Child Death Investigation Policy

Abstract

This document details how sudden or unexpected Child Deaths will be investigated in Surrey.

Policy

1. Introduction

This policy and procedure must be followed when investigating sudden or unexpected child deaths.

2. Scope

The death of an infant or child (less than 18 years old) which:

- was not anticipated as a significant possibility for example, 24 hours before the death or;
- where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

3. Policy Statement

3.1 All investigations into the sudden or unexpected death of a child (SUDC) should be conducted in line with the following guidance:

- Authorised Professional Practice - A Guide to Investigating Child Deaths
- Child Death – How to trigger a Joint Agency Response
- SUDI and SUDC Investigation Workbook

3.2 In cases where there is a suspicion that a crime may have been committed this guidance should be used as a supplement to the Major Crime Investigation Manual 2021

4. Joint Agency Response

4.1 All investigations into Child Death should trigger a Joint Agency Response where the death:

- is or could be due to external causes;
- is sudden and there is no immediately apparent cause (incl. SUDI/C);
- occurs in custody, or where the child was detained under the Mental Health Act;

- where the initial circumstances raise any suspicions that the death may not have been natural; or
- in the case of a stillbirth where no healthcare professional was in attendance

4.2 A Joint Agency Response should also be triggered if such children are brought to hospital near death, are successfully resuscitated, but are expected to die in the following days. In such circumstances the Joint Agency Response should be considered at the point of presentation and not at the moment of death, since this enables an accurate history of events to be taken and, if necessary, a 'scene of collapse' visit to occur.

5. Attendance requirements

5.1 In all cases of SUDC, whether or not there are any obvious suspicious circumstances, an officer of at least Detective Inspector (DI) rank must be tasked to immediately take charge of the investigation and attend the scene.

5.2 Where available, a DI who has received training in Investigating Sudden Childhood Death will be deployed to lead the investigation. Where this is not possible the attending DI must consult with a DI who has received training in Investigating Sudden Childhood Death at the earliest suitable opportunity.

5.3 Where a child death is as a result of a road traffic collision (RTC) normal arrangements for the investigation of RTCs will apply. The reviewing RTC SIO is responsible for ensuring they have consulted with a DI who has received training in Investigating Sudden Childhood Death at the earliest suitable opportunity. They should agree ownership for the investigation and commencement of the joint agency reponse.

5.4 The lead investigatior is responsible for liaison with SOCO as part of the initital response in order to agree a forensic strategy and attendance requirements.

5.5 If at any stage the inquiry indicates that the death of the child is suspicious then a PIP level 3 SIO should be deployed to take command of the investigation.

5.6 The lead investigator will make use of the SUDI and SUDC Investigation Workbook

5.7 They will ensure this information gathering document is completed. It is expected that information will be obtained from different sources and agencies and will be entered into this document as the investigation progresses. Use will be made of parent/carer interview(s), reviews of all medical records including parent-held records, police and social services records, multi-agency discussions and meetings along with a home/scene visit and assessment. This document is be treated as an active document during the investigation of the child's death. Information gathered and recorded in this document is available for sharing with all partner agencies, under the information sharing protocols.

5.8 The lead investigator will ensure there is appropriate NICHE recording of the investigation and use of the NICHE policy file to maintain a record of decisions.

5.9 The lead investigator is responsible for ensuring that operational de-briefs are conducted and the Child Death Investigation de-brief form is completed.

5.10 The lead investigator is responsible for considering wider organisational learning and where appropriate completing the learning template. Organisational Learning Template

5.11 The lead investigator must ensure that a key consideration is the welfare of all staff involved in the initial attendance and investigation through liaison with their line management. The following should form part of considerations; Peer Support, Occupational Health Hub, Employee Assistance Programme (EAP)**,**The Wellbeing Hub, Mental Health First Aiders, Fast time Hot Debriefs, Defuse, Focus Meetings, Wellbeing Meetings / Time to Talk sessions, Wellbeing Health Checks, Chaplaincy, Mental Health app Backup Buddy, Enable - Surrey Police, Wellbeing Strategy Document v8

6. Referral requirements

All unexpected child deaths (Under 18) must be referred to:

- The relevant Coroner.
- Childrens Services - The divisional Child Abuse Team are to enable a strategy meeting to take place with Children's Services in line with Child Protection Procedures.
- OP Marshall (A national database to assist strategic analysis and inform future prevention and detection initiatives in relation to inframalial child homicide or suspicious death investigations) – where criteria is met. Operation Marshall Criteria Document, Op Marshall Form A, Op Marshall Form B, Op Marshall Form C.
- The Child Death Overview Panel (CDOP) as outlined within page 5 of the SUDI and SUDC Investigation Workbook