DUMFRIES AND GALLOWAY
PUBLIC PROTECTION COMMITTEE

Dumfries and Galloway Multi-Agency Response to Sudden Unexplained Child Death or Critical Childhood Illness Guidelines

Management Information	
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1. Background

1.1. Scotland has a higher mortality rate for under 18s than any other Western European country, with over 300 children and young people dying every year and around a quarter of those deaths could be prevented.

1.2. Every child who dies deserves to be treated with respect and care; to ensure a consistent high-quality approach to undertaking child death reviews in Scotland, national guidance was published by Health Improvement Scotland in 2021. This guidance established a system for reviewing and learning from the circumstances surrounding the deaths of all children and young people in Scotland. A National Hub was subsequently set up to co-ordinate all Child Death Review (CDR) activity across Scotland.

1.3. Dumfries and Galloway (D&G) drive forward a multi-disciplinary and multi-agency approach to CDRs, focused on using evidence to deliver change, and ultimately aim to reduce deaths and harm to children and young people. All agencies are committed to ensuring the death of every child and young person is reviewed to an agreed minimum standard.

1.4. Whilst agencies are able to establish their own structure and process for reviewing the deaths of children and young people, it's important that our multi-agency local process aligns to the national guidance, to enable good practice and lessons to be reflected and shared at a national level.

1.5. The purpose of this guideline is to ensure D&G have processes in place which outline and navigate all stages of the review process; from notification, to carrying out the review, to sharing the learning locally and nationally.

2. Principles, Purpose and Scope

2.1. All processes required for health staff in response to SUDI (Sudden Unexpected Death in Infancy) are detailed in the SUDI guidance and support documents – Healthcare Improvement Scotland.

2.2. The purpose of this document is to give clear guidance to all multi-agency staff in D&G who respond to sudden and un/expected critical childhood illness or deaths, ensuring compliance with legislation.

2.3. This guidance outlines the right for all child deaths in Scotland to be fully and sensitively investigated to identify, where possible, a cause of death and to learn lessons for the prevention of future infant/ child deaths. Thorough and sensitive investigations go hand in hand with a supportive approach to the family in their grief and can help to ensure that all statutory requirements are met, and that family members, the community and all professionals are supported through the process.

2.4. The principles in these guidelines broadly relate to all unexpected deaths in children from 22 weeks gestation (excluding stillbirths) onwards and up to age 18 and 26 where the young person was Care Experienced. This includes unexpected deaths in the early neonatal period, unexpected deaths for which a natural cause is not immediately apparent, and deaths from external causes, including accidents, suicides and possible homicides (recognising

that where a police criminal investigation is required, all other multi-agency processes must be consistent with any police investigation priorities).

2.5. The principles also recognise that the exact process followed may require modification according to the age of the child and specific circumstances. The review process and investigation should be as thorough as possible and support the compilation of a detailed and comprehensive history, a meticulous post-mortem examination with all appropriate ancillary tests, and careful discussion between the professional involved. Families recognise the need for police to be involved in some child deaths such as SUDI, and this clearly has to be carried out in an appropriate manner.

2.6. Some child deaths may result from previously unrecognised medical conditions or as a result of unintentional incidents. However, a significant proportion of sudden unexpected deaths in infancy remain unexplained. There is evidence from national and international epidemiological studies that a significant number of sudden unexpected deaths in infants are associated with adverse environmental conditions (such as co-sleeping with carers, passive smoking, and alcohol or substance misuse by the carers). In rare cases, parental actions or actions by third parties through abuse or neglect may have caused or contributed to the death.

2.7. Whatever our understanding of the underlying cause of death or any contributory factors, the bereaved family and the deceased infant deserve to be treated with sensitivity and respect.

2.8. These guidelines provide a framework for professionals in responding to the sudden unexpected death of an infant or young child up to the age of 18 years or 26 if Care Experienced.

2.9. The aims of the response are to:

- Establish, as far as is possible, the cause or causes of the child's death
- Identify any potential contributory or modifiable factors
- provide ongoing support to the family
- ensure that all statutory obligations are met
- learn lessons in order to reduce the risks of future child deaths.

2.10. An unexpected death may be sufficiently explained – by its clinical presentation, or early laboratory or radiological findings – so that the attending doctor is able to issue a medical certificate of the suspected cause of death.

2.11. In all unexpected deaths where a medical practitioner is unable to issue the certificate, it is the responsibility of the Procurator Fiscal (PF) to determine the cause of death and to ensure all statutory requirements are met. However, to do this, they are dependent on the information provided by the professionals involved in caring for the child and responding to the death.

2.12. All professionals involved in this joint agency response have a responsibility to work with the PF in achieving these aims.

2.13. No action in relation to the deceased child should be taken by any professional without the prior agreement of the PF. A standard response has been agreed locally in advance to avoid the need to consult on every case.

This includes agreement on a standard set of investigations to be taken, along with agreement on appropriate mementos for the family (memory box).

2.14. Where there is any doubt about the appropriateness of a course of action, the PF should be consulted first. If there is any suggestion of neglect or abuse, the professionals must contact the PF immediately and the senior police investigator shall initiate investigations according to agreed police procedures.

2.15. The multi-agency response consists of the following essential components. While the manner in which these are implemented may vary across Scotland in accordance with local priorities, needs and resources, no response should be considered complete without these core components:

- careful multi-agency planning of the response
- ongoing consideration of the psychological and emotional needs of the family, including referral for bereavement support
- initial assessment and management, including a detailed and careful history, examination of the child, preliminary medical and forensic investigations, and immediate care of the family, including siblings
- an assessment of the environment and circumstances of the death
- a standardised and thorough post-mortem examination
- a Child Death Commissioning meeting

3. Sudden Unexplained Child Deaths or Critical Injuries

Police Scotland

3.1. Police Scotland defines an unexpected death of a child as the death of an infant or child up until their 18th birthday which was:

i. Not anticipated as a significant possibility prior to either the death or any sudden deterioration immediately before death

ii. Where there was a similarly unexpected collapse or incident leading to or precipitating which led to the death

3.2. Police Scotland have a duty to investigate the unexpected death of a child under Article 2 of the Human Rights Act 1988, which states that everyone's life should be protected by law. It is important to investigate any sudden and unexplained deaths so that homicide can be excluded, and cause of death identified.

Health Improvement Scotland (HIS)

3.3. HIS state that all CDRs should be conducted on the deaths of all live born children up to the date of their 18th birthday, or 26th birthday for care leavers who are in receipt of aftercare or continuing care at the time of their death.

Sudden Death in the Community

3.4. For situations where a child's death or critical injury is unexplained, the police will be the lead agency. In most instances, police are notified of the death or

critical condition of a child via Scottish Ambulance Service (SAS) Control, Emergency Department or the Duty Paediatrician. Uniform officers will attend the home address to offer assistance to the paramedics before attending the hospital. These officers will be in direct communication with the Duty Inspector/ Senior Investigating Officer (SIO) who will be monitoring the situation. They will also seek confirmation from the Duty Paediatrician as to the child's condition.

3.5. On notification that a child or baby has died, or has critical injuries, or is critically unwell without explanation (for example – resuscitated from cardiac arrest in the community), the officers will inform the Duty Inspector, who will notify the Senior Investigating Officer (SIO), and link with MASH Senior Managers. A trained Child Death SIO will also be appointed for all police investigations involving the death of a child.

3.6. Important points to note;

Unexplained deaths in the community:

- the child will be taken to the hospital.
- Contact should be made urgently with the Police - until the Police Child Death SIO has been contacted, medical equipment should not be removed. In cases with any suspicious factors, family members must not be allowed access to the child. In cases with no suspicious factors, senior medical staff may exercise professional judgement in allowing family members to have access to the child. That access must be accompanied by a member of staff at all times until advised otherwise by the Police SIO.
- Once the Child Death SIO has been consulted, a top to toe examination of the child will be carried out. Where possible this will be carried out jointly by police and a paediatrician but if a paediatrician is unavailable then another doctor (A&E etc.) can be used for this purpose.
- The examination is to check for any injuries that may raise suspicions as to the cause of death but is also to explain any injuries that may have been caused during resuscitation attempts and medical intervention.
- Once this is complete and the SIO has provided permission, then medical equipment can be removed, and family members will be allowed supervised access to hold their child.

Unexplained, Non-Suspicious Deaths

3.7. For circumstances where the death is unexplained but not necessarily suspicious, initial response from the police will consist of a thorough investigation of circumstances leading to the death of a child. This will include obtaining full details of all persons present whether child or adult, who have been in the deceased child's presence during an identified time frame. A Police Contact Officer or Family Liaison Officer (FLO) will be appointed to liaise with the family during the investigation.

3.8. As soon as possible following notification, in working hours the Detective Sergeant, Public Protection Unit, will liaise with the following, noting the OOHS provision will be coordinated by the Detective Sergeant in the CID:

i. In hours - MASH (Multi-Agency Safeguarding Hub)
ii. Out of hours - Out of Hours Social Work

3.9. If the incident occurs out-of-hours police will contact Out of Hours Social Work who will consider the need for any interim safety plans for siblings, other relevant children, or vulnerable adults.

3.10. In circumstances where a child or young person has died, and abuse or neglect is known or suspected, it is acknowledged that such events will be challenging for agencies and staff involved, however bereavement support should be in place throughout the entirety of any type of review process.

Suspicious Deaths

- If the death is suspicious, then at no point should anyone be allowed access to the child.
- Once medical interventions have ceased, the child should be left in situ until further instruction from the Child Death SIO.
- Staff should record who has seen the child and what the interaction was so that police can account for this during forensic strategy meetings.

Expected Child Deaths

3.11. In circumstances when a child's death was anticipated and not preventable, and there are no suspicious circumstances, there is no requirement to convene a MASH Managers meeting. Best practice dictates regular multi-agency communication and information sharing should take place between all agencies involved in the child/ young person's care, including the sharing any palliative/ anticipatory care plan with education, social work colleagues and other professionals as necessary.

3.12. Following the death of a child or young person who was expected to die and or who had an Anticipatory Care Plan (ACP) in place, the lead health professional should convene a meeting to discuss and coordinate next steps including bereavement support for the family.

3.13. Multi-agency guidance in relation to the management of children and young people who have an Anticipatory/ Palliative Care Plan in place is currently under development. In the interim staff should access Anticipatory Care Planning resources and tools.

Multi-Agency Acute Response

3.14. A multi-agency approach is key to the effective investigation of an unexpected death and support for the family. Such an approach should be initiated at the point of presentation and should continue throughout the process. This requires all professionals to keep each other informed, to share relevant information and to work collaboratively.

3.15. All children found collapsed or dead should be taken to the nearest emergency department either in Dumfries or Stranraer. As soon as possible after the arrival of the infant in the Emergency Department, a lead health professional should be assigned. This may be the on-call Consultant

Paediatrician or, where suitable arrangements exist, a designated paediatrician for unexpected childhood deaths. This lead health professional will take responsibility for ensuring that all health responses are implemented, and for ongoing liaison with the police and other agencies. This same process should still be applied if the infant has not been brought to the Emergency Department (ED) for any reason. In most cases a child should be taken to an ED unless it is evident that the presentation of the body is not compatible with life or there is apparent criminality that has caused the death. Some professionals may not see why a child was taken to the ED when death could have been confirmed at the scene, but there are many reasons for this.

3.16. Where a child has collapsed in the community and the Scottish Ambulance Service are in attendance, all attempts will be made to preserve life and will in most cases result in the child or young person being transported to the nearest Emergency Department in Dumfries or Stranraer.

3.17. Where no out-of-hours specialist provision for SUDI exists, the on-call paediatrician should take the role of lead health professional but may transfer this responsibility on the next working day. When the responsibility for lead health professional is transferred from one professional to another, there must be a clear handover of responsibilities, and the other lead professionals in other agencies, including the police, Children and Family Social Work and the PFs, should be notified.

3.18. The police should be contacted as soon as possible after the arrival of the child in the Emergency Department, if this has not already been done, and arrangements made for the police lead for the investigation of the death to attend. This investigator should be trained in infant abuse/ death investigation cases.

3.19. If such an investigator is not immediately available, a handover to such a qualified investigator should occur as soon as possible and prior to any multi-agency meeting.

3.20. The investigator should have knowledge of and adhere to the following five national policing principles for dealing with unexpected child deaths:

- balanced approach between sensitivity and the investigative mindset
- multi-agency response
- sharing of information
- appropriate response to the circumstances
- preservation of evidence

3.21. MASH Managers should be alerted and asked to check their records relating to the child, the immediate family members, other members of the household and others with whom the child has lived. Any relevant information identified by Children and Family Social Work should be promptly shared with the Police Senior Investigating Officer (SIO) and the paediatrician immediately or as soon as practically possible.

3.22. On some occasions, particularly if concerns have been raised about neglect, non-accidental harm or unusual circumstances of the death, the police may appoint a Family Liaison Officer to maintain close and continued contact with

the family following the death.

3.23. If a Family Liaison Officer is appointed, the family must be given clear and accurate information on his/ her role.

3.24. Certain factors in the history or examination of the child may give rise to concerns about the circumstances surrounding the death.

3.25. If any such factors are identified, it is important that the information is documented and shared with senior colleagues, the PF and relevant professionals in other key agencies involved in the investigation. All injuries should be recorded immediately and again subsequently, and the lead investigator should arrange a photographic record.

3.26. It is also important to note that the absence of specific factors does not mean the death cannot be suspicious, and the death should be investigated to ascertain circumstances and cause.

3.27. An initial information-sharing and planning discussion should take place before the family leave the Emergency Department.

3.28. This should, as a minimum, include the lead health professional and police investigator, and should desirably include (or if not, take account of information shared from) CFSW and the ambulance crew.

3.29. These discussions should be face to face in the Emergency Department where possible but may need to be telephone based or via MS Teams. Ambulance crews should not routinely be detained from returning to operational response by this process, but clear records and access to the crew by the police, if necessary, should be facilitated by Scottish Ambulance Service (SAS) at the earliest opportunity.

MASH Managers Meeting

3.30. As soon as possible after the death, a further information sharing and planning MASH Managers meeting should be held. This early meeting is a key action as part of the multi-agency response and will normally take place during normal working hours to ensure all relevant managers can attend.

3.31. The meeting should ideally be held via MS Teams and should include the lead health professional if available. If the lead health professional is unavailable, a senior paediatrician should be included. The SIO would not necessarily attend depending on the circumstances. The respective MASH managers from all agencies in health, social work and police should share appropriate information from their agencies to enable agencies to review the history and circumstances of the death, any immediate background information from health, police or social work, and any concerns arising from these.

3.32. Consideration should be given to the safety and wellbeing of any other children in the household. If, at any stage, concerns are raised that abuse or neglect may have contributed to the child's death, or any other significant concerns emerge about possible child protection issues, an inter-agency referral discussion (IRD) should be convened. In these circumstances, the police will normally take the lead in investigating the death and the joint agency response should be adapted to take account of all forensic

requirements.

3.33. MASH Managers Meeting should:

1. Review all available information.
2. Review interim safety plan for any siblings, bereavement support for any children or vulnerable adults in the same household.
3. Consider any child or adult protection measures that may be needed eg. IRD via MASH.
4. Mobilise and allocate resources – this should include named staff who will manage and co-ordinate investigations from each agency. Senior Managers should ensure continuity by considering staff availability.
5. Each manager should consider any communication/ escalation requirements within their own agency.
6. As part of significant occurrence reporting, consider individual organisational risk assessment requirements - this should not be confused with the risk assessment of any child or member involved.
7. The agreed record of the MASH Managers Meeting and any subsequent actions should be recorded disseminated between MASH Managers and stored securely by each agency.
8. NHS MASH Manager will notify the Nurse Consultant Public Protection who will trigger a DATIX (Adverse Event Notification Form) which will initiate the local D&G Child Death Review (CDR) process.
9. A copy of the record of the meeting should be sent to the PF, pathologist, all agencies involved in the meeting and the local Child Death Coordinator.
10. Consideration should be given by the MASH Managers as to what information should be fed into the Child Death Review Commissioning Panel and whether a view/ recommendation can be formed at that stage as to what type of review might be appropriate and proportionate.

Child Death Commissioning Group (CDRCG)

3.34. Immediate actions to support and protect any remaining siblings and or family members should be considered within either a MASH Managers and or a Multi-Agency Support and Response meeting as necessary. In parallel to these meetings NHS D&G will arrange a CDR commissioning meeting to discuss the circumstances of the child's death, identify and any support needs of the family and agree what type of review should be undertaken (See Appendix 3)

3.35. Police are unlikely to have continued involvement in cases where the death of a child is not suspicious.

3.36. Each agency should consider on an individual basis how they can best provide support to any staff involved and will consider whether a single and or multi-agency debrief for staff would be beneficial.

3.37. The CDRCG agenda should not be exhaustive and senior managers should

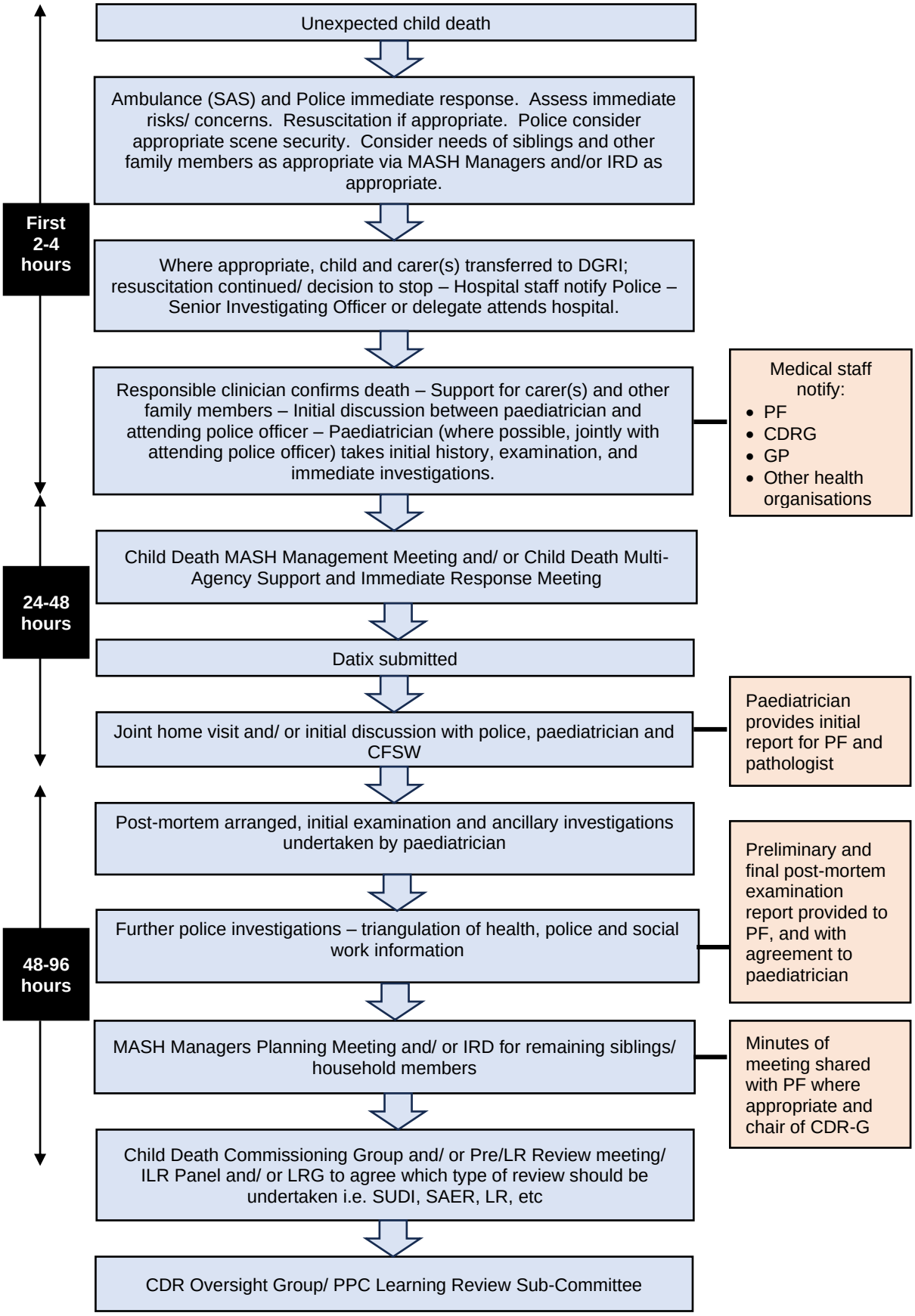
use their discretion and professional judgment to discuss any other relevant information, issues or concerns related to their own service involvement, patient and staff wellbeing and bereavement support as well as any other information which may help inform the decision.

3.38. In the event of a live police investigation in relation to the death of a child, it will be acknowledged by the CDRCG that police will be the lead agency and that some processes detailed within this guidance may not be followed due to extenuating circumstances such as suspected murder or culpable homicide. This may result in some information not being shared with other agencies due to restrictions in place to protect the integrity of the police investigation.

3.39. Once all agencies have had the opportunity to share information and contribute to the discussion a consensus will be reached as to what type of review should be commissioned.

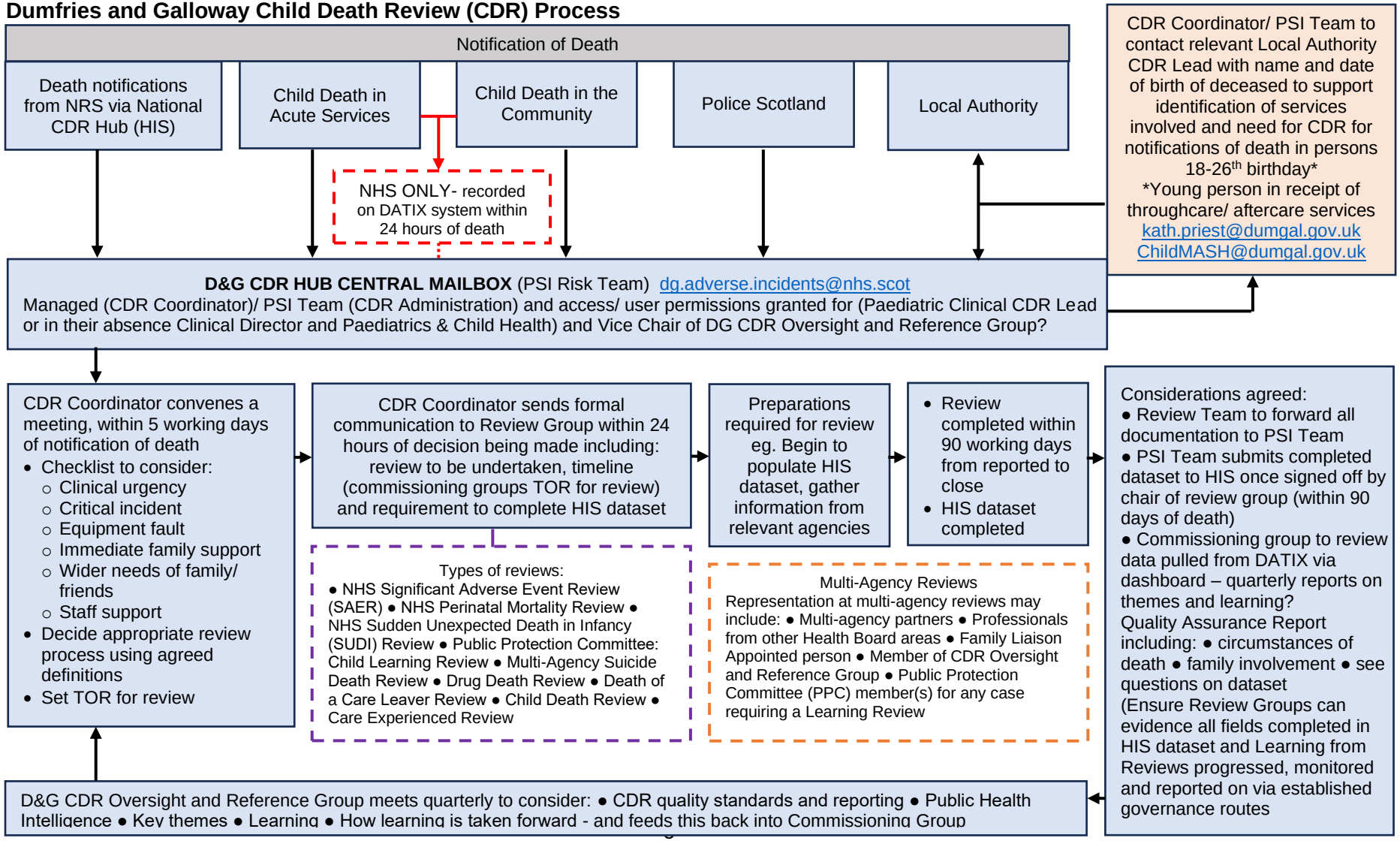
3.40. There are various types of child death reviews that can be undertaken please see a summary of these in Appendix 3.

Appendix 1 – Multi Agency Unexplained Child Death Response Flowchart



Appendix 2 – Multi Agency Child Death Review Flowchart

Dumfries and Galloway Child Death Review (CDR) Process



Appendix 3: Summary of Types of Review

Adverse Event Reviews (for more detailed information please access the National CDR Guidance Page 16 – 22).

Significant Adverse Event Reviews (SAERs)

SAERS are carried out following events that have resulted in unexpected death or harm. These are focused on analysing factors that have contributed to the circumstances of the event.

Death of a Looked After Child Review

Under regulation 6 of the Looked After Children (Scotland) Regulations 2009, local authorities have a duty to notify Scottish Ministers and the Care Inspectorate of the death of a looked after child and make arrangements to carry out a review. Local authorities are required to submit written notification within 24 hours of any death of a looked after child to Care Inspectorate. Within 28 days, the local authority are required to send the Care Inspectorate a detailed report and supporting information.

Aftercare Child/ Young Person Death Review

Deaths of young people in receipt of aftercare under Section 29 (10) (b) of the Children (Scotland) Act 1995 (amended by the Children and Young People (Scotland) Act 2014)

If a local authority becomes aware that a person who is being provided with advice, guidance or assistance by them under this section has died, the local authority must, as soon as reasonably practicable, notify Social Care and Social Work Scotland (known as the Care Inspectorate). Reviews should be conducted on the deaths of all care leavers who are in receipt of aftercare at the time of their death.

Death in Prison Learning, Audit and Review (DIPLAR)

DIPLAR is the joint Scottish Prison Service and NHS Scotland process for reviewing deaths in custody. It provides a system for recording any learning and identified actions and is held within 2 weeks of a death. DIPLAR enables the Scottish Prison Service to contribute to the national suicide prevention policies and develop the evidence base through a reporting and learning system that analyses all suicide reviews to promote learning and improve strategies throughout Scotland.

Drug-Related Deaths Reviews

Drug-related deaths in Scotland are recorded and examined by local critical incident monitoring groups who often collaborate with the police and Procurator Fiscal to identify such cases in their local area. Each area has a data collection co-ordinator who works closely with the local critical incident monitoring group and other key partners to collate the information on each drug-related death. Data collected from all drug-related deaths from NHS boards is recorded on the national drug-related death data set which is managed by Public Health Scotland.

Fatal Accident Inquiries

A Fatal Accident Inquiry is a type of court hearing which publicly enquires into the circumstances of a death. It will be presided over by a Sheriff and will normally be held in the Sheriff Court. If the death has happened as a result of an accident while at work or if the death happened while in legal custody, for example in prison or police custody, an FAI will normally be held. FAIs can be held in other circumstances if it is thought by COPFS to be in the public interest to do so.

Learning Reviews

The overall purpose of a **Learning Review**, previously known as initial case reviews or significant case reviews, is to bring together agencies, individuals and families to learn from what has happened. This is important for processes and systems to improve to better protect children and young people.

Mortality and Morbidity Reviews

The **Mortality and Morbidity** process describes the review of incidents from the initial event to the mortality and morbidity meeting and implementation of identified actions or outcomes. A mortality and morbidity meeting is a unique opportunity for caregivers to improve the quality of care offered through case studies. They provide clinicians and members of the healthcare team with a routine forum for the open examination of adverse events, complications, and errors that may have led to illness or death in patients.

Peri-natal Mortality Reviews

The **Peri-natal Mortality Review** Tool (PMRT) supports standardised peri-natal mortality reviews across NHS maternity and neonatal units on the deaths of babies from 22+ week's gestation to 28 days after delivery. These are reviewed using the Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRRACE) and PMRT.

Police Investigations and Review Commissioner (PIRC)

The **Police Investigations and Review Commissioner** can investigate the following.

- Incidents involving the police, directed by the COPFS. These include deaths in custody and allegations of criminality made about police officers.
- Serious incidents involving the police, at the request of the Chief Constable or the Scottish Police Authority. These include the serious injury of a person in police custody, the death or serious injury of a person following contact with the police or the use of firearms by police officers.
- Allegations of misconduct by senior police officers of the rank of assistant chief constable and above, if requested by the Scottish Police Authority.
- Relevant police matters which the commissioner considers would be in the public interest.

- At the end of an investigation, the commissioner can recommend improvements to the way the police operate and deliver services to the public in Scotland.

Sudden Unexpected Death in Infancy (SUDI)

SUDI is the term used to describe sudden and unexpected death in infancy. A SUDI is deemed to have occurred where there is no known pre-existing condition which would make the death predictable.

SUDI Reviews are undertaken as per CEL21 (2013) using the SUDI toolkit process on all unexpected deaths up to 24 months. Bereavement support links to support families can also be found within the SUDI toolkit.

All processes required for health staff in response to SUDI (Sudden Unexpected Death in Infancy) are detailed in the SUDI guidance and support documents – Healthcare Improvement Scotland.