Sudden unexpected death in childhood (SUDIC)

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Flowchart

**First 2-4 hours**

- Ambulance and police immediate response
- Assess immediate risks/concerns
- Resuscitation if appropriate
- Police consider appropriate scene security
- Consider needs of siblings and other family members

- Where appropriate, child and carer transferred to hospital with paediatric facilities. Resuscitation continued/decision to stop - Hospital staff notify police - Lead police investigator attends hospital

- Responsible clinician confirms death
- Support for carer(s) and other family members
- Initial discussion between paediatrician and attending lead investigator
- Paediatrician (where possible, jointly with attending police officer) takes initial history, examination, and immediate investigations

**24 - 48 hours**

- Initial information sharing and planning meeting/discussion - Consideration of need for s47 strategy meeting

- Joint home visit by police and paediatrician/nurse

- Coroner arranges post-mortem

- Post-mortem examination and ancillary investigations

- Further police investigations - Review of health and social care information

**1 - 6 months**

- Local case discussion - Review of the circumstances of the death - Ongoing family support including appropriate feedback of outcomes of Local Case Discussion

- Coroner’s inquest

- Child Death Overview Panel
Policy statement

Summary

West Yorkshire Police understands that the sudden death of an infant or child is a tragedy. Some deaths result from previously unrecognised medical conditions or unintentional incidents. However, research suggests that between 5–10% of sudden unexpected deaths in infancy (SUDI) might be covert homicides where parental action or actions by third parties through abuse or neglect may have caused or contributed to the death.

The purpose of this policy is to assist police officers and police staff in all cases of Sudden Unexpected Deaths in Children whether or not there is suspicion that a crime may have been committed.

Scope

This policy applies to all police officers and police staff.

Principles

West Yorkshire Police will:

• Whatever the understanding of the underlying cause of death or any contributory factors, treat the bereaved family and the deceased child with sensitivity and respect.

• Adhere to the guidance provided by the ACPO (2006) Murder Investigation Manual (MIM) and the ACPO (2014) Guide to investigating child deaths to develop strategies and provide a clear framework for all investigations.

  The three distinct strategic phases of investigating need to be followed:

  o Instigation and initial response – This involves the deployment of officers to the report of an incident, which may be a homicide, and the action they take to secure the scene, identify suspects and locate evidence, in essence carry out fast track actions and the ‘Golden Hour’ principles.

  o The investigation – this involves developing investigative strategies for establishing cause of death and who, if anyone, is responsible for the death.

  o Case management – pre and post charge or inquest.

• Follow five common principles when dealing with a SUDIC, especially when having contact with family members, which mean:

  o a balanced approach between sensitivity and the investigative mind-set;

  o a multi-agency response;

  o sharing of information;

  o an appropriate response to the circumstances; and

  o preserving evidence.

• Ensure individuals and agencies applying these principles, do so in a way that their actions are legal, necessary, relevant and proportionate in order to comply with the Human Rights Act 1998.
• Investigate a SUDIC in line with principles within the National Decision Model and Code of Ethics. Any failure to adhere to those standards would breach policy as well as ethical behaviour and might have a negative impact on the reputation of the Force.
• Investigate based on the fact that children are not meant to die. This means even when there are no apparent suspicious factors, the police investigation will still be detailed and thorough.
• Acknowledge that the investigation into the death of a child is an extremely complex area of police work and very demanding for investigators in terms of emotional pressure.
• Ensure those professionals involved in caring for the infant and responding to the death provide all relevant information to the coroner to enable them to determine the cause of death.
• Ensure investigating officers, lead investigators and senior investigating officers (SIOs), who respond to sudden unexpected deaths of children, receive appropriate training to enable them to perform the role.
• Retain all documents and information in line with the APP Information management (Management of police information) on the retention and disposal of material gathered during the investigation of serious crime.

Criteria

The principles of this policy apply to the death of an infant or child younger than 18 years old.

Responsibilities

First officer on scene / initial responder

Detective

Initial responders are responsible for:
• Keeping police attendance to a minimum while maintaining the opportunity to secure and preserve evidence. The first responder should be a detective officer in plain clothes (wherever possible) and use an unmarked police vehicle as several police officers arriving at a house can be distressing, especially if they are uniformed officers in marked police cars.
• Assessing and preserving any evidence and secure crime scenes whilst being cognisant to the five investigative building blocks:
Adopting this broader investigative mind-set while remaining sensitive and respectful in line with the above principles.

**Lead investigator**

The lead investigator should be a district based safeguarding detective inspector. In the early stages of the investigation, this may be the night Cadre DI. However, the matter should be handed on to a safeguarding specialist at the earliest opportunity. If for any reason this is impracticable it will be for the local SLT to provide rationale as to why a safeguarding lead has not been appointed.

Lead investigators are responsible for:
- Immediately take charge of the investigation.
- Appointing a team investigators even where there are no apparent suspicions.
- Initially attending the location of the body (usually the hospital) to liaise with the lead clinician and other medical practitioners.
- Providing details of the incident to a PIP (Professionalising the Investigation Process) 3 accredited SIO as soon as practicable.
- Managing the ongoing investigation in line with agreed memorandum of understandings on the primacy of the investigation.

**Investigating officers**

Investigating officers in the team are responsible for:
- Being appropriately training in order to enable them to perform the role and:
  - assessing and managing scenes;
  - carrying out interviews; and
  - following lines of enquiry.
Senior investigating officer (SIO)

**Information**

The senior investigating officer is responsible for:

- If at any stage, the enquiry indicates that the death of a child is suspicious, taking command of the investigation (providing they are a PIP level 3 SIO).
- Where the matter remains unexplained, overseeing the lead investigator.
- Ensuring that policy and actions are maintained to effectively understand, where possible, what has occurred.
- Providing the necessary support and resourcing to ensure any investigation provides the best opportunity to allow the coroner to make an informed decision on the cause of death.

Head of Crime

**Responsibility**

Head of Crime (or their nominated deputy) is responsible for:

- If at any stage, the enquiry indicates that the death of a child is suspicious, deploying a PIP level 3 SIO to take command of the investigation.

Additional information

**Compliance**

This policy complies with the following legislation, policy and explanatory notes:

- **APP Information management**
- **APP Investigation**
- **APP Major investigation and public protection**
- **APP National decision model and Code of Ethics**
- **ACPO A guide to investigating child deaths**
- **Royal College of Pathologists / Paediatrics and Child Health (RCPCH) - Sudden unexpected death in infancy – A multi-agency Protocol for Care and Investigation**
- **ACPO Murder Investigation Manual**
- **Her Majesty’s Coroner’s memorandum of understanding for SUDIC rapid response process.**
- **NPCC Rapid response record**
Policy database administration

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The Equality and Human Rights Assessment for this policy is held on Force Registry which can be accessed via [this link](#).

The table below details revision information relating to this document:

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