

Procedural Response to Unexpected Deaths in Childhood (PRUDiC) North Wales



PREFACE

The original Procedural Response to Unexpected Deaths in Children (PRUDiC) document was drawn up by Public Health Wales at the request of the Welsh Government (WG) in 2010. It was ratified by the North Wales Local Safeguarding Children Boards (LSCBs) in 2011. A North Wales task and finish group has met and agreed the following document which describes the implementation of the PRUDiC in North Wales

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Implementation Process

Date	Action	Contributors
21.11.2011	Discussion regarding role of PRUDiC Practitioner in PRUDiC process	<u>Health</u> Duncan Cameron Sara Scott Carys Ellis Lindsay Groves
22.12.2011	Discussion regarding roles to be undertaken by police and health in PRUDiC process	<u>Health</u> Duncan Cameron Carys Ellis Lindsay Groves <u>Police</u> Sian Beck
11.01.2012	Extraordinary meeting to further above discussions	Lindsay Groves Mark Chesters Sian Beck
03.02.2012	Agree roles of coroner, Welsh Ambulance Service, Emergency Departments. Agree wording of PRUDiC document	<u>N Wales Coroners</u> Dewi Pritchard John Gittins <u>WAST</u> Chris Hinton <u>Emergency Dept</u> Sian Morgan <u>Police</u> Jane Thomas (traffic) Mark Chesters <u>Health</u> Duncan Cameron Lindsay Groves Carys Ellis
14.02.2012	Extraordinary meeting re inclusion of deaths by road traffic accidents	Lindsay Groves John Hanson
26.04.2012	Finalise wording of document and agree timescales for implementation. Discuss checklists	Duncan Cameron Lindsay Groves Stella Madgwick Chris Hinton Mark Chesters Dewi Pritchard <u>Pathology/mortuaries</u> Pearl Huey Peter Derrick
29.06.2012	'Quick Reference Guide'. Each agency to agree its own checklists. Should have been completed by June 2012	ALL

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Consultation Process

Date	Committee	Ratified
01.02.2013	BCUHB Safeguarding Policies and Procedures Subgroup	Discussed. Ratification by this group not felt to be appropriate since multiagency document
15.03.2013	BCUHB Safeguarding Children Operational Forum	15.03.2013
28.03.2013	BCUHB Safeguarding People at Risk Subcommittee	28.03.2013
March – April 2013	North Wales Local Safeguarding Childrens Boards	March April 2013

Implemented in North Wales 1st May 2013

Review Process 2014

Date	Action	Contributors
24.04.14	Reviewed and updated document and checklists with regard to update All Wales PRUDiC Document (PHW)	Lindsay Groves Duncan Cameron Louise Phillips Jo Rammesseur Sara Scott Sian Morgan Chris Hinton Carys Ellis Dewi Pritchard Jones
26.06.14	Reviewed changes and agreed	Lindsay Groves Duncan Cameron Louise Phillips Jo Rammesseur Sara Scott Sian Morgan Chris Hinton Carys Ellis Dewi Pritchard Jones
30.03.15	Addition of Audit Tool as agreed by Safeguarding Children Wales NHS Network	Lindsay Groves

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Introduction

1.1. This procedure sets a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the process of communication, collaborative action and information sharing following the unexpected death of a child.

1.2. The procedural response begins at the point of death and ends with the completed Record of Child Death being sent to the Child Death Review (CDR) Programme following the Case Review Meeting when the final results of the post mortem examination have been shared or the inquest or trial has taken place.

1.3. This procedural response will be followed when:

- a decision has been made that the death of a child is unexpected or there is a lack of clarity about whether the death of a child is unexpected or
- the cause of a child's death is not apparent and it is not possible to issue a death certificate

1.4. The aim of the PRUDiC is to ensure that the response is safe, consistent and sensitive to those concerned, and that there is uniformity across Wales in the multi-agency response to unexpected child deaths. This is a multi-agency procedural response, intended to ensure consistency across Wales and is not agency or discipline specific. It outlines what needs to be achieved and gives broad suggestions about the roles of agencies. It does not replace existing internal agency or professional procedures.

1.5. The procedural response sets out a structure within which reasoned judgements can be made when evaluating an unexpected child death on the basis of all available information. It is important therefore that all staff remain open-minded when considering any death and avoid reaching conclusions inappropriately outside of the agreed processes.

1.6. The procedural response, on behalf of HM Coroner, will be coordinated by the police. The PRUDiC recognises that HM Coroners are independent judicial officers and it does not create any legally enforceable rights, obligations or restrictions upon them.

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1.7. Throughout this procedure, the term 'parent' is used to refer to any parent or carer, including the person with a Special Guardianship Order or Residence Order, foster parents and the local authority for looked after children.

1.8. All child deaths that are unexplained or unnatural are notified to HM Coroner as soon as the fact of death has been confirmed and consideration is given to the need for a full police/coroner's investigation, including an inquest.

1.9. HM Coroner has a duty to conduct an investigation into any violent or unnatural death or where the cause of death is unknown to ascertain how, when and where the deceased came by his/her death. The scope of the PRUDiC is wider than this (see Appendix 4 The 7 key strands) and the procedure will be implemented in all unexpected child deaths.

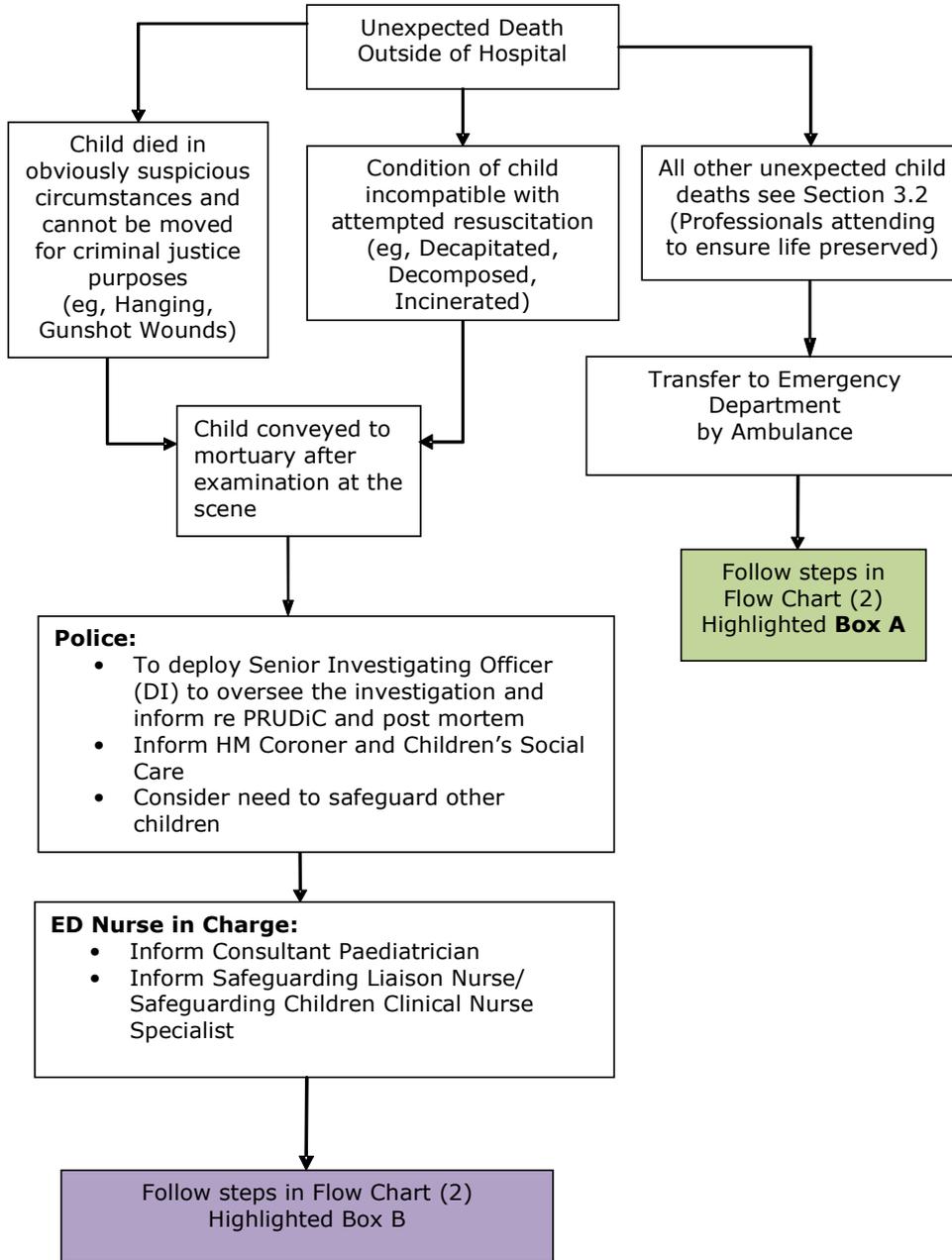
1.10. The procedural response will enable the capturing of immediate information about unexpected child deaths. A number of templates have been developed to assist in the collection of information regarding child deaths: for the Child Death Review Programme a Notification form and a Record of Child Death according to the type of death (see Appendix 5 for a link to Forms). Collective information on cases will inform the CDR Programme Steering Group about trends and patterns in child deaths and inform thematic reviews to generate and influence future prevention strategies.

2. Flowchart of PRUDiC

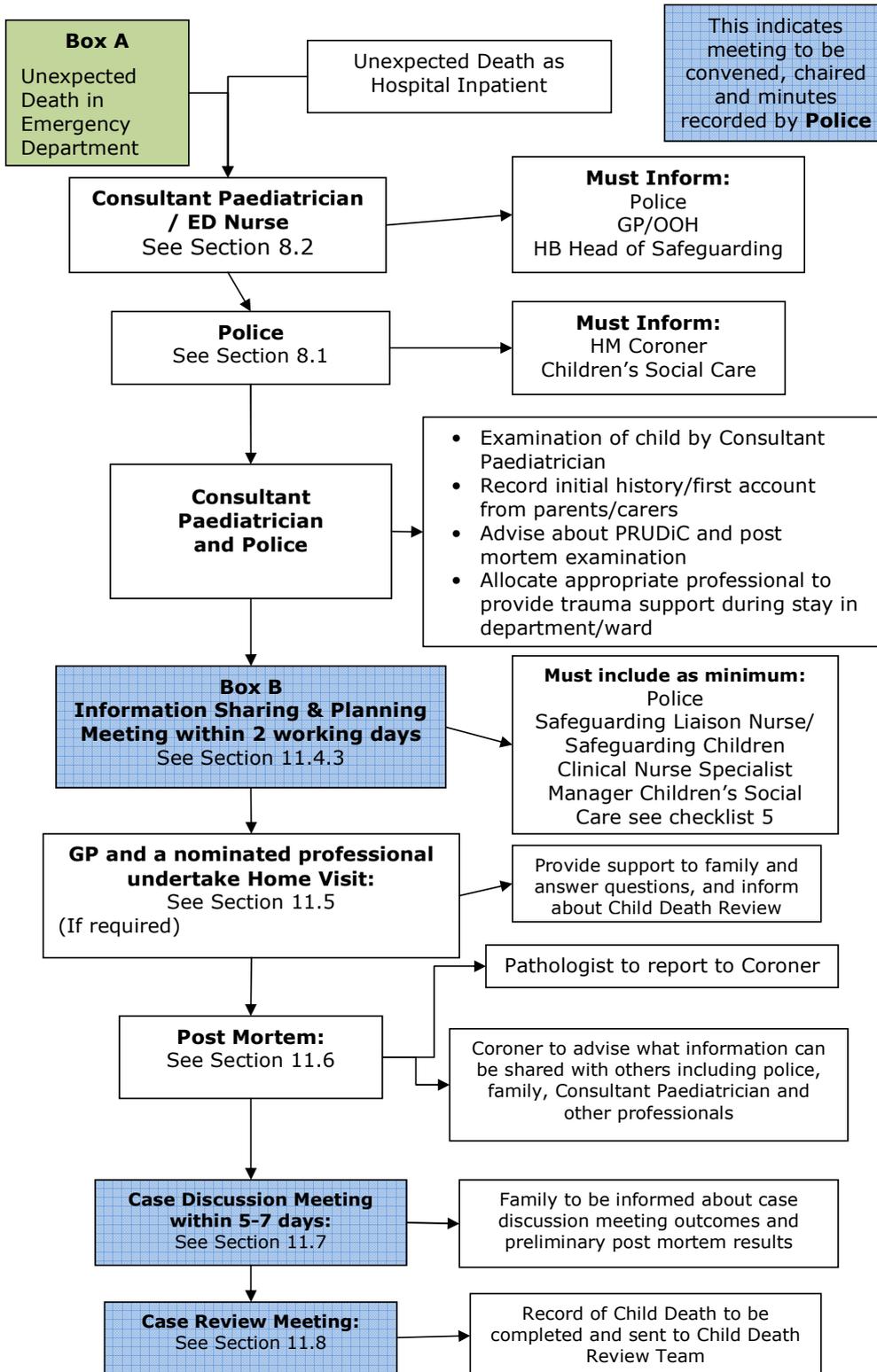
This flow chart should be followed depending on the circumstances for each case. Variance should be recorded along with the rationale. It is emphasised that only in exceptional circumstances should the child be taken directly to the mortuary. In most cases the child should be taken to the Emergency department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

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FLOWCHART OF PRUDiC



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3. Unexpected Death of a Child

3.1. The unexpected death of a child has been defined as:

'The death of a child which was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death'.¹

and as

'The death of a child where there is no known antecedent condition that might be expected to cause the death at that time, and the child dies either immediately or subsequently from the consequences of the precipitating event or collapse'.²

The second part of this definition is especially relevant when there is a significant time delay between the collapse of the child and the eventual death.

3.2. The PRUDiC applies to all unexpected deaths in children from birth until the 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. This does not include stillbirths and the death of pre-viable babies born before 24 weeks.

3.3. If a baby dies within 24 hours of birth before discharge from hospital but with **no** immediate medical explanation apparent for the death, the situation will be discussed by the Consultant Neonatologist and a Named Professional for Safeguarding Children. They will make a decision, informed by the circumstances surrounding the death and information available to them within health, as to whether the case should be regarded as an unexpected death and so fall within the PRUDiC.

¹ Fleming et al.

² American Academy of Paediatrics

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3.4. If a baby dies within 24 hours of birth after discharge from hospital, the death will be treated as an unexpected death and fall within the PRUDiC process.

3.5. If a baby dies within 24 hours of a home birth with no immediate medical explanation apparent for the death, the death will be treated as an unexpected death and fall within the PRUDiC process.

3.6. If a baby dies within 24 hours of birth whilst under medical supervision, (whether in a medical setting or not), and there is a clear medical explanation for the death, this will **not** be treated as an unexpected death.

3.7. Where professionals are uncertain about whether the death is unexpected, the death will be treated as unexpected and this procedure will be followed.

4. Children with an All Wales Emergency Care Plan (AWECP)

4.1 Children who are known to have a life limiting or life threatening illness may have an All Wales Emergency Care Plan in place. This plan should facilitate multi-professional communication before and around the time of death in the event of the child dying in an expected way. The existence of an AWECP should reduce the number of events where a child dies and a PRUDiC is inappropriately triggered.

4.2 If a child who has a life limiting or life threatening illness dies in an unexpected way, or professionals are surprised that death has occurred then the PRUDiC should be triggered. The AWECP (if one is in place for that child) will facilitate the PRUDiC and ensure a timely and sensitive investigation.

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5. Expected Death of a child

5.1 Deaths identified from the outset as falling outside the definition of an unexpected death need not be subject to this PRUDiC but must be notified to the CDR Programme by the professional who confirms the fact of death, using the notification form (see Appendix 5 for a link to Forms).

5.2 Initial bereavement care and support should be provided to the family by the Health Team involved with the child and the family should be informed at an appropriate time of the Child Death Review process.

6. When a Child Dies Unexpectedly in Another Area

6.1. Whenever a child dies unexpectedly in Wales there is an expectation that the PRUDiC process will be implemented. However, it is recognised that there may be occasions when the principles of the PRUDiC process and the family will be better served by another process such as the English Child Death Review Process.

6.2. When a child dies in Wales, but outside of their normal area of residence in Wales, the PRUDiC will occur wherever the family and the principles of the PRUDiC process will be best served. There should be communication between the Senior Investigating Officer (SIO) and the relevant Heads of Public Protection, the Lead Managers for Safeguarding in Children's Services and the HB Heads of Safeguarding in both areas to decide how to proceed.

6.3. When a child dies in England, but is normally resident in Wales, the PRUDiC or the English Child Death Review Process may occur wherever and however the family and the principles of the PRUDiC process will be best served. There should be communication between the SIO and the relevant Heads of Public Protection, the Lead Managers for Safeguarding in Children's Services and the HB Heads of Safeguarding in both areas to decide how to proceed.

6.4. If a child dies in Wales, but is normally resident outside of Wales, the PRUDiC will occur wherever and however the family and the principles of the PRUDiC process will be best served. There should be communication between

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the SIO and the relevant Heads of Public Protection, the Lead Managers for Safeguarding in Children’s Services and the HB Heads of Safeguarding in both areas to decide how to proceed.

6.5. Health Boards who routinely send children to English hospitals for secondary/tertiary care should ensure that those hospitals are aware of the PRUDiC process so that their Head of Safeguarding can be promptly informed when a Welsh child dies and the PRUDiC process initiated. In such cases the understanding between the Coroners is that the death will be investigated by the Coroner for the district where the child resided.

6.6. Where notified of a death in Scotland, Northern Ireland or elsewhere outside of the United Kingdom, the professionals responsible for child death in the local authority where the child is normally resident will consider implementing this procedure as far as is practically possible and fully record any decisions made.

7. Principles of the Procedural Response to Unexpected Deaths in Childhood

7.1. The following principles will be adhered to at all times:

- respect, sensitivity, open mind, and discretion
- achieving a balance between forensic and medical requirements and family support
- a multi-disciplinary approach
- sharing of information
- ensuring equality of service, including the access and communication needs of disabled people
- recognising cultural needs, including language, faith and ethnicity
- preserving evidence
- good record keeping
- conducting enquiries expeditiously so that there are no unnecessary delays to the funeral
- working to the guidance as set out in this procedural response

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7.2. In applying the above principles, individuals and agencies should ensure that their actions are legal, necessary, relevant and proportionate in order to comply with the Children Act 1989, Health Records Act 1990, Human Rights Act 1998, Children Act 2004 and The United Nations Convention on the Rights of the Child. The Coroner and Justice Act 2009

8. Professionals Involved in the PRUDiC

8.1. Emergency Services - will follow their own protocols for WAST (see Appendix 6) and Police (see Appendix 7). This is to ensure life is preserved and the child will be taken directly to an Emergency Department.

8.1.1. It is recognised that in exceptional circumstances it may not be appropriate to take the child to the Emergency Department (for example where the body is decapitated, badly burned or decomposed) and the child may be transported directly to the mortuary. In these circumstances the Welsh Ambulance Service must ensure that the Nurse in Charge at the Emergency Department is informed about the death, that the child is in the mortuary and that the PRUDiC process should be initiated. The local Safeguarding Team should also be informed by Welsh Ambulance Service immediately or on the next working day.

8.1.2. If the child is obviously dead **AND** there are suspicious circumstances and life has been pronounced extinct the Welsh Ambulance Service should inform the police, if they are not already on scene. If police are on the scene they will make the decision about whether or not to remove the child, seeking advice from a police Senior Investigating Officer (SIO) where necessary and following communication with the Coroner. If the child has to remain at the scene the police will consider deployment of specialist officers e.g. Family Liaison Officer.

8.2. Consultant Paediatrician – When the child arrives at the Emergency Department the child will be attended by a medically qualified practitioner, usually the paediatric consultant but for a child aged 16 or over this clinician could be from an adult service. After resuscitation attempts have failed this

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medically qualified practitioner will confirm that life is extinct and will then be responsible for:

- Ensuring the following key professionals are informed **as soon as possible** of the death: the Police, Safeguarding Liaison Nurse and the child's General Practitioner or the out of hours service. **These professionals will be informed by the next working day at the latest.** (If the Out of Hours Service is contacted initially the child's GP should be contacted on the next working day.)
- Providing a full report on the history and physical findings at presentation to the coroner and pathologist. This must include retinoscopic examination of the fundi in children under 2 years where possible.
- Fully documenting any ante mortem samples taken from the child, providing available results to the pathologist and recording those outstanding. Still waiting for guidance from our pathologists
- Requesting that the laboratory retain any residual material after processing the ante mortem samples.
- Informing parents of the PRUDiC process.
- **If a clinician from an adult service is initially involved then they should inform the Consultant Paediatrician on call of the child's death as soon as possible and formally handover to that Consultant Paediatrician who will adopt all subsequent responsibility for the child and the PRUDiC process.**

8.3. The Health Board's Safeguarding Team

- will provide information, advice and support to any health professional who is unfamiliar with the PRUDiC process, particularly those working in adult services.
- will liaise with other agencies and lead the coordination of information gathering within Health to be shared throughout the PRUDiC.
- will ensure full liaison with the police in the event of a suspicious death. (In which case the police SIO will decide what information is disclosed to parents and how.)

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- will complete the Child Death Notification form following the Information Sharing and Planning Meeting, and the Record of Child Death form following the Case Review Meeting, and ensure they are forwarded to the Child Death Review Programme.

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

8.4. Police SIO (Senior Investigating Officer)

The following actions will be undertaken by the police:

- ensuring an initial Information Sharing and Planning Meeting takes place, usually within 2 working days of the death
- ensuring a Case Discussion/Meeting takes place, usually within 5-7 days of the death
- ensuring a formal Case Review Meeting takes place, usually within 3-6 months of the death, although this may be predicated by the post mortem examination, inquest or other investigations

Where the provisions set at 1.3 of this procedure are met, an SIO will be appointed and take responsibility for the management of police resources and for ensuring appropriate and proportional lines of enquiry are instigated. SIO appointments will be in accordance with Force Policy and in consideration of ACPO national guidance. For Road Death the SIO responsibilities will be performed by a Road Death SIO. Where circumstances indicate that attendance at the scene will benefit the enquiry, an experienced detective officer will be tasked to immediately attend the scene. SIOs should be mindful that there may not be any obvious suspicious circumstances and that scene attendance by appropriately experienced officers or staff may benefit the enquiry. This is the case if the child is still at the scene or if the child has been removed to hospital. Where the possibility of child abuse or neglect is present, it is further recommended that this detective officer has child protection experience. The

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police SIO may allocate a police SPOC (Single Point of Contact) to assist with inter-agency communication.

8.5. The Lead Safeguarding Manager in Children’s Social Care –

The Lead Safeguarding Manager in Children’s Social Care will receive notification of any unexpected child death. He/she will be responsible for information gathering within social care and for the sharing of that information with other agencies. He/she will also ensure appropriate representation from children’s social care at all meetings arranged throughout the PRUDiC process. This will ensure that any child protection investigation or safeguarding actions for Children’s Social Care which may arise during the PRUDiC process are addressed.

8.6. The General Practitioner –

Will be fully informed of the unexpected death of a child registered with their practice by the FME or the Consultant Paediatrician. If the death occurs out of hours then the out of hours service will be contacted immediately; the GP will be informed by the FME or the Consultant Paediatrician on the next working day at the latest. The aim is to ensure that GPs are forewarned should they be contacted by the child’s family for support. It is recommended that the GP consults the records of known immediate family members to see whether they have any particular vulnerability and takes appropriate action e.g. inform Adult Mental Health or other services involved with parents. The GP will be invited to attend the Information Sharing and Planning meeting, Case Discussion meeting and Case Review meeting and will receive all minutes. If they are unable to attend any meeting the GP will share any relevant information about the child or other family/household members with the HB Head of Safeguarding in advance of the meeting. Following the Information Sharing and Planning meeting the GP will make the home visit (see 11.5) with the professional nominated by the Information Sharing and Planning meeting.

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8.7. Named Midwife Safeguarding Children.

8.7.1. To be informed and to contribute to the PRUDiC process is a child dies unexpectedly before the age of 28 days.

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8.8 **Additional Professionals** – who may contribute to the PRUDiC include the health visitor, school nurse, children’s community nurse, midwife, Clinical Nurse Specialist Safeguarding Children, pathologist, head teacher and any other relevant professionals, e.g. palliative care, adult psychiatrist and community psychiatric nurse from Child and Adolescent Mental Health Services and Adult Mental Health Services.

9 Supporting Bereaved Families

This is a very difficult time for everyone. The time spent with the family may be brief but actions will greatly influence how the family deals with the bereavement for a long time afterwards. A sympathetic and supportive attitude whilst maintaining professionalism towards the investigation is essential. Grief reactions will vary; individuals may be shocked, numb, withdrawn or hysterical. (See Appendix 2 for Pointers for all Professionals in talking with Bereaved Parents and Appendix 3 for Sources of Family Support).

All professionals should

- Handle the child with naturalness and respect, as if the child were still alive.
- Always refer to the child by name.
- Deal sensitively with religious beliefs and cultural differences, while remembering the importance of evidence preservation.
- Give families time and opportunity to ask questions.
- Give your written contact name and telephone number to the family.
- Address practical issues e.g. where the child will go, what will happen including the PRUDiC, when they will see the child, and communicate sensitively to families.

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All Health Boards should:

- Have a Bereavement Service with one or more Bereavement Advisers to provide a service to families and train other staff.
- Ensure every clinical area has staff with further training and enhanced skills in bereavement care, to include knowledge of cultural sensitivities, the coronial service, post-mortem examinations and funeral arrangements.
- Have a bereavement care pathway to ensure parents and siblings are supported from arrival in the ED onwards.
- Have arrangements in place to ensure that the bereavement care pathway is followed.
- Have a Bereavement pack that would be given to parents to keep and to read when they are ready. This information should also be available on the organisation's internet and intranet sites and could also be available in DVD format which some parents may find more accessible. The pack should include information about PRUDiC and the CDR programme.
- Have links with third sector bereavement services which are fit for purpose and to which they can signpost families.

10. Issues for Consideration in Relation to the PRUDiC

10.1 The PRUDiC timeline (involving three phases) is described in section 11. Within the three phases there are seven key strands for all agencies to consider when a child dies unexpectedly. (See Appendix 4 for further information on the seven key strands.)

The seven key strands are:

- a) Care of the Bereaved Family**
(see Appendix 3 for Sources of Family Support)
- b) Deciding on the Response**
- c) Notification to the CDR Programme**
(see Appendix 5 for a link to Forms)
- d) Child Protection and Safeguarding**
(see Appendix 5 for a link to All Wales Child Protection Procedures)

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- e) **Child Practice Review (previously Serious Case Review)**
- f) **Media Issues**
- g) **Support to Staff**

11. PRUDiC Timeline

The PRUDiC timeline involves three phases:

- Phase one (usually 0-5 days): the management of information sharing from the point at which the child’s death becomes known to any agency until the initial post mortem examination has been completed
- Phase two (usually 5-7 days): the management of information sharing once the initial results of the post mortem examination are available
- Phase three (usually 3-6 months): the management of information sharing including the Case Review Meeting when the final post mortem report is available

In principle it is recognised that all information relevant to the enquiry should be shared by all agencies. However the police and coroner may consider certain information sub judice or subject to continuing investigation which may preclude it being shared. In some circumstances this may include the preliminary and final results of the post mortem examination. In these cases the amount of information released from the police investigation to these meetings must be considered sufficient to inform on the relevant issues. In particular, information shared must have regard to the welfare of other children in the household who may be at risk of harm. Any decision not to share information will be recorded by the police SIO in the police policy book.

The police are responsible for ensuring that accurate minutes of every meeting are recorded, all decisions are documented and that the minutes are distributed to all agencies in attendance.

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11.1 Phase 1: The Information Sharing and Planning Meeting (within 2 working days)

The police Public Protection Unit will convene and chair and minute an initial Information Sharing and Planning Meeting. The meeting will be convened within two working days of the unexpected death, and in most cases prior to the post mortem examination.

The purpose of the Information Sharing and Planning Meeting is:

- to determine which professional will be a single point of contact for the family, accompany the GP on the home visit (see 11.5), inform the family of the Child Death Review Programme and provide them with an 'Information for Families and Carers' leaflet.
- to ensure appropriate support is provided to the family including siblings.
- to ensure appropriate support is provided to the child's immediate peer group.
- for each agency to share information from previous knowledge of the family and records, with particular reference to the circumstances of the child's death. This would include details of previous or ongoing child protection or child care concerns, previous unexplained or unusual deaths in the family, medical conditions including family history of medical conditions, parental substance misuse, parental mental ill health, domestic abuse, previous hospitalisation and GP visits.
- to collate all relevant information to share with the coroner and pathologist prior to the post mortem examination.
- to plan and determine the process of the investigation.
- to enable consideration of any child protection risks to siblings/any other children , and to consider the need for child protection procedures.
- to consider the need for referral to the LSCB for a child practice review.
- to ensure agencies are collecting information in order that the Record of Child Death may be completed following the Case Review Meeting.
- to ensure appropriate support is provided to all professionals who attended the child and family.
- to consider and plan for any media interest in the death.
- to agree who will have responsibility for any actions agreed and by when.

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Where child protection (CP) concerns are identified, the CP and PRUDiC processes will run in parallel. The CP process will not be a substitute for the PRUDiC process, but one will inform the other and vice versa. If CP concerns are identified when the information is shared, a Strategy Meeting will be held chaired by the lead agency (Social Services), according to timescales and processes defined within the All Wales Child Protection Procedures. The Chair of the Local Safeguarding Children Board (LSCB) will be notified for consideration of a Child Practice Review (previously Serious Case Review.)

The Information Sharing and Planning Meeting will include:

- **Police** –A senior Public Protection officer who will convene, chair and minute the meeting and the police SIO who will attend as a contributor
- **Health** – Where appropriate, the Consultant Paediatrician, the Head of Safeguarding or other Named Professional ,the child’s consultants pre-death, the pathologist, the named health visitor, the school nurse, the children’s community nurse, the community midwife, the general practitioner, psychiatrist/community psychiatric nurse and the CAMHS and or Adult Mental Health Service
- **WAST** – a nominated WAST safeguarding professional or representative and where possible the crew who attended the child.
- **Local Authority Children’s Social Care** – A senior children’s social care representative (Senior Practitioner or Team Manager) and the child’s social worker if allocated.
- **HM Coroner/Coroner’s Officer** – Attending this meeting will be a matter for the coroner’s professional judgement. Some coroners will not attend, given that the verdict at inquest must be based solely on the evidence given in court; other coroners will attend, given that the meeting may inform and assist the course of their investigation.
- **Other contributors** - Education (where the child was attending school or nursery), and any other agency/person that may have a contribution to make, e.g. drug/alcohol services, Youth Offending Team.

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This meeting will not be delayed if professionals outside of the PRUDiC core membership (member of Safeguarding team, Consultant Paediatrician, senior children's social care representative, senior Public Protection Unit officer) are unavailable.

At the Information Sharing and Planning Meeting arrangements will be put in place to convene the Case Discussion Meeting, to be held within 5-7 days. If the Case Discussion Meeting is considered unnecessary then the reasons for this decision should be fully documented in the minutes.

Minutes will be circulated to all attendees and invited members.

11.1.2 Phase 1: The Home Visit

The purpose of the home visit is to provide support to the family and where possible to answer their questions on a "needs led" basis, inform them about the Child Death Review Programme, and provide them with an 'Information for Families and Carers' leaflet.

The visit will usually be undertaken by the family's General Practitioner (GP) following discussion with the FME or Consultant Paediatrician or Adult Services Clinician supported by a professional nominated by the Information Sharing and Planning meeting.

The GP should be prepared, by attendance at the Information Sharing and Planning Meeting and through discussion with the FME or Consultant Paediatrician or Adult Services Clinician, to discuss the events surrounding the death with the parents should they so wish and to offer ongoing support to the family.

The accompanying professional nominated by the Information Sharing and Planning Meeting should have knowledge of the PRUDiC process and the Child Death Review Programme and be prepared to answer any questions the parents may have about these.

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The following principles will be taken into account when deciding whether a home visit will take place:

- Visits will not be made to scenes of crime, without the consent of the police.
- Visits will not take place to scenes of road traffic collisions.
- Safety is paramount, and health professionals will not attend the homes of families *on their own*, where a child has died under suspicious circumstances.
- When conducting a home visit, all professionals are reminded of their statutory duty to report to the appropriate authority any concern they may have that a criminal act may have occurred or any safeguarding concerns they may have about the deceased child or any other child.

11.1.3 Phase 1: The Post Mortem Examination (within 5 days)

In all cases a post mortem examination will be performed unless a registered medical practitioner is able to provide a Medical Certificate of Cause of Death, or the coroner otherwise decides.

The post mortem examination will be authorised by the coroner, and should be carried out as soon as possible after the visit to the place where the child died and the Information Sharing and Planning Meeting, unless dictated by a possible public health issue. Any decisions relating to the process and location of the post mortem examination are a matter for the coroner. The post mortem examination will be undertaken in accordance with the guidelines and protocols laid down by the Royal College of Pathologists (see Appendix 5 for a link).

Prior to commencing the post mortem examination, the coroner and pathologist will be given a full briefing on the history and the physical findings at presentation by the Consultant Paediatrician or Adult Services Clinician and the findings of the death scene investigation by the police SIO .

Any photographs or video recordings of the child or the scene will be made available to the coroner and pathologist.

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If the skeletal survey has not been done the pathologist should request one prior to commencing the post mortem. The pathologist will be provided with a report and images by the radiologist relating to the skeletal survey and other imaging which may have been carried out.-The results of the skeletal survey may determine which pathologist should lead the post mortem.

Where possible there will be an information sharing discussion between the chair of the Information Sharing and Planning Meeting and the pathologist before the post mortem examination to identify outstanding or unsuspected issues and to ensure accurate understanding of information.

If the consultant paediatrician or adult services clinician has arranged any laboratory investigations before death, the coroner and the pathologist will be informed prior to the post mortem examination, and the results made available as soon as possible.

The coroner's officer will on request inform all relevant professionals of the time and place of the post mortem examination, including the police and the Consultant Paediatrician. The family will also be informed by the coroner's officer or the FLO (if an FLO has been deployed).

Where the possibility of neglect or abuse is raised, the involvement of a pathologist with forensic skills is essential.

If the police have sought from HM Coroner a forensic post mortem examination conducted by a Home Office pathologist, then the police SIO or their deputy will attend the post mortem examination. If it is not possible for the police SIO to attend, then s/he must send a representative who is aware of all of the facts of the case and who can provide a full briefing of relevant information which may assist the pathologist. The police SIO will decide appropriate resources to attend in line with ACPO guidelines. As a minimum this would normally involve an experienced detective who can represent the interests of the investigative team. S/he may be supported by the Crime Scene Investigator, Crime Scene Manager and Exhibits Officer, as directed by the police SIO.

The interim and final findings of the post mortem will be sent by the pathologist to the coroner immediately the post mortem examination is completed. A copy

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of the post mortem report will then be sent to the police SIO if a forensic post mortem examination has been conducted and unless contraindicated by the criminal justice process to the Consultant Paediatrician.

The release of the child's body is a matter for the coroner, in consultation with the police SIO if a forensic post mortem examination has been conducted.

The coroner will feedback the preliminary and final post mortem results to the family. If abuse or neglect is suspected and/or the police are undertaking a criminal investigation, the coroner through the police SIO will advise the other professionals what information can be shared with the parents and when.

The pathologist as well as the police if present will inform children's social care if child protection concerns have arisen during the post mortem examination.

Where the cause of death has not been determined at the post mortem examination or the death may have been unnatural, the coroner may hold an inquest.

The police/coroner's officer will prepare a report for the coroner once information relevant to the investigation has been gathered. This report is intended to form the basis of the coroner's decision about whether or not an inquest is necessary.

11.2 Phase 2: The Case Discussion/Meeting (within 5-7 days)

All professionals have a responsibility to ensure that any concerns they may have surrounding the death are passed to the police SIO as soon as possible.

If any new information has emerged since the Information Sharing and Planning Meeting a Case Discussion Meeting must be convened, chaired and minuted by the police to ensure that all agencies are informed and updated and that any concerns are identified and managed. All relevant health and children's social care professionals and relevant professionals from other agencies will be invited to attend the Case Discussion Meeting. If permission is given by the coroner, the preliminary results of the post mortem examination will be made available. The meeting should include the pathologist who may contribute by telephone however all other professionals must attend in person.

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The purpose of the Case Discussion Meeting is to:

- ensure the right support is available to the family.
- review the preliminary results of the post mortem examination. (if available)
- refer to children's social care if abuse or neglect of the deceased child is suspected or there are any safeguarding or child protection concerns for any living children.
- consider the need for a referral to the LSCB for a child practice review.
- ensure agencies are collecting information for the Record of Child Death (see Appendix 5 for a link to Forms), in order that this form may be completed following the final Case Review Meeting.
- identify what further investigations or enquiries are required, agree which agency will undertake each task and agree timescales (which may not exceed those set out in this PRUDiC) for doing so.
- to ensure appropriate support is provided to all professionals who attended the child and family.
- to consider and plan for any media interest in the death.

Minutes will be circulated to all attendees and invited members.

The coroner will be informed of any relevant new information coming to light as a result of these considerations. This will be the responsibility of the police SIO.

11.3 Phase 3: The Case Review Meeting (within 3-6 months)

A multi-agency Case Review Meeting is to be held as soon as possible once the results of all relevant investigations have been obtained. The final results of the post mortem examination will be necessary to inform this Meeting. These are usually available within three months of the child's death, but may not be available until after the inquest. Release of the final results of the post mortem examination is at the coroner's discretion. This is more likely if the inquest or trial has been concluded.

All relevant records will be available at this meeting, including the minutes and decisions of the initial Information Sharing and Planning Meeting and the Case

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Discussion/Meeting. If this meeting is held after the inquest, consideration should be given to applying to the coroner for a transcript of the evidence, particularly if no professional at the meeting attended the inquest and significant issues have arisen.

This meeting will be convened and chaired and minuted by the a senior Public Protection Officer and will involve those invited to the previous information sharing meetings and others if the information gathered indicates that this may be helpful to the process.

The purpose of the Case Review Meeting is to:

- Agree how families will be provided with on-going support, giving consideration to siblings and the immediate peer group who may require specialist support services experienced in working with children and young people.
- Share information to identify those factors that may have contributed to the death.
- Explicitly address the possibility of abuse or neglect as causes or contributory factors in the death; this will be recorded. If no evidence is identified to suggest abuse or neglect this will be documented in the minutes of the meeting. Consider whether a referral for a Child Practice Review (previously Serious Case Review) is required.
- identify potential lessons to be learnt
- identify issues for consideration by the ~~N~~CDR Panel Programme
- identify training requirements
- Agree how the parents will be informed about the outcome of the meeting; Information sharing with families must be consistent with the requirements of the coroner and the police enquiries.
- Complete the Record of Child Death according to the type of death (see Appendix 5 for a link to Forms). This will be done by the member of the HB Safeguarding team. The completed form will be sent to the CDR Programme. A copy of the completed form will be held with the Safeguarding team member to inform further communication with the family. Where other investigations are ongoing, the meeting will conclude

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with a record of the current situation. The Record of Child Death from the multiagency Case Review Meeting in all cases will be sent to the coroner.

Minutes will be circulated to all attendees and invited members.

The Consultant Paediatrician will write a letter to the parents offering to meet them to discuss the available information concerning the cause of the child's death, answer any questions, and offer future care and support. If this meeting has taken place before the inquest, consideration will be given to a further meeting after the inquest.

The Child Death Review (CDR) Programme will review the deaths of all children. This will be a paper exercise based on the information available from those who were involved in the care of the child, before and after the death, and will include the Record of Death. The CDR Programme will produce annual reports listing all deaths and broad category of death e.g. infection, cancer, congenital abnormality, accident. The CDR Programme will facilitate the identification of preventable factors to enable recommendations to be published. These recommendations in particular will focus on issues that may be preventable

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Appendix 1:
Glossary of Terms

ACPO – Association of Chief Police Officers

CP – Child Protection

ED – Emergency Department

GP – General Practitioner

LSCB – Local Safeguarding Children Board

CDR – Child Death Review

PRUDiC – Procedural Response to Unexpected Deaths in Childhood

SIO – Senior Investigating Officer (Police)

Appendix 2:
Pointers for all professionals in talking with bereaved parents

Adapted from advice given by the Lullaby Trust

- When you arrive, always say who you are and why you are there, and how sorry you are about what has happened to the child.
- The parents will be in the first stages of grief and may react in a variety of ways, such as shock, numbness, anger or hysteria. Allow the parents space and time to cry, to talk together and to comfort any other children. These early moments of grieving are very important. Parents may want to hold their child and this can be facilitated, if appropriate, but may need to be supervised.
- In talking about the child preferably use the first name, or, if you don't yet know the name, say 'your child', or 'he' or 'she'. Don't refer to the child as 'it'.
- Have respect for the family's religious beliefs and culture, including funeral practices. Be aware that individuals may only adhere to parts of a religion and that there are enormous variations within every set of beliefs.

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- Consideration should be given to when the body can be released for the funeral. Parents should be kept fully informed if there is to be a delay.
- Be sensitive to non-traditional family structures, e.g. same sex relationships, stepfamilies, foster parents and grandparents as guardians.
- If English or Welsh are not their first language, an interpreter should be arranged.
- Ask the family how they wish to be addressed, how to pronounce their name and how to spell it. Do not record or address a Muslim man or a Sikh man or woman by his/her religious name alone.
- Take things slowly, allowing the parents to gather their thoughts and tell the story in their own way.
- Be prepared to answer practical questions, for example about where the child will be taken and when they can next see him/her.
- Most parents feel guilty when their child has died. When talking to them try to ask questions in a neutral way, e.g. 'Would you like to tell me what happened?' Avoid questions that sound critical, such as 'Why didn't you?'
- Don't use such phrases as 'suspicious death' or 'scene of crime', and try to avoid comments that might be misunderstood by, or distressing to, the parents.
- Consideration should be given to breastfeeding mothers

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Appendix 3:

Sources of Family Support

- **The Child Bereavement Charity**

Support for parents and children who have been bereaved.

Helpline: 0800 02 88840

09.00 - 17.00, Monday - Friday

www.childbereavement.org.uk

- **The Child Death Helpline**

The Child Death Helpline is a helpline for anyone affected by the death of a child of any age, from prebirth to adult, under any circumstances, however recently or long ago. Calls are answered by a bereaved parent, trained and supported by professional staff. Please note this is a listening service not a counselling service although they can provide details of services in local areas.

Helpline (Freephone): 0800 282 986

Additional freephone number for all mobiles: 0808 800 6019

The helpline is open every day of the year from

19.00 - 22.00, every evening

10.00 - 13.00, Monday - Friday

13.00 - 16.00, Tuesday - Wednesday

<http://www.childdeathhelpline.org.uk/>

- **The Compassionate Friends**

Support for bereaved parents and their families.

Helpline: 0845 123 2304

10.00 - 16.00/ 19.00 - 22.00, every day

www.tcf.org.uk

- **Cruse Bereavement Care**

Support for anyone who is bereaved.

Helpline: 0844 477 9400

Children and Young People's Helpline (Freephone):

0808 808 1677

09.30 - 17.00, Monday - Friday

www.cruse.org.uk

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- **The Lullaby Trust (formerly the Foundation for the Study of Infant Deaths)**

Support and information for anyone who has suffered the sudden death of an infant, including their family, friends and professionals involved with the death. The Foundation has a wide range of leaflets and information for bereaved families and professionals. It also has a network of befrienders who are bereaved parents. Arrangements can be made for a befriender to contact the bereaved family to offer additional support.

Helpline (Freephone): 0808 802 6868
10.00 - 23.00, Monday - Friday
18.00 - 23.00, Weekends & Bank Holidays
<http://www.lullabytrust.org.uk>

- **Survivors of Bereavement by Suicide**

Support for those bereaved by suicide.

Helpline: 0844 561 6855
09.00 - 21.00, every day
www.uk-sobs.org.uk

- **Winston's Wish**

Support for bereaved children and young people aged up to 18 years.

An interactive website is also available.

Helpline: 0845 203 0405
09.00 - 17.00, Monday - Friday
www.winstonswish.org.uk

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Appendix 4:

Seven Key Strands for all Agencies to consider when a Child Dies Unexpectedly

All of these strands will need management throughout the PRUDiC. Deaths involving child protection concerns and those needing a Child Practice Review (formerly serious case review) and/or attracting media attention will be especially challenging and will be managed by the LSCBs. The seven key strands are:

a) Care of the bereaved family: Ensuring at every phase that the needs of the bereaved family are of paramount consideration to any professional involved with a family where a child is dying or has died. This includes the welfare and protection of remaining siblings, spiritual needs and possible involvement of the extended family. (See Appendix 3 for Sources of Family Support).

b) Deciding on response: Where professionals are uncertain about whether the death is unexpected, death will be treated as unexpected and the Prudic procedure will be followed.

c) Notification to the CDR Programme : The CDR Programme will be notified of all child deaths-following the Initial Information Sharing Meeting using the Child Death notification form (see appendix 5 for a link to forms)

d) Child Protection: Emerging information giving rise to child protection concerns about remaining siblings and/or other children in the household or peer group must take priority and will require formal referral to children's social care in line with All Wales Child Protection Procedures (see Appendix 5 for a link to All Wales Child Protection Procedures).

e) Child Practice Review (formerly Serious Case Review): All agencies need to be mindful of any emerging information giving rise to the need for the LSCB to consider conducting a child practice review. The decision to undertake the review must be taken by the Chair of the LSCB where the child normally resided.

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f) Media issues: All Local Safeguarding Children Boards should have a process for managing media interest. Staff must be enabled to proceed with their functions without intrusion and the family provided with privacy. There should be a coordinated response to media enquiries and press releases, agreed by all relevant agencies (where possible at the information sharing meetings). Agencies must be mindful of not compromising potential criminal investigations. Media attention and enquiries will be managed by the police press office and the coroner where the child actually died.

g) Support to staff: Child deaths will have varying degrees of impact on staff. Agencies need to be aware that clear procedures, effective communication and leadership, will provide staff with confidence and enable them to respond appropriately to families. Agencies should have arrangements in place to support staff who may be affected by the issues involved.

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Appendix 5: Resources

- Association of Chief Police Officers (ACPO) 2006 Guidelines Infant Death: Murder Investigation Manual

- All Wales Child Protection Procedures
<http://www.awcpp.org.uk>

- **Care Pathways**

Agencies are encouraged to develop local operational care pathways, e.g. flowcharts of responsibilities, proformas including history taking and physical examination.

- **End-of-Life Plans**

All-Wales Emergency Care Pathway

Together for short lives

www.act.org.uk/page.asp?section=99&search=end+of+life+plan

- **CDR Programme Forms**

Child Death Notification form

Record of death form (according to the type of death)

These can be found at

<http://howis.wales.nhs.uk/sitesplus/888/page/50436>

- **Information Sheets related to responding when a child dies, on the Department for Children, Schools and Families website, including:**

Death Registration and Inquests

Deaths in Children with Life-Limiting Conditions

Organ and Tissue Donation

Supporting Families

The Home Visit – Reviewing the Circumstances of Death

The Role of Children’s Social Care

The Role of Health Professionals

<http://childdeath.ocbmedia.com/Information-sheets-and-proformas/>

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- **Human Tissue Authority Guidelines**

<http://www.hta.gov.uk/licensingandinspections/sectorspecificinformation/postmortem.cfm>

- **Kennedy Report** (Sudden unexpected death in infancy: A multi-agency protocol for care and investigation)

<http://www.rcpath.org/NR/rdonlyres/30213EB6-451B-4830-A7FD-4EEFF0420260/0/SUDIreportforweb.pdf>

- **Pathology Guidelines**

The Royal College of Pathologists: Guidelines on Autopsy Practice – Best Practice Scenarios

Scenario 8 – Sudden Unexpected Death in Infancy (SUDI)

<http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/A/AutopsyScenario8Jan05.pdf>

Scenario 9 – Stillborn Infant – Singleton

<http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/G/G001Autopsy-Stillbirths-Jun06.pdf>

Scenario 10 - Neonatal Death

<http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/G/G002Autopsy-NeonatalDeath-Jun06.pdf>

- **Standards for Radiological Investigations of Suspected Non-accidental Injury RCR and RCPCH March 2008**

http://www.rcr.ac.uk/docs/radiology/pdf/RCPCH_RCR_final.pdf

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Appendix 6: Welsh Ambulance Services NHS Trust

WAST Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

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

The attending EMS staff should:

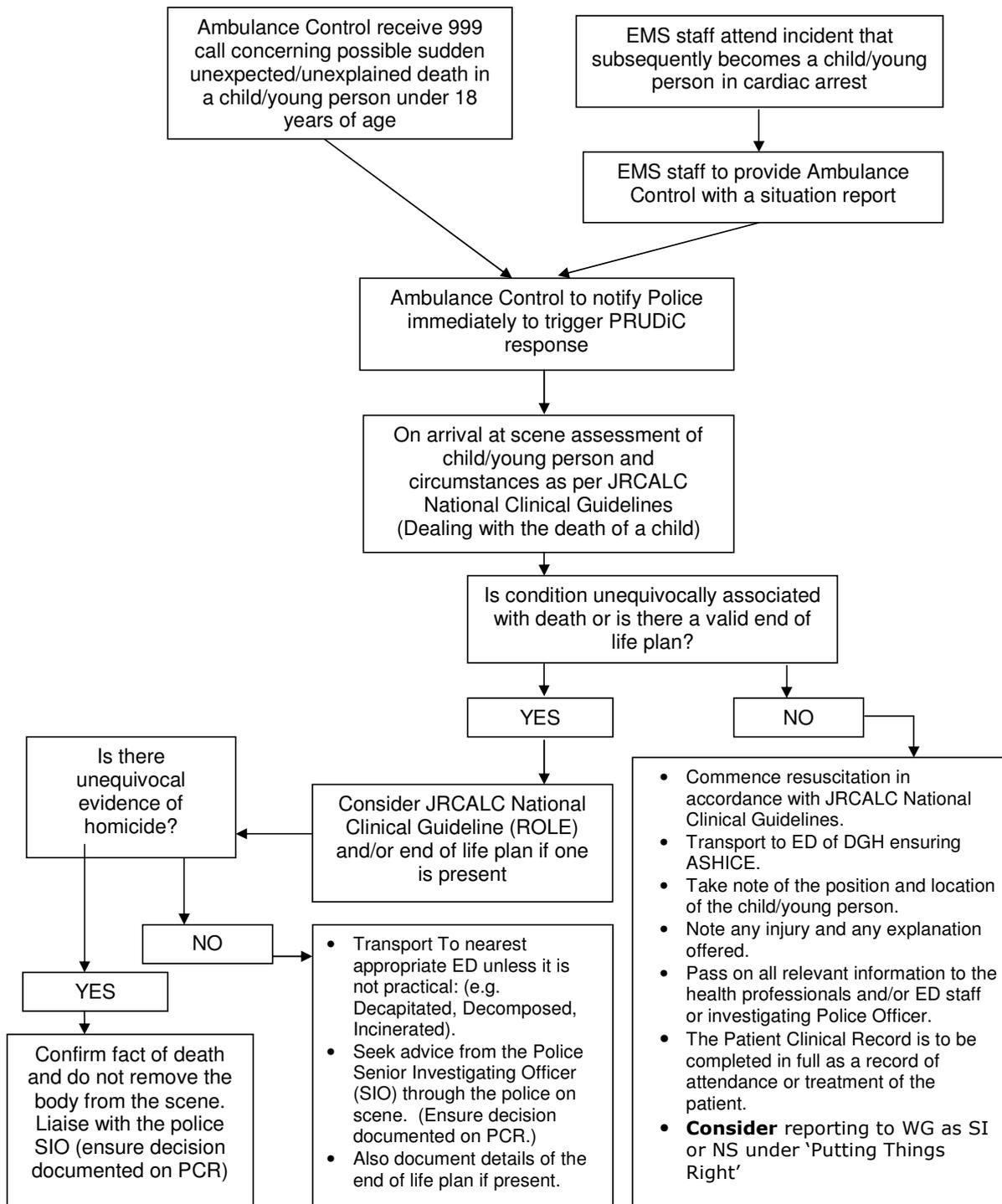
- a) Not automatically assume that the death has occurred.
 - b) Clear the airway and if in any doubt about death, apply full CPR.
 - c) Inform the emergency department (ED) giving an estimated time of arrival and patient's condition.
 - d) Transport the child to an ED at one of the District General Hospitals (DGH).
 - e) Take note of the position and location of the baby or child.
 - f) Note any injury and any explanation offered.
 - g) Pass on all relevant information to the health professionals and/or ED staff or investigating Police Officer.
 - h) The Patient Clinical Record (PCR) is to be completed in full as a record of attendance or treatment of the patient.
- Ambulance staff should remove the child/young person to the ED of the local DGH rather than to the mortuary, even if the death has been determined at home unless the child is obviously dead AND there are suspicious circumstances where removing the body from the scene could cause loss of evidence.
 - Exceptions to this would include situations that are unequivocally associated with death as a result of decapitation, decomposition, incineration where removal is not practical.
 - Seek advice from the Police Senior Investigating Officer (SIO) through the Police on scene (ensure decision documented on PCR).
 - Best practice would recommend that the crew gain confirmation that the Police will be informing the relevant paediatrician if the child is not being conveyed to ED to ensure the correct procedures are triggered.
 - The main reason for taking the child/young person to the ED rather than the mortuary are that an immediate examination can be made by the paediatrician and parents/carers can talk with the paediatrician and be provided with bereavement support.
 - In circumstances of a suspicious death the first Police Officer on scene should make this decision, seeking advice from a Police Senior Investigating Officer (SIO) as appropriate. (This decision should be captured on the PCR).

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- The first professional on scene (e.g. ambulance, GP) should note the position of the child, the clothing worn and the circumstances of how the child was found.
- If the circumstances allow, note any comments made by the carers, any background history, any possible drug misuse and the conditions of the living accommodation.
- Any such information must be passed on to the receiving doctor, the Police and the Consultant Paediatrician.
- Any concerns should be reported directly to the Police and to the receiving doctor at the hospital as soon as possible
- Consider the need to report (as a Serious Incident (SI) or No Surprises (NS) incident) to WG in accordance with the 'Putting Things Right' guidance.

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WAST Procedural Response to Unexpected Deaths in Childhood (PRUDiC)



Appendix 7:

Role of Police

The relevant guidance for the police is the Association of Chief Police Officers (ACPO) 2006 Guidelines on Infant Death Investigation. The full guidelines must be referred to during an investigation. These guidelines are available within Force and within the Murder Investigation Manual 2006 (supplementary reading CD-ROM).

Road Traffic Collision

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

Homicide and Suspicious Child Death Summary Sheet

The topic of child death investigation has received unprecedented media coverage in the current political climate following the case of Baby Peter ('P'). ACPO Homicide sub-group are currently reviewing suspicious child death cases in order to assess if there are similar circumstances apparent which could assist investigators in future investigations. In order to facilitate this the NPIA are coordinating the responses from SIOs who are asked to submit form 76 to the NPIA at the outcome of any child homicide investigation or suspicious death enquiry (coroners inquest verdict). Your support and cooperation in supplying this valuable data would be greatly appreciated.

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Appendix 8:

Role of HM Coroner

HM Coroner must be informed of any death, the cause of which is apparently unknown or apparently unnatural, or in certain other specified circumstances, and will order an investigation into the circumstances and cause of that death. After the death is pronounced, the coroner has control of the body until s/he releases it. The coroner can release the body at any time during his investigation and before he decides if an inquest is necessary.

The coroner's officer will inform the family of HM Coroner's roles and procedures and keep the family informed of the child's whereabouts until the coroner has signed release paperwork for the child. It is important this information is shared only by the coroner's officer as any misinformation may cause additional distress to the family.

As the legal authority charged with the investigation and certification of all unexpected deaths, the coroner must be kept informed of all significant information obtained from the multi-agency communications and interviews with parents.

The coroner, usually via a coroner's officer, is responsible for informing the family about what organs and/or tissue samples have been retained to allow discussion of options for disposal. The family's wishes regarding disposal must be made known to the pathologist and the coroner.

The record of death from the multi-agency Case Review Meeting will in all cases be sent to the coroner, and in some instances the coroner's officer will choose to be present at this meeting. This completed form will ensure that, where the cause of death has been certified by the coroner without an inquest, any new or more accurate information is appropriately notified to the registrar of births and deaths for onward transmission to the Office for National Statistics.

For those instances in which the coroner has ordered an inquest, the information from the Case Review Meeting may inform and assist the conduct of the inquest.

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If the death is recognised from the outset as being from natural causes, the attending doctor will sign the medical certificate of cause of death. The coroner may notify the registrar that no coronial inquiry is to be held. The death can then be registered and a death certificate issued. If there is to be a post mortem examination and/or an inquest or trial, the coroner will notify the registrar of the medical cause of death at the appropriate time.

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Appendix 9: Membership of the Multi-agency Working Group

Ali	Davies	Safeguarding Manager (Children) Powys County Council
Andrea	Mazloom	Operational Manager Social Services Cardiff County Council
Andrew	Barkley	Acting Senior Coroner, Bridgend, Glamorgan Valleys & Powys
Andrew	MacNab	Consultant in Emergency Medicine ABMUHB
Angela	Wragg	Specialist Nurse Safeguarding Children Powys Teaching HB
Beverley	Heatman	Child Death Review Manager Public Health Wales
Charles	Allanby	GPC Wales
Christine	Hinton	Safeguarding Children Specialist Paramedic WAST NHS Trust
Debbie	Pachu	County Lead Safeguarding Children Hywel Dda HB
Gloria	Smith	Safeguarding Children Training & Development Facilitation - Public Health Wales
Ian	Smith	Named Professional Safeguarding Children WAST NHS Trust
Jane	O'Kane	Professional Head of Health Visiting ABMUHB
Jane	Randall	Head of Safeguarding Cwm Taff LHB
Jane	Rowlands-Mellor	Senior Nurse Bereavement Service Cardiff & Vale UHB
Janet	Young	Lead Forensic Physician TASCOR
Jo	Parker	AMD Primary Care Governance ABMUHB
Kathryn	Lewis	Head of Safeguarding Children ABMUHB
Lindsay	Groves	Acting Consultant Community Paediatrician & Named Doctor Child Protection BCUHB
Liz	Pearce	Head of Safeguarding & Standards RCTCBC
Lorna	Price	Designated Doctor for Safeguarding Children & LAC – Public Health Wales (Chair)
Mari	Higginson	Clinical Nurse Specialist Safeguard Children ABMUHB
Michelle	James-Ellison	Consultant Paediatrician ABMUHB
Nigel	Farr	National Safeguarding GP Public Health Wales Representing RCGP
Paula	Davies	Nurse Team Leader District Nursing ABMUHB
Pauline	Galluccio	Named Nurse Child Protection Powys LHB
Pearl	Huey	Service Manager for Cellular Pathology BCULHB

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Rhian	Burke	Bereaved Family Representative
Rhiannon	Thomas	Safeguarding Children Specialist Nurse WAST
Shane	Williams	Detective Chief Inspector Criminal Investigation Department - Carmarthen
Sian	Moynihan	Lead Consultant Community Paediatrician Assistant Clinical Director Cardiff & Vale UHB
Stephen	Leadbeatter	Senior Lecturer in Forensic Pathology Cardiff & Vale NHS – Histopathology
Susan Anne	Jones	Lead Nurse School Health Nursing ABMUHB
Tom	Atherton	Senior HM Coroner Cardiff & The Vale of Glamorgan
Velupillai	Vipulendran	Named Doctor Safeguarding HDHB
Virginia	Hewitt	Named Midwife for Safeguarding Children ABMUHB
William	Davies	Detective Chief Inspector Public Protection Unit Pontypool

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