs and circumstances of each incident and in accordance with local force policy.

- Where relevant contact the force media team (considering the circumstances of the death, likely media interest, and existing public knowledge of the incident).
- Attend initial joint agency response meeting(s) and subsequent multi-agency discussions.
- Notify relevant local child death review process (see **13 Child death review processes**).
- Discuss/arrange the post-mortem examination with the coroner (or COPFS) and CSM/CSC.
- Where necessary liaise with the coroner (or COPFS) for permission to transport the body out of local area for examination. This may be necessary where the paediatric post-mortem examination can only be undertaken at a specialist location such as a children's hospital.

- Where appropriate attend the post-mortem examination and provide the pathologist with a briefing (see **9.3 Police attendance at post-mortem examinations**).

6.8.3 Follow up actions for lead investigators after the initial investigation

- Ensure updates are provided to the parents at appropriate stages of the investigation.
- It is recommended that the initial and later full findings of the post-mortem examination are explained to the family by the lead health professional, accompanied by the lead investigator.
- Where no further investigation is required, i.e. because the death is deemed not suspicious, the lead investigator should explain to the parents how the police investigation will conclude, and that the police will support the coroner where the case moves to inquest (not Scotland).
- Update relevant local child death review processes (see **13 Child Death Review processes**).

6.9 Officer allocated to the family

The officer allocated to the family should obtain a full briefing from the lead investigator and, at their direction, undertake the following actions where required:

- Liaise with the family at the earliest opportunity and offer support to contact relatives/friends.
- Obtain full details of all people who have had contact with the child in the 48 hours prior to death (48 hours is a reasonable time threshold for the purposes of initial information-gathering however this may change as the investigation develops).
- Obtain statements from the parents.
- In conjunction with the lead health professional, obtain detailed medical history of the child and immediate family members.
- Obtain an identification statement.

A Family Liaison Officer (FLO) is unlikely to be deployed unless the death is deemed to be suspicious, or it involves a fatal road traffic collision involving a child. The deployment of a FLO should be made in consultation with the lead investigator and FLO Coordinator.

6.10 Senior Investigating Officer (SIO)

Forces should ensure that their senior on-call detectives are suitably trained and conversant with the investigation of child deaths. It is recommended that forces appoint an SIO to provide oversight in all cases of SUDIC. This is not to conduct the investigation but to give confidence that the lead investigator has sufficient resources and specialist support to conduct all necessary lines of enquiry.

Where there are grounds to suspect the death is suspicious, an accredited PIP3 SIO should be appointed to take charge of the investigation. Where there is a handover between the lead

investigator and the SIO, the decision-making should be recorded with associated rationale. The responsibilities of the SIO include:

- Debriefing the lead investigator.
- Reviewing the resources allocated to the investigation.
- In consultation with the coroner (or COPFS), lead investigator, CSM/CSC and the relevant pathologist(s), agree the timing and type of post-mortem examination to be conducted.
- Maintain a policy file. Decisions and rationales must be recorded.
- Ratify the information to be shared with partner agencies. The SIO must ensure full disclosure that will allow all agencies to safeguard other children. If, in rare circumstances, sharing information may prejudice or hamper the police investigation, disclosure of facts should be made at a meeting between the SIO and a senior manager representing social services. This will allow the needs of the investigation and safeguarding to considered, and an appropriate decision made.

6.11 Crime Scene Manager (CSM)/Crime Scene Coordinator (CSC)

The roles, responsibilities and deployment criteria for forensic examination specialists differs between forces and lead investigators should familiarise themselves with local force policies and procedures.

The lead investigator should work with the CSM/CSC to:

- Identify the scenes.
- Develop a forensic examination strategy and allocate resources to each scene.
- Support, coordinate and attend the post-mortem examination and ensure photographic/360° imaging evidence and any exhibits relevant to the post-mortem examination are made available for discussion.

6.12 Crime Scene Investigator (CSI)/CSM attending the location of death

The CSI/CSM attending the location of death should:

- Obtain a case briefing from the lead investigator and agree parameters for the examination (conduct briefings out of hearing of the parents or others).
- Attend in an unmarked vehicle and do not wear 'Police' marked clothing (where possible).
- Unless forensic material will be compromised, leave items in situ until the lead investigator and lead health professional have attended the scene, where material can be recovered in joint consultation.
- Where possible complete photography/360° imaging prior to the joint visit.

- Make comprehensive scene examination notes. These should include (not an exhaustive list):

    - The room size, position of windows and doors, level of clutter, ventilation, security, heating and heating timer information and current thermostat temperature.
    - Anything which may appear unusual or out of place for the room.
    - The sleeping arrangements for the family. Whether the child slept in a cot, sofa, the floor or elsewhere. The sleeping location in relation to other objects within the room.
    - Flooring types and surfaces and the height to the floor of any surface or object the child could have been sleeping on or fallen from (particularly relevant if initial accounts suggest the child fell or could have been dropped).
    - The type of bed linen and the number of individual layers of linen. If a quilt is used as bedding, if possible, record the tog rating. Also note the type of mattress cover, (cotton, cellular mesh or vinyl) and if pillows are used. Note the size of the mattress.
    - The ambient air temperature readings as close to the child's sleeping place and level with the mattress or sleeping surface. These should be taken as soon as possible after arrival and 15 minutes later. There is no need to wait for the joint visit.
    - The presence of cigarettes, drugs, container of feeds/liquids, alcohol and medication.
    - If bottles of milk, juice or other substances are in the child's sleeping place.
    - Any drugs/medications observed within the scene.
    - The presence of trip hazards (for example uneven flooring or exposed carpet edges).
    - Lighting conditions at the premises (missing light bulbs or poorly illuminated areas).

- Check each layer of bedding for the presence of adhesive tape, cling film, (which may be associated with suffocation), blood staining, vomit, or other stains. Label, note and photograph the position on the bedding to support a future reconstruction if required.
- Bedding and bed linen for the child should be seized if there is a potential forensic value, for example, traces of blood, vomit or other residues. Unless there is a specific investigative reason there is no requirement to seize the mattress.
- Check throughout the house for feeding bottles (used or readymade), soiled nappies and medication relating to the child. These items should be seized.
- Look in cupboards and fridges for indications leading to potential welfare and care concerns.
- Review the child's clothing. Do not seize unless there is a relevant investigative reason, or they are likely to yield forensic material (for example blood stains, vomit or bodily fluids).
- Only consider recovering items of clothing said to have been worn by the child immediately prior to death, if removed by paramedics or parents (consider clothing that may have been discarded or hidden prior to the arrival of paramedics).
- In cases involving stillbirths, or a death immediately after birth, search objectives should include the presence of drugs that can terminate pregnancy such as misoprostol and mifepristone (see **10.4 Termination of pregnancy**). Evidence that the drugs are present or have been used should be brought to the attention of the lead investigator immediately.

- Photographs and 360° images should be obtained and made available for the post-mortem examination briefing.
- Depending on the circumstances and the outcome of the post-mortem examination, further consideration should be given to a specialist light sources examination of the crime scene.

6.13 CSM/CSI attending the child

Where the child is at the home address or place of death the CSM/CSI attending the child should:

- Undertake a staged visual forensic assessment of the body, including photographing:
    - the position of the child and any relevant clothing (noting any damage or staining);
    - lividity, if present and visible;
    - the face and any froth or blood around the face and mouth;
    - any blood elsewhere on the body;
    - any visible injuries;
    - the hands.
- Before moving the body take swabs from the mouth and nose area and from the hands.
- Consider fibre taping the body and/or outer clothing before moving. This could assist with interpretation of events but will be case dependent.
- Consider other relevant in situ forensic sampling (dependent on circumstances).

Where the child is at the hospital the CSM/CSI attending the child should:

- Support the examination of the body of the child (see **7.17 Body examination**).
- Undertake a staged visual forensic assessment of the body, including photography as above.
- Remove and seize clothing in conjunction with the consultant paediatrician, who should inspect the body for any obvious injuries or disfigurements. Each stage will be a managed process and recorded photographically.
- Replace seized clothing with other suitable clothing. Wherever possible, the views of the parents should be considered as they may have clear views about how their child is dressed.

Once the examination is complete (and, where appropriate, the parents have had the opportunity to hold their child), the child will need to be moved to the mortuary, maintaining the continuity of the body. If a subsequent skeletal survey/radiological imaging is required, the child must be transported in a manner which ensures that continuity, security and integrity are maintained.

Carrying out this activity in a hospital emergency department should be undertaken sensitively and discretely with consideration to the potential effect on the parents of the child and staff.

7 The investigative approach to SUDIC

The investigative approach to SUDIC needs to take into account a number of distinct elements: the requirement to follow specified procedures (such as the joint examination of the child); the involvement of several other agencies; as well as the highly emotive backdrop. For the lead investigator this can be a potent mix, requiring a calm and methodical approach in order to make sense of often ambiguous circumstances and to develop an understanding of how the child died.

7.1 Importance of minimising the impact of emotion on decision making

It goes without saying that SUDIC incidents can be distressing for all involved, including investigators who must retain the ability to make sound decisions. Emotionally driven decision-making often lacks the objectivity needed to rationally assess information, prioritise effectively and to take appropriate action as a result. Investigators need to monitor their own emotional reactions to these types of incidents and be prepared to undertake a dynamic process of self-questioning, repeatedly testing their own thought processes as the investigation develops.

7.2 The decision-making challenge within SUDIC investigations

Investigation of SUDIC presents unique decision-making challenges, often presenting with minimal or ambiguous indications as to the cause of death or the surrounding circumstances. At the point of reporting, the presenting circumstances of a child death arising from natural causes, could be identical to those of a homicide. Very young children in particular will not possess many of the lifestyle indicators found in teenagers and adults, such as financial transactions, telephone or social media activity. This can leave investigators in a difficult position as they try to establish what happened during the final hours of the child's life.

In the absence of information that might ordinarily be present in the sudden death of an adult, lead investigators should contemplate the timing of key decisions carefully, considering whether new, and potentially important information might be about to become available, such as the outcome of a post-mortem examination. Equally some investigative actions, such as scene preservation or the obtaining of blood and urine samples from parents will usually need to be carried out quickly to minimise forensic attrition.

7.3 Scrutiny processes relating to investigations of SUDIC

The sudden unexpected death of a child is often subject to particular scrutiny through a number of processes which will rely on the quality of the police investigation in order to reach satisfactory conclusions. These can include family law proceedings, coroner's inquests (England, Wales and Northern Ireland), fatal accident inquiries (Scotland), and statutory child death review processes (such

as Child Death Overview Panel meetings and Child Safeguarding Practice Reviews in England). It is vital that an apparent absence of criminality does not distract lead investigators from conducting a robust and comprehensive investigation. The possibility, for example, of later being required to attend a family court hearing to explain details of the investigative response cannot be discounted.

7.4 National Decision Model

Decision making in policing is often complex. Decisions can be required in challenging circumstances and within timeframes beyond your control. Often decisions are required where only incomplete or contradictory information is available at the time. Additionally, some decisions must be made in circumstances where those involved are deliberately trying to mislead the investigation.

To help everyone in policing make decisions and to provide a framework in which decisions can be examined and challenged, both at the time and afterwards, the police service has adopted the national decision model (NDM).

The NDM has at its centre the Code of Ethics and using the model encourages officers and staff to act in accordance with the Code. Decision makers will receive the support of their organisation in instances where it can be shown that their decisions were assessed and managed reasonably in the circumstances existing at the time, even where harm results from those decisions and actions.

See also:

College of Policing Authorised Professional Practice – National Decision Model
https://www.college.police.uk/app/national-decision-model/national-decision-model

7.5 The use of the three-principle framework within SUDIC investigations

In addition to the NDM, the three-principle framework provides the lead investigator with a system of repeating tests, operating as a filter through which all key decisions can be passed before taking action. Whilst the circumstances of every child death investigation are unique, and no framework can absolutely guarantee a successful outcome, the three-principle framework will support defensible decision-making processes that will enable the lead investigator to demonstrate that their approach was diligent, methodical and structured.

Each principle is described in detail below and can be framed as questions for the lead investigator to ask themselves at critical points in the investigation.

7.5.1 Principle 1 – excellence

Investigators will always err on the side of taking all available investigative steps unless they are able to strongly justify doing otherwise. Investigators will remain mindful of the likelihood of scrutiny through other processes. The investigative standard is therefore one of excellence, ensuring that **all** reasonable and viable investigative opportunities are properly pursued. Lead investigators should ask themselves:

- *Have I taken all investigative steps available to me unless I can strongly justify not doing so?*
- *Have I maintained a standard of excellence throughout my investigative response?*

7.5.2 Principle 2 – balance

Investigators will maintain the balance between an investigative mindset, and compassion and sensitivity throughout, being careful not to allow one perspective to overshadow the other as they deal with the incident. Investigators will remain vigilant for the impact of bias and stereotyping, being careful not to let their thought processes be adversely influenced.

It can be useful to visualise this balancing process as akin to walking a 'tightrope of suspicion' with compassion and sensitivity on one side and the investigative mindset on the other. Investigators should remain balanced on this figurative rope as they carefully progress through the investigation, only feeling comfortable to step off onto one side or the other when the available information justifies it. In some instances, the complexities of SUDIC investigation will mean that this position of careful balance must be maintained for many weeks or months, particularly where expert analysis of post-mortem pathology is ongoing. Lead investigators should ask themselves:

- *Have I maintained a balanced approach throughout my investigation?*
- *Have I been influenced by bias or stereotypes?*

7.5.3 Principle 3 – community

Whilst dealing with the intense and emotive nature of a SUDIC investigation, investigators will remain mindful that the community expectation is that the investigative response aspires to a standard of excellence and remains balanced throughout.

Within SUDIC investigations, human emotions can run high, and this can exert influence on investigators to pursue particular courses of action. For example, investigators attending the hospital emergency department environment can often encounter distressed parents and relatives, or medical professionals who are attempting the difficult job of establishing a possible cause of death. Strong views can be expressed, and emotional responses are often very much in evidence. It is at these points

in the investigation that it can be useful for the lead investigator to 'step away' from the situation in order to reflect and re-evaluate on the available information. Sometimes this 'stepping away' can be a literal physical act, at other times it may just be a few moments of quiet self-contemplation.

It can also be useful to ask a colleague to act as a critical friend and to provide professional challenge for courses of action that are being considered, testing to ensure that the three-principle framework is being followed. Lead investigators should ask themselves:

- *Have I remained mindful that the community expectation is that the sudden unexpected death of a child should be investigated to a standard of excellence and that the investigative approach should remain balanced throughout?*

7.6 Debrief of the consultant paediatrician

Debriefing the consultant paediatrician is a key point in the investigation and should be carried out by the lead investigator at the earliest opportunity. The debrief should establish the history which has been provided to the paediatrician by those involved and the behaviour of the parents whilst in the paediatrician's presence. The lead investigator should establish whether there are:

- any signs of illness or infection;
- any non-accidental injuries (NAI);
- any injuries likely to have been caused during resuscitation;
- any other injuries and whether they can be accounted for prior to resuscitation;
- any evidence of retinal haemorrhages (see **10.1 Head injury, non-accidental head injury or abusive head trauma** regarding head injuries).

It should be agreed with the consultant paediatrician how their findings will be recorded, usually in the form of a report. The report should be made available to the pathologist(s). In complex cases, a witness statement may also be required. Obtaining this statement should be considered as part of the witness strategy and should be obtained by a suitably trained and experienced investigator.

7.7 Ophthalmology and funduscopic examination

Ophthalmology is a branch of medicine concerned with the diagnosis and treatment of disorders of the eye. The examination of a child's eyes following death can identify the presence of retinal haemorrhages (abnormal bleeding within the delicate blood vessels of the retina of the eyes). The presence of retinal haemorrhages, accompanied by other specific injuries, are a strong medical indicator for non-accidental head injury (see **10.1 Head injury, non-accidental head injury or abusive head trauma**). Hospitals will have different arrangements for the examination of a deceased child by

an ophthalmologist. The lead investigator should discuss with the consultant paediatrician/lead health professional to establish local practices for eye examinations of a deceased child.

The Royal College of Paediatrics and Child Health, Royal College of Pathologists and Royal College of Ophthalmologists published a statement in 2022 regarding the importance of eye examination as soon as possible after any unexplained child death. The Royal Colleges recommended that the statement, provided at Appendix A of this document, be treated as an addendum to the 2016 *Kennedy guidelines*.

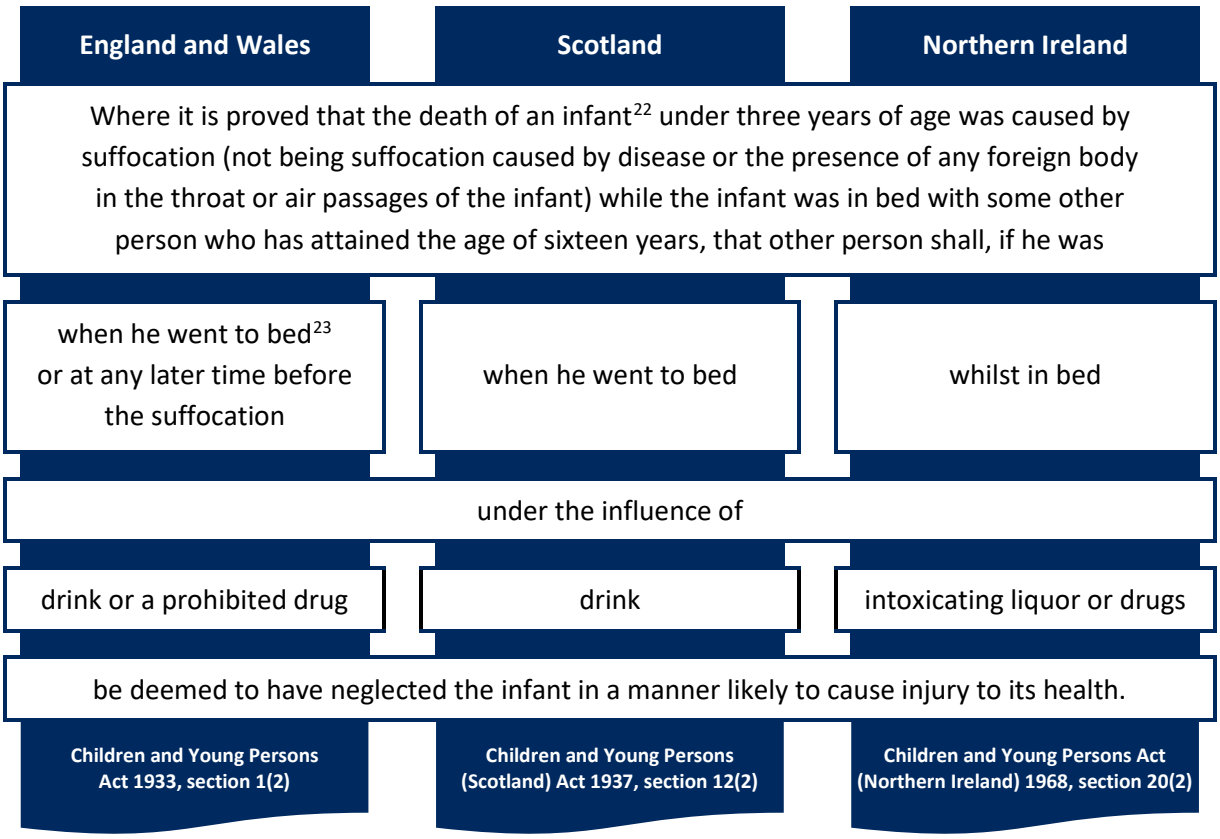
An ophthalmologist or consultant paediatrician may provide an opinion on whether retinal haemorrhages can be detected. Examination of the optic fundi (inside on the back surface of the eye) is seldom possible if the child has been dead for more than three to five hours, because the cornea becomes opaque. Where expert medical evidence is required for ophthalmological findings, advice should be sought from the local designated doctor for child death. The National Crime Agency (NCA) Forensic Medical Advice Team (see **12 Forensic Medical Advice Team**) can source relevant experts in consultation with the lead investigator if required.

7.8 Co-sleeping and overlay

Co-sleeping is discouraged by public health officials but is not a criminal offence. In England, Wales, Scotland and Northern Ireland there are similar criminal offences of neglect which apply where a child under three years has died from suffocation while co-sleeping with a person who has attained the age of sixteen years. These offences, often referred to as 'overlay', have slight variations across the UK as shown below.

The term 'overlay' can often be misleading. Partner agencies may use the term 'overlay' to refer to the accidental death of a child as the result of co-sleeping in the absence of drugs or alcohol. For clarity the term 'criminal overlay' should be used by police investigators to differentiate circumstances where a criminal offence is suspected, and the death is being investigated on that basis.

Cases of criminal overlay are difficult to prosecute without obtaining timely drug and alcohol samples which demonstrate that the adult was under the influence of drink or drugs at the time of death.



7.9 Drug/alcohol samples from parents

It is important to ascertain if the person(s) with care of the child at the time they died was intoxicated through drugs and/or alcohol. As well as being an element of criminal offences, more generally it may have impaired their ability to recognise that the child was in distress, provide first aid, or seek medical assistance. The lead investigator should consider obtaining drug and alcohol samples as soon as possible from those persons who had care of the child at time of death. If there is a delay in obtaining these samples, the results might not accurately reflect the level of intoxication at the relevant time.

At the time of the lead investigators attendance the cause of a child's death is often unknown and could remain so until post-mortem examination results are available. In the hospital emergency department, the body of a child who has died of natural causes could present identically to a child who died because of suffocation or physical trauma, or other conditions without obvious external indications. When the lead investigator first sees the child's body it will likely be in a different place, position, and state of dress to when they died, which can make understanding the circumstances of the death more difficult. Often the only person(s) who will know the exact circumstances in which a child was found are those who had care of the child at that time. Although uncommon, that person or persons could be responsible for the death, or have been negligent to some degree, and in those

[22] Referred to as 'child' in the Children and Young Persons (Scotland) Act 1937.
[23] The reference in subsection (2)(b) to the infant being 'in bed' with another ('the adult') includes a reference to the infant lying next to the adult in or on any kind of furniture or surface being used by the adult for the purpose of sleeping (and the reference to the time when the adult "went to bed" is to be read accordingly).

circumstances, they would have a powerful motive to lie, mislead or minimise when providing their initial account. The seeking of samples could provide evidence of intoxication which could otherwise be lost, but which may prove invaluable once the postmortem results are known.

It is not mandatory to obtain samples on every occasion. The decision should be based on the circumstances of the case, such as the proximity of the person(s) who had care of the child at the time of death. For example, in circumstances where a teenage child drowns in an accident while playing out with friends, when their parents were at work, there is unlikely to be a sound justification.

The lead investigator should also consider the requirements of other processes at a later stage, such as coronial proceedings and/or family court, where the results of drugs or alcohol tests could prove useful. Where there is any suspicion of alcohol and/or drug use by those persons who had care of the child at time of death or during the hours leading up to the death, it is recommended that samples should always be requested. The use of alcohol or drugs, and allegations about their use, will not however, always be apparent during the initial stages of an investigation. It is therefore recommended that samples are requested from person(s) who had care of the child at time of death unless there is a clear reason not to do so.

7.9.1 Legal powers relating to samples

In England, Wales and Northern Ireland there is no legal power to compel a parent to provide a sample of blood or urine without their consent. If a person is under arrest a sample of blood and/or urine (an 'intimate sample') may be taken from a person if a police officer of at least the rank of inspector authorises it to be taken, and the person gives their consent in writing[24]. The police officer can only give authority if they have reasonable grounds—

a) for suspecting the involvement of the person from whom the sample is to be taken in a recordable offence; and
b) for believing that the sample will tend to confirm or disprove their involvement.

Where the appropriate consent to the taking of an intimate sample from a person is refused without good cause, in any court proceedings against that person for an offence, the court or jury may draw such inferences from the refusal as appear proper.

In Scotland there is no power for the police to take blood or urine samples from a suspect under arrest without a court warrant.

[24] In England and Wales the powers are provided by section 62 of the Police and Criminal Evidence Act 1984 and in Northern Ireland by article 62 of The Police and Criminal Evidence (Northern Ireland) Order 1989.

7.9.2 Requesting voluntary samples

When a person is not under arrest a request can still be made for them to voluntarily provide samples of blood and/or urine. Experience has shown that parents are more likely to agree to give a voluntary sample where it is explained:

- that the police have a duty to investigate the circumstances of the death;
- there are grounds for suspecting that the parent was under the influence of drugs or alcohol whilst caring for the child at the time of their death;
- what those grounds for suspicion are;
- that urine and blood samples will establish the amount of drugs and/or alcohol consumed;
- that the samples, while voluntary, may be later used in criminal or civil proceedings.

The request should be made with compassion and sensitivity. At this stage, unless there are grounds to suspect an offence the caution is not required. This suggested form of words provides a framework for an ethical request for voluntary samples.

> ***"I need to ask you if you are willing to provide blood or urine samples for use in the investigation into the death of [child's name].***
>
> ***You do not need to provide the samples and I have no legal power to compel you to do so.***
>
> ***These samples will help us to investigate the circumstances of (child's name) death.***
>
> ***I need to make you aware that there are certain circumstances where the presence of drugs or alcohol in your samples may render you liable for prosecution of a criminal offence.***
>
> ***Do you provide consent for blood and/or urine samples to be taken?"***

The lead investigator should refer to local force policy and arrangements for taking samples. These samples are taken for investigative purposes and are distinct from those taken during clinical treatment or for pathology testing. As such, hospital doctors should not be asked to take them.

7.9.3 Refusal to provide voluntary samples

Where the request for voluntary samples, made to a person who is not under arrest, is refused, the lead investigator must carefully consider the next steps. It is important to recognise the distinction between a refusal to provide voluntary samples when not under arrest, with a refusal to provide an intimate sample when under arrest in England, Wales and Northern Ireland. No inference can be drawn from a refusal to provide voluntary samples when not under arrest. In the event of refusal, consideration should be given to whether there are reasonable grounds and necessity for arrest.

An arrest in these circumstances in pursuit of taking samples need not necessarily result in a lengthy period in custody. Where appropriate, consideration can be given to releasing the suspect after sampling (or refusal) and undertaking the suspect interview on a later occasion.

<table>
<tr><th>Suspicious circumstances</th><th>Non-suspicious circumstances</th></tr>
<tr><td>Arrest and make request in custody for blood and/or urine (intimate samples) under relevant provisions.</td><td rowspan="2">Samples taken on a voluntary basis only.

It is recommended that samples are sought in all SUDIC cases unless circumstances suggest there is no practical value (for example a teenager drowning while parents at work).

Samples may be of significance in other proceedings, for example coronial or family law proceedings.

Remember:
• Requests should be made ethically, with compassion and sensitivity.
• Use the form of words at 7.9.2.
• If the circumstances are deemed not suspicious the person is not a suspect and no caution is required.</td></tr>
<tr><td>Alternatively, to avoid arrest and custody if sole purpose is to exercise powers to obtain intimate samples, caution and seek to obtain samples outside of custody*.

In case of refusal, consider arrest.</td></tr>
</table>

* This option is dependent on the availability of local arrangements for taking of samples.

7.10 Initial accounts and interviews with parents

There may be sufficient information from the initial attending officers and medical staff to establish an accurate initial account. Otherwise, it may be prudent to obtain a brief initial account from the parents, prior to more detailed witness statements being obtained later.

Where two parents are present the lead investigator should use their discretion about whether these accounts should be taken separately or in the presence of both parties. In most cases, it is recommended that separate initial accounts should be taken because it:

- allows the person to speak candidly and in their own time;
- avoids potential confusion about who said or did what;
- prevents one partner from talking over or speaking for both of them;
- allows safe disclosure if one of the partners has potentially suffered domestic abuse.

It is recognised that separating parents may be difficult and likely to cause distress. It can be useful to explain that an individual's statement is usually taken without other witnesses present and that this is to ensure that the statement is a record of their own recollections and not those of someone else.

It is recommended that full statements are taken as soon as possible, and prior to the post-mortem examination. Everything possible should be done to minimise the distress caused to interviewees. It is, however, important to obtain a detailed history of the events leading to the child's death, including at least the last 48 hours of life. Again, this may change as the investigation develops. The statement should also cover the child's medical history.

7.11 Witness interview strategy

When planning witness interviews consider the guidance provided in the Ministry of Justice (2020) *Achieving Best Evidence in Criminal Proceedings: Guidance on Interviewing Victims and Witnesses, and Guidance on Using Special Measures*, and consider consulting a witness interview advisor.

Consider who to take statements from, including:

- parents, legal guardians or carers;
- the last person to have care of the child before death (if different from above);
- medical staff (including ambulance crews);
- police officers who attended the scene;
- any other person relevant to the life and/or death of the child.

Where possible it is important to plan each interview in consultation with the lead health professional and the social services representative, to avoid unnecessary duplication of questions to the witness.

Where there are no immediate grounds to treat the death as suspicious, consider conducting the interview of the parents with the lead health professional as joint interviewers. The person(s) who had direct care of the child prior to the death should be treated as significant witnesses.

Where there are suspicious circumstances, the lead health professional can be asked to assist the interview advisor and should be able to monitor interviews if appropriate.

See also:

Ministry of Justice (2022) *Achieving Best Evidence in Criminal Proceedings: Guidance on Interviewing Victims and Witnesses, and Guidance on Using Special Measures*
https://www.gov.uk/government/publications/achieving-best-evidence-in-criminal-proceedings

College of Policing Authorised Professional Practice – Investigative Interviewing
https://www.college.police.uk/app/investigation/investigative-interviewing/investigative-interviewing

7.12 Joint home visits

When a child dies unexpectedly in a non-hospital setting and the death is not obviously suspicious, the visit to the scene of death and subsequent examination should be conducted jointly by the police and lead health professional. This could be a nurse or health visitor, but in many areas, it will be the consultant paediatrician or consultant community paediatrician. The lead investigator should coordinate the visit in consultation with all parties and the CSM/CSC.

The purpose of a joint home visit is to identify all possible factors (from both a police and health care perspective) that may help to identify why a child has died. Where a joint visit is not agreed, the reasons should be recorded as a policy decision by the police lead investigator.

This visit may be undertaken with the parents. If present, they can explain what happened and describe exactly where everything and everyone was. This may give a much clearer account than if given elsewhere. If there is a reasonable suspicion of criminal offences, an appropriate forensic strategy should be implemented by the lead investigator before the visit. This may include the use of appropriate powers to secure the premises. For further information on home visits see the *Kennedy guidelines*. If there is suspicion of criminal offences at the time of the visit the lead investigator must also consider whether it is appropriate for the parents to be present, and if they are to be present, that any questioning of the parents complies with the *Police and Criminal Evidence Act 1984*.

The scene should be preserved until the visit. The visit should take place as soon as practically possible. The *Kennedy guidelines* recommend that where there is likely to be a delay in arranging the joint visit, the police lead investigator should consider whether the police should carry out an initial visit to review the environment, ascertain whether there are any forensic requirements and appropriately record what is found. Prior to the visit it should be explained to the parents that:

- their home will be discreetly secured to allow for the visit and various checks to be made; and
- it may be necessary to remove items to help the investigative process and establish the circumstances of their child's death.

7.13 Seizing items from the home

The roles, responsibilities and deployment criteria for forensic examination specialists differs between forces and lead investigators should familiarise themselves with local force policies and procedures. Where deployed, the CSI/CSM attending the home address and/or scene of death can advise on what items should typically be seized from the scene.

The Personal Child Health Record (commonly known as the 'red book') should always be seized. Investigators should take advice from the CSI/CSM and lead health professional to avoid seizing items which may have no investigative value and may cause unnecessary distress to the family.

It is recommended that the scene be photographed before any items are removed as this may help prove or disprove a parent's account of events. Scene photography should be undertaken in line with local force policy. A record should be made of any items removed, and the parents should be notified of this list as soon as possible.

In cases involving stillbirths, or a death immediately after birth, search objectives should include the presence of drugs that can terminate pregnancy such as misoprostol and mifepristone (see **10.4 Termination of pregnancy**). Evidence that the drugs are present or have been used should be brought to the attention of the lead investigator immediately.

Sensitive discussions with the family should establish which items they wish to have returned at the conclusion of the investigation. When returning items consider how and by whom the items will be returned. Police evidence bags, packaging and labels which may identify the items as 'crime scene' or 'police exhibits' should be removed prior to return. The lead health professional, social worker or police officer allocated to the family may help with the return of property.

7.14 House-to-house enquiries

The need for house-to-house enquiries should be considered on a case-by-case basis. Where the decision is made to conduct house-to-house enquiries, investigators should be briefed about what can be disclosed and questions to ask. The potential distress to the family should be considered and minimised where possible.

7.15 Joint agency response meeting

A child death will trigger a team of professionals from several agencies to come together, coordinated by the lead health professional. The first meeting should be held within 24 hours but may be extended up to 72 hours depending upon the circumstances and findings of the initial investigation. The joint agency response meeting should be an open and comprehensive information sharing process (see **7.16 Information sharing (medical records and other sensitive data)**). The joint agency response meeting should review the circumstances known at the time to establish key issues and agree a joint investigative strategy.

Attendees may include the designated consultant paediatrician, the lead investigator (or their nominee), social worker, family general practitioner (GP), midwife, health visitor, school nurse, and any relevant others. Where information is shared between agencies, agreement should be reached about what can and cannot be disclosed to any other person. The lead investigator should ensure that any police information shared is relevant to the investigation of the child death as once the information is shared beyond the control of the police, there is risk of onward inadvertent/inappropriate disclosure by partners.

If child protection concerns are identified the relevant multi-agency response is required. This should involve a formal strategy discussion under the local authority's duty to investigate in England and Wales, and Northern Ireland[25]. In Scotland an Inter-agency Referral Discussion would be required[26].

The designated paediatric consultant and/or lead health professional is responsible for reviewing all medical records relating to the deceased child and any relevant family members. This will provide a complete medical history of the child's health for the pathologist prior to carrying out the post-mortem examination. Any information that could assist the police investigation should also be disclosed to the lead investigator.

The medical records to be reviewed will include those held by:

- the local hospital emergency department, hospital paediatrician and/ or consultant;
- community nurses (including health visitors, school nurses and children's community nurses);
- family general practitioner.

7.16 Information sharing (medical records and other sensitive data)

Following the death of a child understanding the information held by agencies including health, education and social services is vital. Information sharing is the bedrock of effective child safeguarding practice and the *Data Protection Act 2018* (DPA) and the UK General Data Protection Regulation (GDPR) provides a framework which enables information sharing when it is necessary, proportionate and justified to do so.

The publications HM Government (2023) *Working Together to Safeguard Children* and the Department for Education (2024) *Information Sharing Advice for practitioners providing safeguarding services for children, young people, parents and carers* documents provide comprehensive guidance on intra-agency sharing of personal data. The College of Policing Authorised Professional Practice on Information Management provides police specific advice. Those organisations and agencies with safeguarding responsibilities will have a range of existing local information sharing agreements and arrangements in place.

Lead investigators should familiarise themselves with local information sharing arrangements and wherever possible use them as the basis for obtaining access to required records. In England, Wales and Northern Ireland a senior coroner has powers under the *Coroners and Justice Act 2009* to compel the production of documents in a death investigation. However, every effort should be made to obtain documentation through effective partnership working rather than formal powers.

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[25] In England and Wales, the Children Act 1989, section 47 applies, and in Northern Ireland The Children (Northern Ireland) Order 1995, article 66.
[26] In Scotland the Children's Hearings (Scotland) Act 2011 and the National Guidance for Child Protection in Scotland apply.

Seeking consent from a parent for access to records about a child should only be used in exceptional circumstances and only where an alternative legal basis for access cannot be identified. Using consent would mean an individual has agreed for the information to be shared and that they have a clear choice about its future use. If the individual later withdrew their consent the information would need to be destroyed. Lead investigators will need to use the personal data they obtain to fulfil their professional and statutory duties. They will need to do this irrespective of the future wishes of the parent which makes obtaining the data via consent an inappropriate approach. It is good practice for lead investigators to be upfront, transparent, and honest with parents about records they seek to obtain, whenever it is safe to do so, but this does not equate to obtaining consent.

See also:

HM Government (2023) *Working Together to Safeguard Children*
https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

Department for Education (2024) *Information Sharing Advice for practitioners providing safeguarding services for children, young people, parents and carers*
https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice

College of Policing Authorised Professional Practice – Information Management
https://www.college.police.uk/app/information-management/information-sharing

7.17 Body examination

Following the sudden unexplained death of a child taken to a hospital emergency department, but prior to the body being moved to the mortuary, a consultant paediatrician should undertake a physical examination of the child's body as per Appendix 4 of the *Kennedy Guidelines*. The lead investigator should be present for the examination. The examination should document observations including:

- presence of frothy fluid around the nose and mouth;
- presence of blood or vomit on the body or clothing;
- state of general nutrition and whether there are any signs of dehydration;
- weight, length, head circumference and rectal temperature;
- dysmorphic features (abnormal difference in body structure), skin creases and birthmarks;
- presence or otherwise of rigor mortis and lividity (red-purple colouring of the skin);
- external marks or injuries such as bruises, petechiae, abrasions (scratches/grazes), lacerations, bite marks, incisions, burns, ligature marks or patterned injuries;
- marks/injuries caused by medical intervention (tubes, intravenous lines, cannulae or similar should be left in situ);
- examination of the external genitalia and anus;
- fundal examination (back of eyes) for presence of retinal haemorrhages.

The consultant paediatrician will also seek to collect a series of samples as set out in the *Kennedy guidelines* (table 1, page 37 of that document). These are commonly referred to as the 'Kennedy samples'. These samples should be taken only after discussion between the lead investigator and lead health professional. If after the examination of the body the death is considered suspicious the lead investigator should discuss with the CSI/CSM before any further examination of the body or sampling is undertaken. Where samples are to be taken these will include:

- blood and urine samples;
- cerebrospinal fluid (fluid surrounding the brain and spinal cord);
- nasopharyngeal aspirate (sample from upper part of the throat behind the nose);
- swabs from identifiable lesions.

In some cases, these additional samples will be considered by the consultant paediatrician:

- skin biopsy for fibroblast culture in all cases of suspected metabolic disease;
- muscle biopsy if history is suggestive of mitochondrial disorder;
- blood sample for carboxyhaemoglobin, in suspected carbon monoxide poisoning.

To obtain optimum benefit from samples, they should be obtained as soon as practicable after time of death and should be considered when arranging timings for the CSI/CSM examination and debrief of the consultant paediatrician.

Note: the Kennedy samples are not obtained under police powers such as the *Police and Criminal Evidence Act 1984*. The samples are taken to facilitate pathological examination to assist with medical understanding of the cause of death. They must be retained by hospital staff and not handed to police.

7.18 Skeletal surveys

Under the *Kennedy guidelines*, a full skeletal survey should be carried out for all children under the age of 24 months (using radiological or other appropriate imaging). For children over 24 months, the need for such imaging should be discussed with the lead health professional.

The skeletal survey should be undertaken as early as possible, as the findings may indicate trauma which was not found during a physical examination. The survey can be undertaken at the local hospital prior to transfer for post-mortem examination.

Certain bony injuries or patterns of bony injury are particularly characteristic of non-accidental injury. X-ray images should be examined by a consultant radiologist, ideally experienced in paediatric practice. Where such a consultant is not immediately available and cannot be called out at short notice, and where a further opinion is required, the lead health professional may contact a paediatric radiologist

from another region and their opinion be sought remotely. The outcome of x-ray image examination should be notified to the lead investigator and pathologist as soon as possible.

A whole-body CT scan may also be undertaken at this stage. This may identify fractures not apparent on traditional radiological x-rays. The paediatrician will make this decision, but it should always be considered where there is any suspicion of non-accidental injury. Where there is a specific requirement for an MRI or CT scan, this should be discussed with the peri-natal or paediatric pathologist and/or the Home Office registered forensic pathologist (HORFP).

The skeletal survey may increase degrees of concern, and a written report should be made available for the post-mortem examination. For reference purposes, a skeletal survey should include the:

- front and side of the head, and front of the chest, abdomen and pelvis;
- spine and front and coned lateral views of all four limbs;
- coned views of any suspicious areas.

Where expert evidence is required for the interpretation of skeletal surveys, an expert can be sourced via local force arrangements or the NCA Forensic Medical Advice Team (see **11 Medical experts**).

Where the death is being treated as suspicious or is likely to be treated as suspicious, the body should always be accompanied by a police officer or coroner's officer as it is moved around the hospital.

See also:

Home Office (2024) *Police Practice Advice: The Medical Investigation of Suspected Homicide*
https://www.gov.uk/government/publications/sudden-unexpected-death-medical-investigation

7.19 Handling the child

Before the body is examined, sensitive efforts should be made to minimise the handling of the child, but unless there are overtly suspicious circumstances to the child's death, the parents should be treated sensitively, and allowed to express their grief by, for example, holding their child.

The body will have been handled by several parties following death (for example during medical interventions). It is therefore unlikely that forensic evidence will be lost through further holding or gentle handling of the child. However, washing, wiping or cleaning areas of the body may remove forensic evidence (for example, around the mouth). Parents should be tactfully monitored, and where necessary advised not to interfere with the child's body in this way. If this is unavoidable or has already occurred details of the activity should be recorded. See **6.4 First attending officer** and **6.6 First officer attending the hospital**.

After the body has been taken to the mortuary the parents may wish to revisit their child before the post-mortem examination. Where a lead investigator receives such a request, and a forensic paediatric postmortem has been agreed, the matter should be discussed between the lead investigator and the CSM/CSC, who may need to consult the Home Office registered forensic pathologist (HORFP) and/or perinatal/paediatric pathologist (see **9 Post-mortem examinations**). These requests can usually be accommodated under appropriately supervised conditions.

Requests to re-dress the child, remove items of clothing or wash the body should be brought to the attention of the lead investigator and/or CSM/CSC. Any clothing removed should be retained.

Mementos, for example handprints, footprints, a lock of hair and photographs, are important to many parents. The *Kennedy guidelines* recommend that mementos should be offered to the family by health staff in the hospital emergency department, but local arrangements may differ. Where the death is being treated as suspicious it may be appropriate to delay this until after the post-mortem examination where the collection of mementos could interfere with forensic examinations.

7.20 Hospital escalation procedures

Where medical practitioners do not support an investigation, it should be referred to the lead health professional. If the lead health professional cannot resolve the matter, the lead investigator should discuss the potential for resolution with the designated consultant paediatrician for child death.

7.21 Passive data, digital devices and social media

When the death is initially reported to the emergency services via 999 or any other numbers, recordings of any calls made should be reviewed as part of the initial investigation.

In cases of suspected suicide in older children the lead investigator should consider the examination of digital devices to which the child had access prior to their death. These devices may reveal communications data or online activity (including access to social media) that could assist in understanding why the child died. An examination of these devices can also assist in determining whether there was an interaction with third parties which may have adversely influenced the child.

See also:

College of Policing Authorised Professional Practice – Passive Data Generators
https://www.college.police.uk/app/investigation/investigative-strategies/passive-data-generators

College of Policing Authorised Professional Practice – Forensics (Digital)
https://www.college.police.uk/app/investigation/forensics#digital-forensics

8 Welfare of officers and staff

The death of a child is a devastating event for the parents, family and all who know them. Child deaths can also be traumatic and stressful for those professionals involved in the multi-agency response.

The lead investigator should consider devising and implementing a welfare strategy to support officers and staff involved in the initial response and ongoing investigation into the death of a child. Advice can be obtained from the relevant force occupational health and welfare services. As a minimum all officers and staff involved in the response should be debriefed within a reasonable period to enquire about their welfare following the incident. Where available lead investigators should consider referral to local resources such as Trauma Risk Management (TRiM) practitioners.

Oscar Kilo, the National Police Wellbeing Service (NPWS), have a wealth of resources to provide support and guidance for all police forces to improve and build upon wellbeing within their organisation. Oscar Kilo services have been developed for policing, by policing and are designed to meet the unique needs of officers and staff. Lead investigators should encourage their teams to access the Oscar Kilo Wellbeing Toolkit, and the Wellbeing of Investigators Toolkit.

The College of Policing have produced a practical guide to responding to trauma in policing which can help police officers and staff ensure that they are adequately protected and supported in maintaining their physical, psychological and social wellbeing.

The College of Policing have produced guidance to help forces to assess and manage policing activities with a higher level of exposure to psychological hazards, which includes officers and staff regularly deployed to sudden and unexpected deaths of children. It is the duty of each force to assess the psychological hazards affecting officers and staff and put in place reasonable controls, such as psychological screening, to mitigate and manage the psychological risk to their officers and staff.

See also:

College of Policing (2020) *Responding to trauma in policing: a practical guide*
https://www.oscarkilo.org.uk/news/responding-trauma-policing-2020

College of Policing (2017) *Psychological risk management: Introduction and guidance*
https://assets.college.police.uk/s3fs-public/2021-02/psychological-risk-management.pdf

NPCC (2021) *Major Crime Investigation Manual* – section 2.1.3 Welfare and wellbeing
https://library.college.police.uk/docs/NPCC/Major-Crime-Investigation-Manual-Nov-2021.pdf

Oscar Kilo: The National Police Wellbeing Service
https://www.oscarkilo.org.uk/

9 Post-mortem examinations

A post-mortem examination, also known as an autopsy, is the examination of a body after death by a pathologist. The aim of a post-mortem examination is to determine how the death came about by:

- establishing whether the death is attributable to a natural disease process;
- considering the possibility of accidental death (trauma, poisoning, scalding, drowning);
- considering the possibility of asphyxia/airway obstruction;
- considering the possibility of non-accidental (inflicted) injury;
- documenting the presence or absence of pathological processes.

See also:

Chief Coroner's Guidance No. 32 Post-mortem examinations
https://www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-no-32-post-mortem-examinations-including-second-post-mortem-examinations1/ (relevant to England and Wales only)

Home Office (2024) *Police Practice Advice: The Medical Investigation of Suspected Homicide*
https://www.gov.uk/government/publications/sudden-unexpected-death-medical-investigation

9.1 Pathologists

Child death investigations will involve a perinatal or paediatric pathologist who specialise in conducting post-mortem examinations on unborn and newborn babies, and children up to the age of 18 years. These specialists are vital because children are not small adults, many of the diseases they can suffer from differ from those in adults, and those differences can be subtle.

In the case of suspicious deaths or homicide, forensic pathologists conduct post-mortem examinations on behalf of the coroners and police forces in England, Wales and Northern Ireland, and in Scotland the Crown Office and Procurator Fiscal Service (COPFS). The Home Office Register of Forensic Pathologists accredits pathologists who have sufficient qualifications, training and experience to undertake suspicious death and homicide cases. The reports of Home Office registered forensic pathologists (HORFPs) on the register are critically reviewed, they have yearly appraisals and attend regular continued professional development training.

There are also numerous sub-specialty pathologists who specialise in examining specific organs such as brains (neuropathology), hearts (cardiac pathologist), eyes (ophthalmic pathology) and bones (osteoarticular pathology). Unlike forensic pathologists there is no equivalent register for perinatal, neonatal and paediatric pathologists, nor for the sub-specialty pathologists. The NCA Forensic Medical Advice Team (FMAT) work in collaboration with the Home Office Pathology Unit and maintain a list and process for the use of sub-specialty pathologists as well as perinatal, neonatal and paediatric pathologists (see **11 Medical experts**).

9.2 Types of post-mortem examination

There are three types of post-mortem examination that can follow the death of a child. The type of post-mortem examination will depend on the circumstances of the death.

9.2.1 Hospital post-mortem examination

This type of post-mortem is sometimes requested by parents or hospital doctors to provide more information about an illness or the cause of death, or to further medical research. Although in these circumstances the cause of death is already known a post-mortem examination can reveal further information. This can be very important for parents who may want to have another baby in the future.

Unless a coroner (or COPFS) has ordered a post-mortem examination (see below), a hospital post-mortem examination can only be carried out with consent or authorisation from the next of kin ('consent' is the legal term used in England, Wales and Northern Ireland and 'authorisation' is the legal term used in Scotland).

A hospital post-mortem examination may involve a complete examination of the child or may be limited to a particular area of the body, such as the head, chest or abdomen in the cases of a specific condition or abnormality. This type of post-mortem examination is never suitable following the sudden unexpected death of a child.

9.2.2 Coroner's (or COPFS) post-mortem examination

Where the cause of a child's death is not known, or is not clear to a doctor, the coroner (or COPFS) has responsibility to investigate. In these circumstances the coroner (or COPFS) can decide that a post-mortem examination is required to establish the cause of death. Where the death is not apparently suspicious a coroner's (or COPFS) post-mortem examination will usually be performed by a perinatal or paediatric pathologist.

Prior to the post-mortem examination, the pathologist should be in receipt of a comprehensive medical history and report on the circumstances of the child's death. Where appropriate the lead investigator should contribute to this understanding.

A paediatric pathologist will perform a post-mortem examination on children up to the age of 18 years where a medical condition is suspected to have partially or fully contributed to death. This is because children present with a different range of conditions from adults, and paediatric pathologists are experts in unique childhood diseases. However, in cases where the child is reaching adulthood, the paediatric pathologist will make a medical assessment as to whether they remain the most appropriate

pathologist to carry out the examination. For example, a 17-year-old male may present as an adult in physiological terms and therefore not suited for a paediatric post-mortem examination.

A perinatal or paediatric pathologist is not required to perform a post-mortem examination where the death was caused by physical trauma alone, for example, where the child or young person dies in a road traffic collision. These deaths will usually be referred to the main pathology unit. However, if the child may have suffered a fit or heart attack prior to death, for example, in a drowning scenario, then the perinatal/paediatric pathologist would be involved to establish what part the medical condition played in the death.

9.2.3 Forensic post-mortem examination

In cases that are potentially suspicious, suspicious, or clearly involve a homicide offence the post-mortem examination will likely require a perinatal or paediatric pathologist, and a Home Office Registered Forensic Pathologist. The post-mortem examination will be performed jointly. This type of examination is known in different places by different names, including 'Home Office', 'special' or 'double-doctor' post-mortem examinations. A forensic paediatric post-mortem examination would typically be held where:

- there are unexplained injuries;
- there are abnormalities on the skeletal survey;
- there was co-sleeping (whether drugs or alcohol are suspected or not);
- the child is subject to a child protection plan and there are concerns about violence or neglect;
- there are other unusual circumstances.

The coroner (or COPFS) is responsible for authorising which type of post-mortem examination will be performed and which pathologists will be involved. The decision may be made in consultation with the lead investigator, the perinatal/paediatric pathologist, and where applicable, the Home Office registered forensic pathologist (HORFP) and senior pathologist in the hospital pathology unit [27].

9.3 Police attendance at post-mortem examinations

The roles, responsibilities and deployment criteria for police officers and staff in attendance at post-mortem examinations differ between police forces and coronial jurisdictions. Lead investigators should familiarise themselves with local arrangements.

[27] Regulation 12 of The Coroners (Investigations) Regulations 2013 states that '*[w]here a coroner is informed by a chief officer of police that a homicide offence is suspected in connection with the death of the deceased, the coroner must consult that chief officer of police about who should make the post-mortem examination*'.

In many areas arrangements do not include the routine attendance of lead investigators at a coroner's post-mortem examination. In circumstances where the lead investigator identifies an investigative need to attend a coroner's post-mortem examination, outside of standard arrangements, the lead investigator should liaise with the coroner. The provisions of Regulation 13 of the Coroners (Investigations) Regulations 2013 allow for a chief officer of police to notify the coroner of their desire to be represented at an examination and for the coroner to notify them of the date, time, and place of the examination. Where such notifications are made the chief officer is then entitled to be represented at the post-mortem examination.

The lead investigator (or their deputy) should always attend a forensic post-mortem examination. Specialist forensic resources will also be required at a forensic post-mortem examination. Scene photographs should be made available for the forensic pathologist prior to the post-mortem examination being conducted. Photographs should be taken to document and record the post-mortem examination and any samples recovered recorded as necessary.

An enhanced toxicology analysis (not just a basic screen for common drugs of abuse) should be discussed with the pathologist and CSM/CSC. The pathologist should be advised of any drugs or medications recovered from the scene. Where the results of toxicology and/or other testing are sent directly to the lead investigator these should be forwarded to the pathologist(s) as soon as received.

Specialist imaging such as infrared/ultraviolet or alternative light sources techniques should be considered to record non-recent injuries or bruising.

9.4 Location of the post-mortem examination

Perinatal or paediatric pathologists are part of a small specialty with relatively few practitioners in the UK. The availability of both the pathologist(s) and appropriate facilities may result in a request for the child's body to be moved to another hospital for the post-mortem examination. In England and Wales this could involve the movement of the body out of a coroner's jurisdiction. Before the movement of a body for these purposes, the lead investigator should consult with the relevant coroner (or COPFS).

9.5 Recovery and retention of samples at the post-mortem examination

A coroner's post-mortem examination (as opposed to a forensic post-mortem examination) is undertaken for the purposes of ascertaining the cause of death or the identity of the deceased. The coroner's power to take and retain human tissue samples are therefore limited to those purposes and the coroner can only retain the samples for so long as they need to be retained to fulfil those purposes.

A forensic post-mortem examination is undertaken for two different purposes. The first seeks answers to the four statutory questions for the coroner (i.e. establishing the identity of the deceased, and how, when and where they died). The second seeks to determine if a crime has occurred, and if there is

forensic evidence that could assist the police investigation. The taking and retaining of human tissue samples for evidential purposes requires lawful authority. Exhibits from a forensic post-mortem examination should therefore be seized and retained under sections 19 and 22 of the *Police and Criminal Evidence Act 1984* to allow for the retention of evidence for so long as is necessary.

An exhibits officer will be required for a forensic post-mortem examination to record details of all exhibits retained, including human tissue samples. A written record of these items must be provided for the pathologists(s) and coroner. All forensic exhibits must be packaged and stored according to force standard operating procedures in compliance with relevant ISO quality standards. Advice on suitable packaging and storage should be sought from the CSM/CSC. The lead investigator, with the CSM/CSC, should take overall responsibility through exhibits reviews to ensure that all tissue samples are recorded, retained, tracked and disposed of appropriately.

The *Human Tissue Act (HTA) 2004* governs the removal, storage, use and disposal of human bodies, organs and tissue. The storage of human tissue removed during a post-mortem examination authorised by a coroner does not require the consent from the family of the deceased. However, the Coroners (Investigations) Regulations 2013 require that the coroner seeks the views of the family of the deceased about the disposal of tissue samples at the end of retention period. The options are for the tissue to be returned for burial or cremation; for the tissue to be disposed of in a lawful manner; or for the tissue to be retained for use for research or other purposes, with appropriate consent.

The person obtaining consent must have the knowledge and understanding to be able to explain to the parents the potential benefits and/or harms that might come from the retention or disposal of the relevant samples. This includes an understanding of the further investigation (including metabolic, histological, and genetic) that may be performed in the future on the samples. It is unlikely that a non-healthcare professional will have this knowledge and therefore it is recommended that the lead health professional explains and seeks consent from the parents at an appropriate time on behalf of the coroner (or COPFS). The relevant consent form should be completed and forwarded to the coroner (or COPFS) at the earliest opportunity.

10 Specialist investigative guidance

10.1 Head injury, non-accidental head injury or abusive head trauma

These terms are used to describe cause of death by a pathologist, a diagnosis by a paediatrician, or as an investigative line of inquiry by the police.

In general, identification of non-accidental head injury (NAHI) will depend on the presence of the 'triad of injuries' including encephalopathy (defined as any disease of the brain affecting the brain's function including hypoxia), subdural haemorrhages (bleeding in the subdural space of the brain), and retinal haemorrhages (bleeding within the retina of the eyes). The presence of these injuries together is a strong medical indicator for NAHI. The medical evidence should not be solely relied on and there should be further supportive evidence which may include, but is not limited to, inconsistent accounts, implausible explanations, other indicators of neglect or abuse, or evidence of violence by the parents (previous convictions and/or bad character).

NAHI is thought to be caused by acceleration/deceleration forces causing trauma to the brain and eyes, for example by shaking a child. It can sometimes involve impact with a surface, which may result in a related fracture and/or surface bruising. It can also involve bleeds and/or fractures in the neck which need to be considered as well as the main brain bleeds.

Cases which depend on the triad will inevitably involve complex evidence provided by expert witnesses (see **11 Medical Experts**). Pre-trial engagement with key experts to identify, and if possible, address any contentious issues in this area should be encouraged.

See also:

Crown Prosecution Service (2021) *Non-Accidental Head Injury Cases (NAHI, formerly referred to as Shaken Baby Syndrome [SBS]) – Prosecution Approach*
https://www.cps.gov.uk/legal-guidance/non-accidental-head-injury-cases-nahi-formerly-referred-shaken-baby-syndrome-sbs

10.2 Fabricated or induced illness

Fabricated or induced illness (FII) is a rare form of child abuse. FII was formerly known as *Munchausen syndrome by proxy* and occurs where a parent exaggerates or deliberately causes symptoms of illness in the child, or claims the child is ill when they are not. Examples of FII can include the administration of drugs or laxatives to simulate illness or behaviour which causes the child to collapse. This type of behaviour can, in extreme cases, result in the death of the child.

The fabrication of symptoms may present as food intolerance, protracted vomiting, and diarrhoea. Induced illnesses may include apnoea (where breathing stops temporarily), excess sodium (salt or

bicarbonate of soda) and physical abuse, for example, assault, or the rubbing of substances, such as, coffee, soil, excreta or boiling water into cuts.

The reasons for FII are not fully understood. There can be psychological explanations including mental ill health, personality disorders, or the result of previous trauma or abuse. The parent may also be seeking attention, support or closeness to the child. There have also been examples of financial motivation such as gaining access to disability benefits and entitlements for the child.

The child's GP medical records and any hospital records may help to identify if Fll is a feature of an investigation. Medical records could highlight warning sign such as:

- symptoms/patterns of illness that are acute, unusual, puzzling or physiologically inexplicable;
- the alleged perpetrator being the only witness to episodic symptoms;
- repeated hospitalisation and/or tests that have failed to reveal a conclusive diagnosis;
- the perpetrator welcoming painful or medically intrusive tests on the child;
- physiological findings that are consistent with induced illness.

See also:

NHS (2023) *Overview of Fabricated or Induced Illness*
https://www.nhs.uk/mental-health/conditions/fabricated-or-induced-illness/overview/

Royal College of Paediatrics and Child Health (2021) *Guidance on Perplexing Presentations (PP)/Fabricated or Induced Illness (FII) in Children*
https://childprotection.rcpch.ac.uk/resources/perplexing-presentations-and-fii/

10.3 Life-limiting cases

This includes cases where a child survives physical injuries but is left with long term physical limitations. In the most serious cases, these children may not live as long as would otherwise be expected, and the perpetrator for the initial assault could be charged with a homicide offence at a later date.

The documentation from the original investigation could be key in helping to support a conviction in the latter case if it goes to court. Continuity and storage of exhibits and interview recordings must be maintained, especially if, due to the extended timescales, the child's care arrangements change, for example, by adoption.

Early investigative advice from specialist prosecutors is vital (either the Crown Prosecution Service, Crown Office and Procurator Fiscal Service, or the Public Prosecution Service for Northern Ireland). During the initial investigation it is useful to obtain statements from specialist clinicians about the long-term prognosis and impact for the child.

These cases need to be flagged on crime recording systems and coded appropriately.

10.4 Termination of pregnancy

The termination of pregnancy (commonly referred to as abortion) is a highly emotive issue. The laws relating to abortion differ across the nations of the United Kingdom. The purpose of this section is to provide an overview of the law on abortion, how those laws have changed in recent years, and where this may be relevant to circumstances presented to child death lead investigators. It is not intended to be a comment on, or add to, the debate on the ethics of abortion or the law but reflects the relevant legislation in force at the time of publication.

10.4.1 National variations in abortion legislation

In England, Wales and Northern Ireland the *Offences Against the Person Act 1861* contained the offence of administering drugs or using instruments to procure abortion (section 58) and the offence of procuring drugs to cause abortion (section 59). The *Offences Against the Person Act 1861* has never extended to Scotland. In Northern Ireland the section 58-59 offences were repealed in 2019[28]. The offences remain in force as enacted in England and Wales.

The *Abortion Act 1967* applies to England, Wales and Scotland and in certain circumstances makes lawful actions that would otherwise constitute offences in England and Wales under sections 58 and 59 of the *Offences Against the Person Act 1861*. For this exemption to apply an abortion can only be performed where two registered medical practitioners are of the opinion, formed in good faith, that the pregnancy is in the first 24 weeks[29], and that continuing the pregnancy would involve greater risk to the physical or mental health of the pregnant woman than if the pregnancy was terminated. An abortion may also be carried out after 24 weeks to save the woman's life, prevent grave permanent injury to the physical or mental health of the woman, or where there exists a substantial risk that the child would be born with significant disabilities.

The *Abortion (Northern Ireland) (No. 2) Regulations 2020* introduced a new abortion framework for Northern Ireland. The regulations allow for early termination of pregnancy, without conditionality, where a registered medical professional is of the opinion, formed in good faith, that the pregnancy has not exceeded 12 weeks gestation (11 weeks + 6 days). The regulations also allow for termination of pregnancy up to 24 weeks (23 weeks + 6 days) where two registered medical professionals are of the opinion, formed in good faith, that continuing the pregnancy would involve greater risk to the physical or mental health of the pregnant woman than termination of the pregnancy. The regulations also allow for termination of pregnancy at any gestation in cases of severe foetal impairment, or a risk to the life of the pregnant woman, or a risk of grave permanent injury to her health.

[28] Northern Ireland (Executive Formation etc) Act 2019.
[29] The length of pregnancy is calculated from the first day of a woman's last menstrual period.

10.4.2 Types of abortion

There are two types of abortion: 'surgical' abortions and 'medical' abortions. Surgical abortions involve a surgical procedure at a hospital or clinic under either local or general anaesthetic. Medical abortions involve the pregnant woman taking medication which ends the pregnancy. Where the pregnancy is less than 10 weeks (9 weeks + 6 days) this is known as 'early medical abortion'.

An early medical abortion involves taking two different medicines, usually in tablet form, about 24-48 hours apart. The first medication is called mifepristone and it works by blocking a hormone called progesterone that is needed for a pregnancy to continue. The second medication is called misoprostol and it works by causing the uterus to contract and expel the pregnancy.

The process for early medical abortions has changed since the Covid-19 pandemic. The pre-pandemic arrangements involved a consultation with a medical professional at a hospital or clinic, and in some cases having an ultrasound scan to determine the length of the pregnancy. Where the pregnancy was less than 10 weeks (9 weeks + 6 days) an early medical abortion could be offered. The legislation required that the first medication be taken at a place approved for the purposes of treatment for the termination of pregnancy, usually a hospital or clinic. The second medication was provided for the woman to take at home 24-48 hours later, after which the woman would pass the pregnancy.

To ensure continuing access to early medical abortion during the pandemic, while reducing the risk of Covid-19 transmission, temporary arrangements were introduced in England, Wales and Scotland (not Northern Ireland). These allowed for the medical consultation to take place over the telephone or by video call, and for doctors to prescribe both medications to either be collected or sent by post to the pregnant woman to take at home, rather than at a hospital or clinic. In 2022 these arrangements were made permanent in England, Wales and Scotland[30].

10.4.3 The basis for investigation

Potential offences relating to the termination of pregnancy outside of the legally permitted circumstances are reported to police in a variety of circumstances. Lead investigators may be presented with reports of unattended stillbirths in the community about which concerns have been raised, a live birth following an attempted termination of pregnancy, or an unattended live birth where the baby survived only a short period. The need for an investigation in these circumstances arises from several sources.

In England, the HM Government (2018) *Child Death Review Statutory and Operational Guidance (England)* and HM Government (2023) *Working Together to Safeguard Children* documents state that

[30] House of Commons Library (2022) *Research Briefing: Early medical abortion at home during and after the pandemic*

a joint agency response is required in the case of a stillbirth where no healthcare professional was in attendance[31]. In Wales *PRUDiC* includes stillbirths where there are signs of life. In England and Wales where there is doubt about whether a child was born alive or stillborn, a coroner can either make preliminary inquiries to try to establish the position or can begin an investigation[32]. In Northern Ireland the coroner has jurisdiction in relation to a deceased unborn child that had been capable of being born alive[33]. It should also be noted that a lawful termination of pregnancy can still trigger a coroner's duty to investigate in circumstances where a termination of pregnancy causes a child to be born alive and then death is caused by prematurity, as the baby will have died an unnatural death. In Scotland sudden, unexpected and unexplained perinatal deaths must be reported to the Crown Office and Procurator Fiscal Service (COPFS) for investigation[34]. Police investigative support may be required in all of these circumstances.

There are also criminal offences relating to termination of pregnancy in certain circumstances. These offences differ across the nations of the UK (see **2 Relevant Offences**) and where it is suspected that offences have been committed a police investigation will be required.

10.4.4 Investigative considerations

The response to an unattended stillbirth, or a live birth where there is information giving rise to a suspicion of an attempted termination of pregnancy outside of the legally permitted circumstances, will require the highest levels of compassion and sensitivity from investigators. Whatever the cause, the delivery of a stillborn baby, or a live birth when termination of pregnancy was expected, will likely be extremely traumatic for the woman involved and those present at the time, and could result in long lasting emotional and psychological effects. The overriding priority in such circumstances is always the need for medical attention for the woman, and where born alive, the baby.

It is important for lead investigators to recognise that not only are stillbirths a rare occurrence (in 2022 the stillbirth rate in England and Wales was approximately 4 in 1000 births[35]), but that of those already relatively rare events the proportion of stillbirths resulting from a deliberate act to terminate a pregnancy outside of the law will likely be extremely small. Investigators will need to keep an open mind and give due consideration to each of the following areas.

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[31] However, the guidance does not apply in the event of a lawful termination of pregnancy, even if an infant is liveborn and subsequently dies, and therefore, although a referral to the coroner will be required in these circumstances, a joint agency response and child death review would not be required.
[32] *Chief Coroner's Guidance No. 45 – Stillbirth, and Live Birth Following Termination of Pregnancy*.
[33] Attorney General for Northern Ireland and Siobhan Desmond v The Senior Coroner for Northern Ireland [2013] NICA 68.
[34] Crown Office and Procurator Fiscal Service (2015) *Reporting deaths to the Procurator Fiscal*.
[35] Office for National Statistics (2023) *Births in England and Wales: 2022*.

Source of cause for concern

Lead investigators should carefully review the origins of the cause for concern. In some cases, concerns will have been raised by healthcare professionals. On other occasions concerns may be raised by relatives or friends of the woman involved. Lead investigators must be cognisant of the potential for reporting persons to have faced a significant moral dilemma over their decision to bring the matter to the attention of the authorities. There is the potential for the reporting person to have made a decision that has put them in conflict with the woman involved, relatives or friends, colleagues, or other professionals who may have disagreed with the decision to report to the police.

Clarity of purpose

Lead investigators should be clear that the purpose of an investigation in these circumstances is to pursue all reasonable lines of enquiry with a view to it being ascertained whether a person has committed an offence under legislation passed by Parliament. The decision whether to prosecute in such complex cases is an independent process undertaken by the relevant prosecution service[36]. The tests applied by the prosecution services consist of two parts: whether the evidence is sufficient to support a prosecution; and whether a prosecution is in the public interest. An effective investigation will be one that collects all available relevant information to inform both parts of these tests and therefore public interest can only be properly considered when the investigation is complete.

Knowledge and intention

When investigating potential offences relating to the termination of a pregnancy outside of the legally permitted circumstances, knowledge and intention are central to understanding whether an offence has been committed. Knowledge of the pregnancy by the woman, her understanding of the length of gestation, and her intentions regarding the pregnancy may be demonstrated through disclosures or admissions by the woman herself, witness accounts from those who observed signs of pregnancy or to whom disclosures were made by the woman, digital and communications data and documentary material and records.

Use of abortifacients

Abortifacients are substances that when consumed can induce abortion in pregnant woman. This includes medications such as mifepristone and misoprostol which are used for early medical abortions. Although these medications are only available on prescription in the UK after appropriate authorisation there are online vendors who offer to supply these medications and other substances for the purpose of inducing abortion.

Establishing that prescribed early medical abortion medications have been taken outside of the legally permitted time limits for abortion does not in itself prove an offence. The reasons for these

[36] In England and Wales this is the Crown Prosecution Service, in Scotland the Crown Office and Procurator Fiscal Service, and in Northern Ireland the Public Prosecution Service.

circumstances arising can be complex. There could have been a deliberate act to terminate or attempt to terminate a pregnancy outside of the law. Equally, a miscalculation of the length of pregnancy could be the result of human error or have a medical explanation. Information may have been provided to medical professionals by the woman in good faith who was unaware of the actual length of pregnancy, and this in turn could have resulted in the prescribing of early medical abortion medications in good faith. The 'good faith' legislative provisions were designed specifically for these circumstances to protect both the woman and the medical professional.

Medical records

Medical records may provide evidence of a woman having visited her general practitioner in relation to her pregnancy or having sought advice from other healthcare professionals. The records may prove knowledge on the part of the woman as to the length of her pregnancy. The medical records may also provide information which may allay concerns about the circumstances, for example a medical basis for an increased risk of the pregnancy resulting in miscarriage, stillbirth or premature birth.

Where it is suspected that there had been a deliberate termination of pregnancy, through the use of early medical abortion medications outside of the legally permitted time limits, records held by the abortion provider will likely be relevant. These records may contain information provided to them by the woman about her pregnancy, including about the length of pregnancy. The abortion provider records may contain evidence of false answers having been provided by the woman to deceive medical professionals. This may have resulted in the prescription of early medical abortion medicines by the medical professional, in good faith, having been misled about the actual length of the pregnancy.

Consent should be sought for access to appropriate medical records, although where the involved parties do not wish to cooperate with the investigation consent may not be granted. Medical professionals may be unwilling to disclose personal health information to a third party without consent and legal options to compel disclosure are limited. In these circumstances there are alternative opportunities to seek the information that would otherwise be unavailable.

The *Abortion Regulations 1991* require any practitioner who terminates a pregnancy in England or Wales to provide the Chief Medical Officer with certain details in an HSA4 form as set out in Schedule 2 of the regulations. This includes personal details about the woman, the gestation length, the grounds for the abortion and the method of termination. Regulation 5 of the *Abortion Regulations 1991* prohibits disclosure of this information by the Chief Medical Officer except in limited circumstances. Disclosure is permitted to a police officer not below the rank of superintendent for the purposes of investigating whether an offence has been committed under the law relating to abortion. *The Abortion (Northern Ireland) (No. 2) Regulations 2020* provide the same notification requirements and route to access records in Northern Ireland.

In Scotland the *Abortion (Scotland) Regulations 1991* previously included the same provisions however following the introduction of the *Abortion (Scotland) Amendment Regulations 2021* the requirement

to give notice of an abortion to the Chief Medical Officer no longer includes any identifiable patient information, only the name of the doctor who terminated the pregnancy. The *Abortion (Information) (Scotland) Directions 2022* require the Health Board who employs a medical practitioner who terminates a pregnancy to provide specified information to Public Health Scotland. This include personal details about the woman, the gestation length and method by which gestation had been estimated, the grounds for the abortion and the method of termination.

Evidence of a live birth

In cases where it is necessary to establish whether there has been a live birth, the existence of independent life or otherwise would usually be established by a pathologist, although in practice it is difficult to determine at post-mortem examination whether an infant died shortly before or after birth. Lead investigators should also consider whether there is other available evidence of a live birth. Signs of life can include breathing, crying, or sustained gasps; a heartbeat; a pulsing umbilical cord; or making definite movement of voluntary muscles[37]. Evidence of this could come from sources including witnesses and audio recordings of 999 calls (including the initial connection to the 999 operator).

Search strategy

A search of relevant premises should be considered where it is suspected that an abortifacient has been taken to terminate a pregnancy outside of the legally permitted circumstances. The search objectives will be dependent on the information forming the basis of the cause for concern but will likely need to include abortifacient(s), packaging, documentation and empty medication blister packs.

The drugs mifepristone and misoprostol are often provided in a combination pack under the brand name Medabon. Mifepristone is a drug intended only for the termination of pregnancy and is marketed under the name mifepristone and the brand name Mifegyne. Misoprostol has more than one medicinal use. Misoprostol is marketed under the brand name Topogyne for medical termination of pregnancy, the brand name Angusta for the induction of labour and the brand name Cytotec for the treatment of ulcers in the stomach and intestines. Misoprostol is also an ingredient in brand name medications Arthrotec and Misofen used to treat gastroduodenal ulceration. Where medications such as Cytotec, Arthrotec and Misofen are located during a search, lead investigators will need to establish if these have been prescribed to any other person who has access or control of the premises.

Abortifacient medications and other substances are sold online. Unfortunately, these international marketplaces are often unregulated and may supply products that could pose a significant risk to human health. These can include counterfeit, unapproved, or expired medications, or herbal remedies containing toxic quantities of naturally occurring abortifacient substances.

[37] *Chief Coroner's Guidance No. 45 – Stillbirth, and Live Birth Following Termination of Pregnancy*.

Where medications are located during a search, and it is unclear whether these may be relevant to an investigation, these can be researched using the Medicines & Healthcare products Regulatory Agency products (MHRA) database available at https://products.mhra.gov.uk/. Information on medicines manufactured and/or licenced in other countries are available through a variety of online databases.

Where any abortifacient medications or substances are recovered during a search it is vital that the lead investigator ensures medical professionals providing care to the woman (and in the case of a live birth, the baby) are informed as it may inform treatment. Where necessary the need for urgent toxicological examination of medications or substances recovered for the purposes of effective medical treatment must take precedence over the forensic or evidential value of the items.

Evidence of knowledge and intention in relation to the pregnancy may be demonstrated through digital evidence. The seizure and examination of digital devices used by the woman during her pregnancy should be considered. Internet search history, digital communications with third parties, and health apps such as menstrual cycle and fertility trackers may all provide information to help investigators establish a woman's knowledge and intention in relation to the pregnancy.

Many people are reliant on their digital devices to contact family and friends, and access other sources of information and support. Consideration must be given to the impact of seizing digital devices from a woman under investigation in these very difficult circumstances. Where it is necessary to seize digital devices lead investigators should consider providing the woman with a replacement device if the seizure of devices would inhibit access to family, friends or sources of support during the investigation, and there are no other means of communication available to the woman.

Vulnerability and potential third-party involvement

Lead investigators must recognise that those making the decision to end a pregnancy could be vulnerable and in need of support. The gathering of evidence in these sensitive cases must extend to fully understanding the backgrounds and lived experience of those involved. This should include whether the decision to seek the termination of the pregnancy outside of the legally permitted circumstances was impacted by:

- the woman having a physical, mental or learning disability, or suffering from mental ill-health.
- a lack of knowledge of the availability and access to abortion services, or previous negative previous experiences with healthcare or other public services.
- the woman being subjected to pressure either towards or away from abortion, either directly by other people, or more generally through societal, religious or cultural pressures.
- a woman's reliance on a partner or partner's family for financial support, isolation from people outside their immediate family or community, fears associated with insecurity or uncertainty of immigration status and language barriers.

- the nature and status of the relationship between the woman and the father, and any history of domestic violence, emotional abuse and/or controlling and coercive behaviour.

Needs of the woman

Where it is suspected that a woman sought the termination of her pregnancy outside of the legally permitted circumstances there will likely be a need to conduct a formal interview under caution. The medical needs of the woman must always take priority over investigative needs.

Lead investigators should carefully consider both the timing of any interviews, and whether arrest is necessary in order to carry out the interview. In compliance with Code G of the *Police and Criminal Evidence Act 1984* the lead investigator must take into account the situation of the victim, the nature of the offence, the circumstances of the suspect and the needs of the investigative process.

The potential emotional and psychological impact of an interview needs to be considered. The woman will need to be both medically fit and appropriately supported before any interview takes place. It is recommended that interviewers familiarise themselves with this guidance when planning and preparing interviews.

Specialist advice may be required both before and during the interview. Lead investigators should consider the use of specialist suspect interviewers and an interview advisor. In appropriate cases, an interview advisor may seek the assistance of a forensic clinical psychologist in devising an interview strategy. The NCA Major Crime Investigative Support (MCIS) team includes the National Interview Adviser and can advise on the use of forensic clinical psychologists and other specialist interview advisors. The MCIS can be contacted by email mcis@nca.gov.uk or telephone 0345 000 5463.

Irrespective of whether an interview takes place under arrest or as a voluntary attender an appropriate risk assessment should be undertaken following the interview. Particular attention should be paid to any identified concerns regarding physical and/or mental health. Lead investigators and interviewers must ensure that the interviewee is signposted to appropriate sources of support.

Sources of support who can help someone find appropriate care for free and in confidence:	
GP services, NHS 111 Online or local sexual health services	https://www.nhs.uk/nhs-services/
British Pregnancy Advisory Service	https://www.bpas.org/
MSI Reproductive Choices UK	https://www.msichoices.org.uk/
National Unplanned Pregnancy Advisory Service	https://www.nupas.co.uk/

11 Medical experts

Perinatal, paediatric and forensic pathologists will often require the assistance of a range of experts to provide additional specialist expertise before they can report post-mortem examination findings.

Which experts are required should be discussed with the pathologist(s) by the lead investigator, and where appropriate the coroner (or COPFS), and the relevant prosecution service. Consideration should be given to the value added by the expertise requested by the pathologists as there are relatively few experts in a number of niche fields, where capacity is limited, which can lead to delays in proceedings.

Depending on the circumstances of the death different medical experts may be required. To assist lead investigators to understand the differing roles played by medical experts the following descriptions are provided for experts regularly instructed in child death investigations.

Paediatric radiologist	Paediatric radiology is a sub-specialty involving the radiographic imaging of children using x-rays, CT (Computerised Tomography) scans, MRI (Magnetic Resonance Imaging) scans and ultrasound scans. In post-mortem analysis a paediatric radiologist can identify bone abnormalities and assist in assessing whether a child suffered a non-accidental injury.
Paediatric neuroradiologist	Paediatric neuroradiology is a sub-specialty that is involved in neuroimaging the central nervous system (brain, head, neck and spine) of children. In post-mortem analysis a paediatric neuroradiologist can assist in assessing whether a child suffered a non-accidental head injury, predominantly looking at brain/bones.
Paediatric ophthalmologist	Paediatric ophthalmology is a sub-specialty involving the study of disorders of the eyes in children. In post-mortem analysis paediatric ophthalmologists can assist in assessing whether a child suffered a non-accidental head injury, predominantly looking at the eyes.
Paediatric neuropathologist	Paediatric neuropathology is a sub-specialty involving the study of diseases in the central (brain and spinal cord) and peripheral nervous systems of children. In post-mortem analysis a paediatric neuropathologist can assist in assessing whether a child suffered a non-accidental head injury, predominantly looking at the brain.
Cardiovascular pathologist	Paediatric cardiovascular pathology is the study of diseases of the heart in children, including congenital heart defects.
Bone pathologist (osteoarticular)	In cases where a deceased child is found to have suffered bone fractures, a bone pathologist can assist with determining whether the injuries occurred around the time of the death or provide a timeframe in which the injuries occurred before death, and the potential causation.

In some cases, the lead investigator may need to better understand about the child in life as well as death. Specialist clinical expertise may assist the investigation team and inform the pathologists final

opinion. Some medical experts may be able to assist with aging injuries, the potential timings of the fatal incident and how the child would have behaved prior to death.

Paediatrician	A paediatrician diagnoses and treats health conditions that affect children. In a child death investigation, a paediatrician can review medical records and the findings of pathologists and assist with understanding whether a child has suffered physical abuse, neglect and/or sexual abuse. In cases where a child sustained non-fatal injuries before their death a paediatrician may be able to offer an opinion as to how the child would have presented and behaved prior to death.
Obstetrician	An obstetrician is a doctor who specialises in care during pregnancy and labour and may provide an expert opinion in cases where there are concerns about harm to a child during pregnancy, or concealed pregnancy.
Neonatologist	A neonatologist is a doctor who specialises in the care of new-born babies (both premature and full-term) and may provide an expert opinion in cases involving concealment of pregnancy or failure to provide adequate care to a new-born.

Different forces have varying arrangements for the sourcing and instruction of medical experts. Lead investigators should familiarise themselves with local force policies and procedures and seek advice from the relevant CSM/CSC in the first instance. Lead investigators can consult the Forensic Medical Advice Team (FMAT) within the National Crime Agency (see **12 Forensic Medical Advice Team**). The FMAT have a number of medical experts listed with them who can provide both advisory and expert opinions in a multitude of forensic medical disciplines. The FMAT can also support and advise on decision making with regards to the value of an expert opinion to an investigation before instructing any medical experts.

12 Forensic Medical Advice Team

The Forensic Medical Advice Team (FMAT) within the National Crime Agency can provide forensic medical investigative support and advice for live and non-recent cases free of charge to police forces across the UK[38].

FMAT is home to the Operation Marshall database (see **12.1 Operation Marshall**), and the National Injuries Database (NID). The NID is a unique resource that can assist with the identification of unknown injuries and provides case examples of known injuries and weapons for comparisons. FMAT can also provide good practice for all types of imaging of injuries (i.e. alternative light sources/CT scanning) as well as the technique of image overlay and court presentations of injury evidence.

FMAT is also the national central gateway to expert medical advice for UK policing with access to over 350 clinical and pathological experts. The FMAT perform basic due diligence checks prior to adding an expert to their records which are reviewed and updated annually. Operational feedback is captured about the experience of the expert working with the police and a robust negative feedback process is available if required.

FMAT can provide details of an experts' terms/fees, secure and preferred contact details, and General Medical Council status as well as information about whether the expert has undergone witness training and given evidence in court. FMAT can scope and facilitate the instruction of an expert on behalf of a force, including setting up terms of agreement, supporting the question setting exercise and advise on the key medical material required.

FMAT also hold a library of generic reports on subjects including smothering, neglect, criminal overlay, and the offence of causing or allowing the death of a child. These can support when requesting early investigative advice or a charging decision. In addition to the medical expertise available via the FMAT the Major Crime Investigative Support (MCIS) team within the National Crime Agency also maintain an Experts Advisers Database (EAD) which can be used to identify and source other forensic experts who can add value to investigations.

Different forces have varying arrangements for the sourcing and instruction of experts. Lead investigators should familiarise themselves with local force policies and procedures and seek advice from the relevant CSM/CSC in the first instance. To contact the NCA FMAT directly either email fmat@nca.gov.uk or telephone 0203 893 6660, or via the NCA MCIS team by email mcis@nca.gov.uk or telephone 0345 000 5463.

[38] Please note that costs associated with instruction of experts are the responsibility of the relevant force.

12.1 Operation Marshall

The Operation Marshall database is a national resource managed by FMAT that collates information on all intrafamilial child (under 18 years) homicide and suspicious death investigations from forces within the UK. The information held includes the cause of death, types of injuries sustained and any weapons used, suspect and victim details, risk factors involved, lessons learned, experts used during the investigation and at trial, and the outcome of the case at court.

The Operation Marshall database allows for strategic analysis to inform prevention and detection initiatives for intrafamilial child homicide or suspicious death investigations. The data is used to:

- Provide operational support for child death investigations.
- Source reference cases for the National Injuries Database.
- Source forensic experts for the Expert Advisers Database and medical experts for the FMAT.
- Identify patterns in child death investigations and inform national strategic assessments.
- Provide a dataset for research, including risk factors associated with child deaths.
- Identify learning and good practice to be shared in national guidance, training courses and continued professional development events.

Data is collected from cases including:

- murder or manslaughter, including arson, strangulation, suffocation, non-accidental head injury (NAHI), poisoning;
- suspicious cases of SUDIC;
- accidental death or misadventure;
- concealment of birth and/or neglect;
- fabricated or induced illness.

Data collection is in three parts at key stages in a child death investigation:

Form A	Brief case details including the location and circumstances surrounding the death to be submitted after the post-mortem examination when the cause of death (including preliminary) is known.
Form B	Requires further details about the victim, suspect and experts used, and should be completed during the investigation once the risk factors are known.
Form C	Requires the outcome, key learning points from the investigation and experts used during the trial. This is to be completed post-trial where criminal proceedings occur.

The completed forms should be submitted electronically to childdeathinfo@nca.police.uk.

12.2 Data searches

At the request of lead investigators, the Operation Marshall database can be keyword searched for similar cases. The results are compiled into an operational report detailing the circumstances of each case returned, cause of death, relevant risk factors, experts used, case outcome and contact details of the investigating officer. To contact the Operation Marshall team for advice, guidance or to request a search of the database email childdeathinfo@nca.police.uk.

12.3 National Child Mortality Database/Child Death Review Programme

The National Child Mortality Database (NCMD) is an NHS England funded programme which gathers information on all children who die in England, via the child death review process (see **13 Child Death Review processes**).

The Child Death Review Programme (CDRP) in Wales is an NHS Wales/Public Health Wales funded programme, which collects information about all deaths of children in Wales or Welsh children who die elsewhere.

The aim of both the NCMD and the CDRP is to improve and save children's lives in the future by learning from child deaths. Where appropriate, the FMAT collaborates with the NCMD and the Child Death Review Programme (Wales) to share data about child death investigations.

See also:

National Crime Agency Major Crime Investigative Support
https://www.nationalcrimeagency.gov.uk/what-we-do/how-we-work/providing-specialist-capabilities-for-law-enforcement/major-crime-investigative-support

13 Child Death Review processes

The responsibilities to formally review child deaths vary across England, Scotland, Wales and Northern Ireland but all have the same objective: a multi-agency investigation that seeks to understand how and why the child died, and to identify learning with the intention of preventing future deaths. It is recommended that police lead investigators familiarise themselves with arrangements in their area.

13.1 Child Death Review process (England)

In England the relevant guidance is the HM Government (2018) *Child Death Review Statutory and Operational Guidance (England)*. The child death review process must be carried out for all children (under 18 years of age) who die, regardless of the cause of death. This includes the death of any live-born baby where a medical certificate cause of death has been issued. The guidance is clear that the review process is not required for stillbirths, late foetal loss, or terminations of pregnancy (of any gestation) carried out within the law. Where there is a live birth following a planned termination of pregnancy conducted within the law a review is not required.

Where the birth of a baby is not attended by a health professional, and the child is reported to have been stillborn, child death review partners may enquire into the circumstances to determine whether the baby was born alive. If it is established that the baby was born alive, a child death review is required. In these cases, investigators should carefully consider the reported circumstances, including gestation, and whether the pregnancy may have been concealed.

In England the child death review partners with statutory obligations are the local authority, and the NHS integrated care board (ICB). The responsibilities of child death review partners in England are set out in sections 16M-Q of the *Children Act 2004*[39] and include maintaining a Child Death Overview Panel (CDOP). The panel conduct case reviews into the deaths of all children normally resident in their area, to learn lessons and share any findings for the prevention of future deaths.

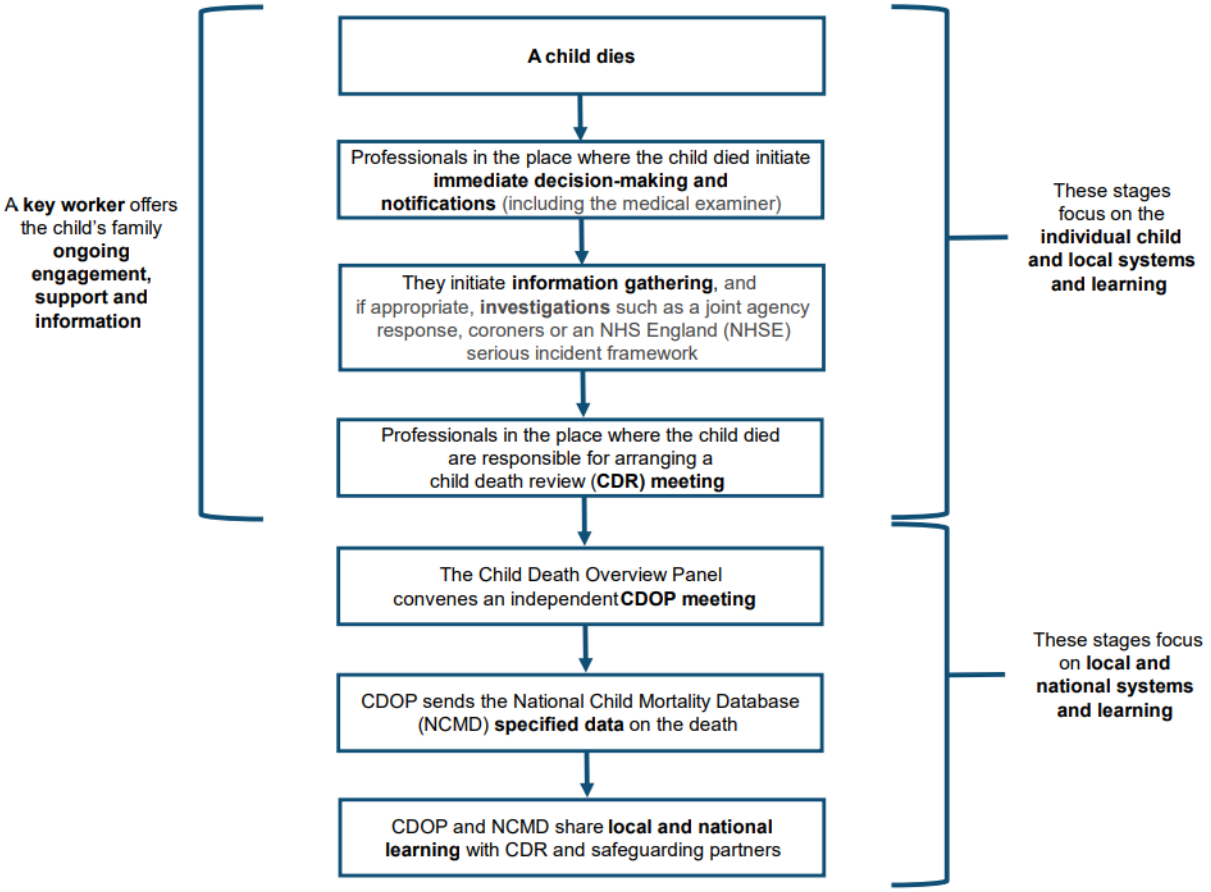
The child death review process is initiated by the notification of a death to the child death review partners. There are three standard forms: the Notification Form (previously 'Form A') for initial notification of a death to CDR partners; the Reporting Form (previously 'Form B') for gathering information from agencies or professionals; and the Analysis Form (previously 'Form C') used later to conclude the review process. In many areas the eCDOP case management tool is used to provide notifications through an online web portal.

Before the CDOP conducts their independent review there should be a Child Death Review Meeting where all matters relating to an individual child's death are discussed. This meeting should be attended

[39] Children Act 2004 sections 16M-Q (as inserted by sections 24-28 of the Children and Social Work Act 2017).

by professionals who were directly involved in the care of the child during his or her life, and any professionals involved in the investigation of the death (not limited to medical professionals). The outcome of this meeting will inform the CDOP review.

Overview of the child death review process in England[40]:



13.2 Sudden Unexpected Death in Infancy (SUDI) Review (Scotland)

In Scotland the relevant guidance is the Healthcare Improvement Scotland (2021) *National Guidance when a Child or Young Person Dies*. The National Hub for Reviewing and Learning from the Deaths of Children and Young People are responsible for ensuring that the death of every child in Scotland is subject to a quality review. This includes Scottish children and young people who die outside Scotland, and children and young people who die in Scotland that do not reside in Scotland. These reviews are conducted by NHS boards, local authorities and health and social care partnerships.

The criteria for completion of a review is the death of a live born child up to the date of their 18th birthday. This does not include babies born with signs of life of less than 22 weeks gestation, stillbirths, late foetal loss, or terminations of pregnancy (of any gestation) carried out within the law. In

[40] Reproduced from HM Government (2023) *Working Together to Safeguard Children*.

circumstances where the birth was not attended by a healthcare professional an organisation may carry out initial enquiries to determine whether the baby was born alive. Cases where there is a live birth after a planned termination of pregnancy carried out within the law are not subject to a child death review.

The purpose of the review is to learn and make improvements and the process should involve four stages: initial reporting and notification; assessment – determining the appropriate review process; review; improvement planning and monitoring. The *National Guidance when a Child or Young Person Dies* recognises that a range of review processes exist (including those with a statutory basis)[41].

After the sudden and unexpected deaths of an infant (aged up to 24 months) where the death cannot be explained a SUDI Review can take place once the post-mortem examination result is known, and the police and Crown Office and Procurator Fiscal (COFPS) investigations are completed. Healthcare Improvement Scotland will notify the relevant NHS board designated SUDI paediatrician when the Procurator Fiscal has authorised a SUDI Review to proceed.

The SUDI paediatrician will convene a multidisciplinary case discussion to look at all aspects of the death, including possible causes or contributing factors to see what lessons can be learned and to plan support for the family.

The SUDI Review is a multidisciplinary meeting which may include a paediatrician, pathologist, GP, health visitor, community midwife, social worker and any other professional relevant to that particular child. The purpose of the meeting is to discuss all aspects of the death, including possible causes or contributing factors to see what lessons can be learned and to plan support for the family, particularly in identifying support needs for any future pregnancies.

13.3 Procedural Response to Unexpected Deaths in Childhood (Wales)

In Wales the relevant guidance is the *Procedural Response to Unexpected Deaths in Childhood (PRUDiC)* which sets a minimum standard for a response to unexpected deaths in childhood. The procedural response will be followed when a decision has been made by the police that the death of a child is unexpected and the *PRUDiC* is to be initiated. The role of the police in the *PRUDiC* process is described in Chapter 13 of the *PRUDiC* document.

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. The *PRUDiC* does not apply to stillbirths (birth post 24 weeks gestation, where baby did not breathe or show signs of life); neonates where the birth was

[41] Healthcare Improvement Scotland (2021) *National Guidance when a Child or Young Person Dies* – Appendix 1.

in hospital and was attended by a professional, who had never been discharged into the community, and where the death was expected; and those with life-limiting conditions known to Palliative Care Teams where death was expected.

In some force areas in Wales, an Immediate Response Group (IRG) may be convened following child death(s) which have been identified as critical incidents. An IRG is a multi-agency forum to manage the consequences of critical incidents and to ensure those who are affected, including family, friends, professionals and the wider community, are effectively supported. An Immediate Response Group (IRG) would likely be convened in Wales for all suicides (suspected or apparent) of children and young people under the age of 18 years. The IRG does replace the PRUDiC meeting but may run immediately afterwards according to local arrangements.

The *PRUDiC* process is illustrated by a flowchart reproduced for reference at Appendix B. The *PRUDiC* timeline involves three phases:

- Information Sharing and Planning Meeting and post-mortem examination (within 0-5 days);
- Case Discussion Meeting (within 5-28 days);
- Case Review Meeting (CRM), when final post-mortem report available (within 12 months).

The Case Review Meeting (CRM) will involve a senior police officer, Health Board Head of Safeguarding, a Children's Social Care representative of appropriate seniority and other relevant professionals. The CRM will consider those factors that may have contributed to the death, any safeguarding or child protection concerns, the need for the Regional Safeguarding Children Board to consideration a Child Practice Review, and whether the family require ongoing professional support.

The outcome of the review will be sent to the Child Death Review Programme (CDRP) who collect information about all deaths of children in Wales or Welsh children who die elsewhere. The CDRP identify patterns and trends pertaining to child deaths and identify opportunities to prevent the same thing happening to another child or young person in the future.

13.4 Arrangements in Northern Ireland

The *Safeguarding Board Act (Northern Ireland) 2011* legislated for the establishment of a Child Death Overview Panel in Northern Ireland but the relevant provisions have not been enacted at this time.

See also:

HM Government (2018) *Child Death Review Statutory and Operational Guidance (England)*
https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

Children Act 2004
https://www.legislation.gov.uk/ukpga/2004/31/contents

Healthcare Improvement Scotland (2021) *National Guidance when a Child or Young Person Dies* https://www.healthcareimprovementscotland.scot/publications/national-guidance-when-a-child-or-young-person-dies/

NHS Wales (2023) *Procedural Response to Unexpected Deaths in Childhood (PRUDiC)* https://phw.nhs.wales/services-and-teams/national-safeguarding-service/safeguarding-latest-guidance/prudic-procedural-response-to-unexpected-death-in-childhood/

The Safeguarding Board Act (Northern Ireland) 2011 https://www.legislation.gov.uk/nia/2011/7/contents

14 Case reviews

Child protection comprises of complex multi-agency arrangements involving many different organisations. The statutory obligations on these organisations, the terminology they use and the guidance they are required to follow vary across England, Scotland, Wales and Northern Ireland. There is however a clear process in each nation for reviewing the death of children resulting from abuse or neglect. The aim of these reviews is to identify what needs to change at a local or national level, and to share that learning to improve practice to promote the welfare of other children.

14.1 Child Safeguarding Practice Reviews (England)

The relevant guidance for England is HM Government (2023) *Working Together to Safeguard Children* and the Child Safeguarding Practice Review Panel (2022) *Guidance for Safeguarding Partners*. These outline the legal requirement for a local authority in England to notify the Child Safeguarding Review Panel if it knows or suspects that a child has been abused or neglected, and the child dies[42]. Following such a notification the local safeguarding partners are required to undertake a rapid review. The local safeguarding partners are the relevant local authority, NHS Integrated Care Board (formerly known as Clinical Commissioning Groups), and the chief officer of police for the area.

After a rapid review it is for the local safeguarding partners to determine whether a Local Child Safeguarding Practice Review (LCSPR) is appropriate. A copy of the rapid review report should be sent to the Child Safeguarding Practice Review Panel by the local safeguarding partners along with their decision about carrying out a LCSPR. The purpose of a LCSPR it to identify improvements to local practice. As most sudden and unexpected deaths of children will have been appropriately reviewed by the Child Death Review process a LCSPR is only likely to be held if additional local learning is likely to be achieved by a further review. Where a LCSPR is held following a child death the police representation at a CSPR will be determined in line with local arrangements.

In some circumstances a LCSPR will coincide with criminal proceedings and the police investigation may hold material of value to those seeking to learn lessons from the death of the child. There is a general principle that requests for information gathered by the police will not result in disclosure until the conclusion of criminal proceedings. However, it is recognised that the overriding interest in safeguarding children means that lessons need to be learnt as soon as possible to protect children who may currently be at risk. The Crown Prosecution Service (CPS) have an agreed protocol that allows for discussion with the SIO and the local safeguarding partners to agree what material can safely be disclosed to meet the needs of a LCSPR, without hindering a criminal investigation[43].

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[42] Section 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017).
[43] Crown Prosecution Service (2020) *Protocol for Liaison and Information Exchange when criminal proceedings coincide with Child Safeguarding Practice Reviews in England*.

In cases which raise complex issues, or concerns of national importance the Child Safeguarding Practice Review Panel may conduct a National Child Safeguarding Practice Review.

14.2 Learning Review (Scotland)

The relevant guidance for Scotland is the Scottish Government (2021) *National Guidance for Child Protection in Scotland* and the Scottish Government (2021) *National Guidance for Child Protection Committees Undertaking Learning Reviews*. In Scotland a Child Protection Committee will undertake a Learning Review when a child has died, and there is additional learning to be gained from a review being held that may inform improvements in the protection of children and young people, and one or more of the following applies:

- abuse or neglect is known or suspected to be a factor in the child's death;
- the child or a sibling is on, or has been on, the child protection register;
- the death was suicide, alleged murder, culpable homicide, reckless conduct, or act of violence.

The guidance defines the purpose of the Learning Review as '*…an opportunity for in-depth analysis and critical reflection in order to gain greater understanding of inevitably complex situations and to develop strategies to support practice and improve systems across agencies*'. They are not considered to be investigations but are instead designed to promote improvements in child protection.

There will be occasions when a Learning Review will coincide with criminal proceedings. The Police Service of Scotland, the Crown Office and Procurator Fiscal Service (COFPS), and Child Protection Committees on Learning Reviews have agreed a national protocol which provides detailed guidance on managing Learning Reviews, criminal proceedings, and Fatal Accident Inquiries simultaneously[44].

14.3 Child Practice Review (Wales)

The relevant guidance for Wales is the Welsh Government (2016) *Working Together to Safeguard People Volume 2 – Child Practice Reviews*. The guidance outlines the legal requirement for Safeguarding Children Boards in Wales to conduct a Child Practice Review (CPR) where the abuse or neglect of a child is known or suspected, and the child has died[45].

There are two types of CPR in Wales. A concise review is undertaken where a child had died following abuse or neglect, but the child was not on the child protection register nor a looked after child on any date during the preceding 6 months. An extended review is required where the child was on the child

[44] See Annex 2 of the Nat*ional Guidance for Child Protection Committees Undertaking Learning Reviews* for details of the *National Protocol for the Police Service of Scotland, the Crown Office and Procurator Fiscal Service (COFPS), and Child Protection Committees on Learning Reviews*.
[45] Regulation 4 of The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015.

protection register and/or was a looked after child (including a person who has turned 18 but was a looked after child) on any date during the preceding 6 months.

The purpose of a CPR is to identify learning to improve future practice. The review will engage with the family of the child who died to listen to their perspectives and experiences. The review will also involve practitioners, managers, and senior officers of relevant agencies, and use a learning event to explore their work with a child and family. The outcome of a CPR will be an anonymised child practice review report which will be submitted to the Welsh Government and published.

As with LCSPRs in England and Learning Reviews in Scotland, in some circumstances a CPR in Wales will coincide with criminal proceedings. The Crown Prosecution Service (CPS) have an agreed protocol that allows for discussion with the SIO and the regional Safeguarding Children Boards to agree what material can safely be disclosed to meet the needs of a CPR, without hindering a criminal investigation.

14.4 Case Management Reviews (Northern Ireland)

The relevant guidance for Northern Ireland is the Safeguarding Board for Northern Ireland (2017) *Learning from Practice - Case Management Review Process Multi-Agency Guidance*. The guidance outlines the duty placed on the Safeguarding Board for Northern Ireland (SBNI) to carry out a Case Management Review (CMR) in specific circumstances[46]. The criteria for holding a CMR following the death of a child are as follows:

- abuse or neglect of the child is known or suspected; or
- the child or a sibling of the child is or has been placed on the child protection register; or
- the child or a sibling of the child is or has been a looked after child.

If any of the above apply, and the SBNI has concerns about the effectiveness in safeguarding and promoting the welfare of children, and the SBNI determines that there is significant learning to be gained that will lead to substantial improvements in practice, then a CMR must be held. The purpose of a Case Management Review is to strengthen the child protection system in Northern Ireland, with a primary focus not on finding fault but examining organisational systems and processes to ensure they meet the needs of children and their families and keep the vulnerable safe.

Where a criminal investigation coincides with the CMR early discussions should take place between the SBNI, the Police Service of Northern Ireland (PSNI) and the Public Prosecution Service (PPS) to ensure the CMR process neither inadvertently interferes with nor conflicts with those proceedings.

[46] Regulation 17 of The Safeguarding Board for Northern Ireland (Membership, Procedure, Functions and Committee) Regulations (Northern Ireland) 2012.

See also:

HM Government (2023) *Working Together to Safeguard Children*
https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

Child Safeguarding Practice Review Panel (2022) *Guidance for Safeguarding Partners*
https://www.gov.uk/government/organisations/child-safeguarding-practice-review-panel

Children Act 2004 (as amended by the Children and Social Work Act 2017)
https://www.legislation.gov.uk/ukpga/2004/31/contents

Crown Prosecution Service (2020) *Protocol for Liaison and Information Exchange when criminal proceedings coincide with Child Safeguarding Practice Reviews in England*
https://www.cps.gov.uk/publication/protocol-liaison-and-information-exchange-when-criminal-proceedings-coincide-child

Scottish Government (2021) *National Guidance for Child Protection in Scotland*
https://www.gov.scot/publications/national-guidance-child-protection-scotland-2021-updated-2023/

Scottish Government (2021) *Guidance for Child Protection Committees Undertaking Learning Reviews*
https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2024/06/national-guidance-child-protection-committees-undertaking-learning-reviews-2/documents/national-guidance-child-protection-committees-undertaking-learning-reviews/national-guidance-child-protection-committees-undertaking-learning-reviews/govscot%3Adocument/national-guidance-child-protection-committees-undertaking-learning-reviews.pdf

Welsh Government (2016) *Working Together to Safeguard People Volume 2 – Child Practice Reviews*
https://www.gov.wales/safeguarding-children-guidance-child-practice-reviews

The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015
https://www.legislation.gov.uk/wsi/2015/1466/contents/made

Safeguarding Board for Northern Ireland (2017) *Learning from Practice - Case Management Review Process Multi-Agency Guidance*
https://www.safeguardingni.org/about-us/committees-panels/case-management-review-panel

The Safeguarding Board for Northern Ireland (Membership, Procedure, Functions and Committee) Regulations (Northern Ireland) 2012
https://www.legislation.gov.uk/nisr/2012/324/contents/made

NPCC (2021) *Major Crime Investigation Manual* – section 3.4 Statutory Safeguarding Reviews
https://library.college.police.uk/docs/NPCC/Major-Crime-Investigation-Manual-Nov-2021.pdf

15 Parallel proceedings

While the police are investigating the death of a child there may be additional ongoing legal proceedings including those in the family court[47], civil court, and by regulatory/disciplinary bodies.

The protection of surviving siblings in a family where a child has died is paramount. Family court cases will not be deferred to allow a criminal case to conclude, and the family court may seek information held by the police during the ongoing investigation. A child whose death was subject of investigation under these guidelines may have been an only child at that time, but parents may go on to have more children years later. This can lead to the family court seeking information from the original investigation, sometimes several years later.

Following some child deaths there may be concerns about the actions taken by professionals involved with the child. This can result in regulatory/disciplinary bodies (such as the General Medical Council and similar) taking action in relation to an individual's professional registration. Where lead investigators receive requests for information during the course of an ongoing criminal investigation, they should seek advice from the relevant prosecution service (either the Crown Prosecution Service, Crown Office and Procurator Fiscal Service, or the Public Prosecution Service for Northern Ireland).

15.1 Expert witnesses in family court proceedings

Where a family court process occurs ahead of criminal proceedings the lead investigator should consider whether any expert witnesses used in the family court proceedings could be used in subsequent criminal proceedings if the expert witness is willing to do so. This can have a positive impact and may save time and avoid duplication of effort. Equally, where a criminal case precedes the family court proceedings, an expert report used in that process, can be provided to the family court where permission has been sought from the expert.

It is for the family court to determine whether expert witness reports and/or testimony provided in family court proceedings can be disclosed to the police, and it is likely that a report would require an addendum from the expert witness to meet the criminal standard. Where an expert witness has provided evidence in a family court process (either in a written report or witness testimony) the testing of that evidence in a court setting (albeit to the lower burden of proof than in criminal proceedings) may have identified areas of weakness which can inform the criminal investigation and subsequent reports.

[47] For ease of reading, the term 'family court' is used throughout to refer to all proceeding in England and Wales in the Family Court and the Family Division of the High Court, in Scotland to the sheriff courts and the Court of Session, and in Northern Ireland to the Family Proceedings Court, Family Care Centre and High Court.

15.2 Complying with duty to disclose to family court

The lead investigator may receive formal notification of proceedings in the family court and may be legally required to disclose information to the court. This could involve the revelation to the court of investigative material known only to the police investigation. Subsequent disclosure to interested parties to the proceedings can occur, including parents, even if they are suspects in criminal proceedings. The police and prosecution services are obliged to comply with court orders.

Lead investigators in England and Wales are advised to familiarise themselves with the *Disclosure of Information between Family and Criminal Agencies and Jurisdictions: 2024 Protocol*. The protocol, agreed between the judiciary, local authorities, police representatives, the National Police Chiefs' Council and the Crown Prosecution Service, provides guidance on the procedures to be followed for disclosure from the police to family proceedings, and where disclosure is sought by an investigator.

If police have information that it is believed could be of assistance to the family court, but disclosure would either impact the investigation or the use of police tactics, an application for public interest immunity (PII) can be made. In these cases, the court may still order disclosure. The lead investigator should expect to have to make full disclosure, particularly if the police have information that a child is at significantly more risk than is known to the local authority (regardless of potential PII issues).

In the very early stages of a police investigation, before the progression of family court proceedings relating to surviving siblings, the lead investigator should consider potential disclosure issues as part of the investigation and pre-interview briefing strategy. For example, were a parent a suspect in the death of a child, an interview advisor may stage the disclosure of information about the extent of injuries to the child to test the veracity of a suspect's account. It is extremely unlikely that any injury evidence could be successfully withheld from the suspect for an extended period as the information would be of value within the family court proceedings, to which the parent would be party. Under these circumstances, disclosure to the Family Court could not be avoided or delayed.

Lead investigators should consider seeking early advice from the relevant prosecution service and/or legal services team in relation to issues concerning the disclosure of information to local authorities and family courts.

15.3 Obtaining material from the family court

There is a presumption that family courts are closed courts, therefore the police will not automatically be able to access court material. If, however, there is a competing public interest the court may take this into consideration, for example, there is a public interest in bringing an offender who has harmed a child to justice, or preventing an innocent person being wrongly accused.

The timescales for obtaining material can have a significant impact on criminal investigations. The process for applying for family court records differs across the United Kingdom, but in all cases, the process of obtaining material from family court will be phased. This will usually involve an initial request for a case index and/or outcome, the identification of parts of the material relevant to the criminal investigation, and an application to the court for specific documents (blanket requests are not permissible). Lead investigators should familiarise themselves with local arrangements, seek advice from their legal services team where required, and apply for material as early as possible.

See also:

NPCC (2021) *Major Crime Investigation Manual* – section 1.7.6 Parallel proceedings
https://library.college.police.uk/docs/NPCC/Major-Crime-Investigation-Manual-Nov-2021.pdf

Disclosure of Information between Family and Criminal Agencies and Jurisdictions: 2024 Protocol
https://www.judiciary.uk/guidance-and-resources/launch-of-the-disclosure-of-information-between-family-and-criminal-agencies-and-jurisdictions-2024-protocol/

16 Family contact

Following a police investigation, COPFS investigation, or coroner's inquest the parents of the deceased child should be offered a meeting with the lead investigator and lead health professional to allow them to ask any remaining questions they may have.

This will provide an opportunity to explain the processes and procedures used by the police when investigating the child's death. Although these processes may have been explained during the course of the investigation, they may not have been fully understood at the time due to the trauma and overwhelming nature of the event.

The meeting will also allow for an explanation of the gradual withdrawal of the police point of contact officer as part of the planned exit strategy. It is recognised that the needs of bereaved parents will not end with the conclusion of the investigation. Parents will have already been provided with referrals to sources of support. Details of the following organisations are provided for reference.

The Lullaby Trust https://www.lullabytrust.org.uk Bereavement Support: 0808 802 6868 Information Line: 0808 802 6869	**Scottish Cot Death Trust** https://scottishcotdeathtrust.org/ Telephone: 0141 357 3946
2Wish https://www.2wish.org.uk Telephone: 01443 853125	**Sudden Unexplained Death in Childhood UK** https://sudc.org.uk Telephone: 07880 350942
Sands https://www.sands.org.uk/ Telephone: 0808 164 3332	**Samaritans** https://www.samaritans.org Telephone: 116 123
Child Death Helpline https://www.childdeathhelpline.org.uk Telephone: 0800 282 986	**Cruse Bereavement Care** www.cruse.org.uk Telephone: 0808 808 1677
The Compassionate Friends https://www.tcf.org.uk Telephone: 0345 123 2304	**Child Bereavement UK** https://www.childbereavementuk.org Telephone: 0800 02 888 40
Survivors of Bereavement by Suicide https://uksobs.org Telephone: 0300 111 5065	**Winston's Wish** https://www.winstonswish.org/ Telephone: 08088 020 021

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Scottish Government (2021) *National Guidance for Child Protection in Scotland*
https://www.gov.scot/publications/national-guidance-child-protection-scotland-2021-updated-2023/

Welsh Government (2016) *Working Together to Safeguard People Volume 2 – Child Practice Reviews*
https://www.gov.wales/safeguarding-children-guidance-child-practice-reviews

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https://www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-no-32-post-mortem-examinations-including-second-post-mortem-examinations1/ (relevant to England and Wales only)

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18 Appendix A: Eye examination in SUDIC Joint Statement

Reproduced from the *Eye examination in Sudden Unexpected Death in Children (SUDIC) Joint Statement* published by the Royal College of Paediatrics and Child Health, The Royal College of Pathologists and The Royal College of Ophthalmologists on 28th January 2022.

Eye examination in Sudden Unexpected Death in Children (SUDIC)

This statement from The Royal College of Paediatrics and Child Health, The Royal College of Pathologists and The Royal College of Ophthalmologists set out clarity on the examination of the eyes in the sudden unexpected death of a child.

We are recommending that this statement is an addendum to the 2016 Kennedy report until the next official review takes place.

The report, 'Sudden unexpected death in infancy and childhood: Multi-agency guidelines for care and investigation' (known as the Kennedy Report) in 2016 was developed by a working group convened by The Royal College of Pathologists and endorsed by The Royal College of Paediatrics and Child Health.

The report provides guidelines for all professions involved in the examination of the sudden unexpected death of a child and outlines best practices for each part of the investigation process. The original guidelines published in 2004 followed high profile cases of miscarriages of justice involving the prosecution of mothers for causing the deaths of their babies. These events raised serious concerns about the role of the expert witness in court, issues about standards of proof, the quality of evidence and the procedures adopted for the investigation of sudden unexpected deaths of infants.

We believe 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.

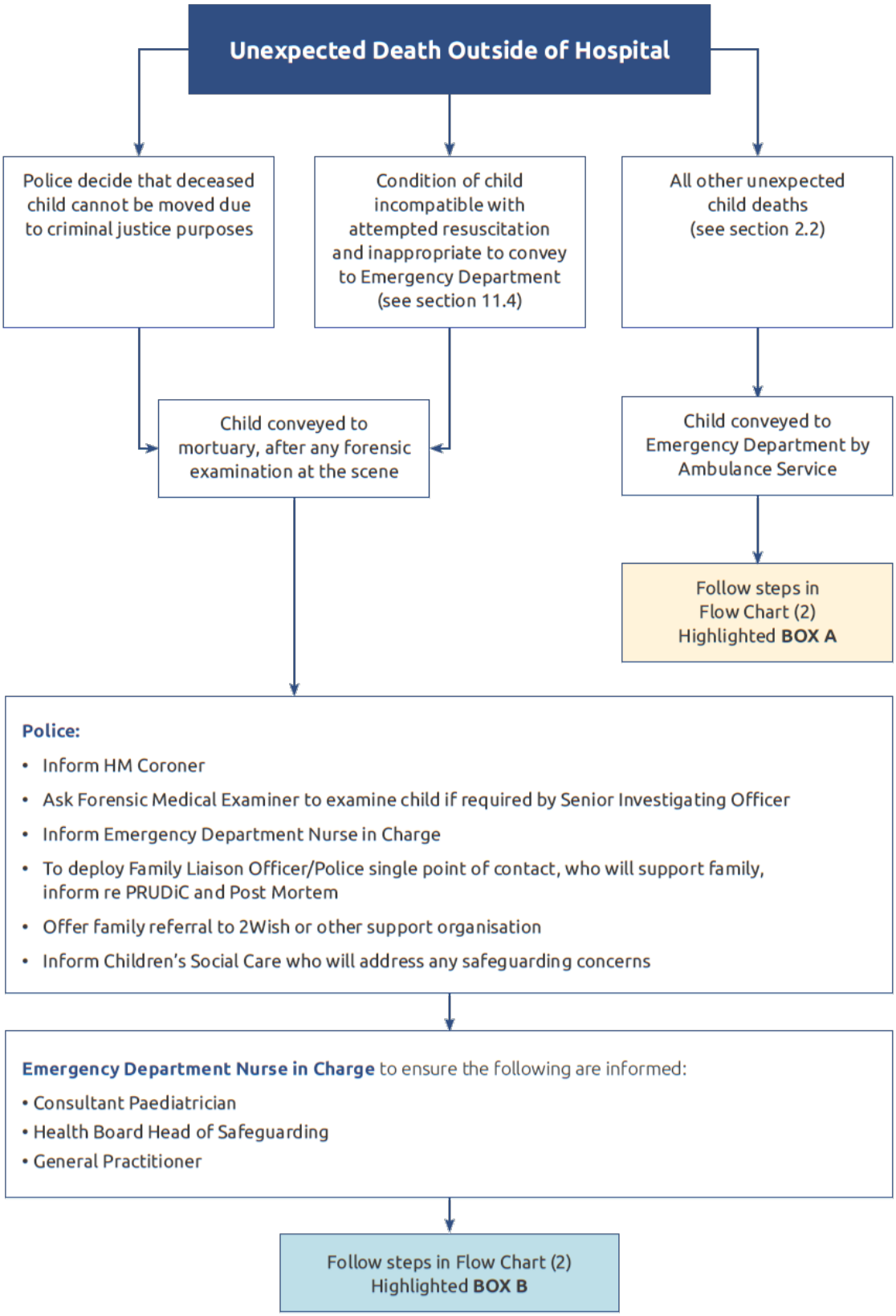
When practicable and where swift examination can occur, the senior clinician can contact an ophthalmologist, following locally agreed protocols.

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.

Retinal haemorrhages in living infants are generally accepted to be a possible indicator of abusive head trauma. Although there are a number of alternative aetiologies, retinal haemorrhages are such an important feature of child abuse, they require evaluation within the context of a thorough clinical assessment. In many cases, a clear view of the retina may not be possible due to corneal clouding following death.

Little has been published on ophthalmological examination in the early post mortem period. However, the presence of multiple retinal haemorrhages could imply that the infant has died of unnatural causes. 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.

19 Appendix B: *PRUDiC* Flowchart – Wales Only[48]



[48] Reproduced from NHS Wales (2023) *Procedural Response to Unexpected Deaths in Childhood (PRUDiC)*.

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