HEDDLU GOGLEDD CYMRU
NORTH WALES POLICE

Response Date:17/08/2026

2026/780 - Roles and responsibilities of North Wales Police and Children's

In response to your recent request for information regarding;

This request concerns currently operative (i.e., in force as of the date of this request) recorded policy, guidance or protocol governing how North Wales Police officers should interact with local authority Children's Services in safeguarding matters. I am not requesting information about any individual case.

Please provide:

Any current policy, procedure, protocol, or memorandum of understanding setting out the respective roles and responsibilities of North Wales Police and local authority Children's Services when both are involved in a safeguarding concern.

Any current policy, guidance or training material addressing whether, and in what circumstances, officers should:

treat Children's Services' assessment or professional judgement as the basis for police decision-making; or independently assess the available evidence before reaching a police conclusion.

Any current policy, guidance or training material using or explaining the concept of "professional curiosity" (or equivalent terms such as "respectful challenge" or "respectful uncertainty") as applied to information received from a partner agency such as Children's Services.

Any current multi-agency protocol or information-sharing agreement between North Wales Police and the six local authorities within the force area that governs investigative responsibility or decision-making in joint safeguarding cases (for example, a Multi-Agency Safeguarding Hub protocol). I am not seeking operational risk-assessment thresholds or case-scoring criteria if these are held separately and would fall under a law enforcement exemption, only the governance/roles content.

Confirmation of which of the following instruments North Wales Police has formally adopted or references in the policies above, with a link or title where the document is already published:

Working Together to Safeguard People (Social Services and Well-being (Wales) Act 2014, statutory guidance) The Wales Safeguarding Procedures The Single Unified Safeguarding Review (SUSR) statutory guidance Any College of Policing Authorised Professional Practice (APP) on multi-agency working or information sharing Any other national policing guidance If no recorded policy exists stating that police

should adopt or defer to Children's Services' assessment, please confirm that no such recorded policy is held, rather than treating this as "not held" in relation to the whole request.

Training
The following is covered within the Child Abuse Module 4 titled: Multi- Agency approach to dealing with Child abuse. The following subjects are covered:

Public protection units and their role and responsibilities.
Other agencies involved in the care and protection of children
Local safeguarding boards
Strategy meetings
Joint visits
Child protection conferences
Protocols for sharing information

All training, operational guidance, and assessments are informed by and reference the All-Wales Safeguarding procedures which North Wales Police adhere to.

It is these guidelines that are promoted within all the training material, across all the courses that the ITDC deliver where safeguarding is included.

https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwin5KD1uI6WAxXmTkEAHdwGOQAQFnoECBYQAQ&url=https%3A%2F%2Fwww.safeguarding.wales%2F&usg=AOvVaw2JE70tvYiC9v8lH3_aLKvh&opi=89978449

https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwin5KD1uI6WAxXmTkEAHdwGOQAQFnoECCcQAQ&url=https%3A%2F%2Fwww.gwentsafeguarding.org.uk%2Fen%2Fsafeguarding-adults%2Fthe-wales-safeguarding-procedures-for-children-and-adults-at-risk-of-abuse-and-neglect&usg=AOvVaw1NnxpZmBEfAyzDlc7ndOMl&opi=89978449

Crime Services
Please note that the North Wales Safeguarding board hold all relevant joint protocols and the force adheres to the relevant national legislation and safeguarding procedures;

- **Working Together to Safeguard People (Social Services and Well-being (Wales) Act 2014, statutory guidance) - working-together-to-safeguard-people-volume-i-introduction-and-overview.pdf**
- **All Wales Safeguarding Procedures - Safeguarding Wales**
- **North Wales Safeguarding Board protocols - Policies and Procedures – North Wales Safeguarding Board**
- **SUSR guidance - Single Unified Safeguarding Review: statutory guidance**
- **College of Policing Child Protection APP - Key definitions | College of Policing**
- **Procedural response to unexpected deaths in childhood (PRUDIC) –** see attached

Training have advised they use the professional curiosity guidance as well as the All Wales Safeguarding procedures within all relevant training.
Additionally, a new College of Policing training product 'Every voice matters' - a four-part e-learning series for police officers and staff working in or preparing to join a multi-agency safeguarding hub (MASH) will be completed by all of the team this year. 2 of the modules will cover the following:
- Module 3 — Every Voice Matters: Information Sharing. Focuses on timely, lawful and proportionate information exchange with partner agencies.
- Module 4 — Every Voice Matters: Monitoring MASH Practice. Covers oversight, challenge and governance to ensure practice is consistent, accountable and responsive to change.

Sharing agreements;
All our MARAC Information Sharing Agreements with the six local authorities are published and available to the public as part of WASPI. They are available online here for the requestor to access: Register of ISPs - Welsh Accord on Sharing of Personal Information

The relevant ID's are:

DS016324	060 - Multi Agency Risk Assessment Conference (MARAC) - Wrexham
DS016335	091 - Multi Agency Risk Assessment Conference (MARAC) - Gwynedd
DS016336	092 - Multi Agency Risk Assessment Conference (MARAC) – Flintshire
DS016350	093 - Multi Agency Risk Assessment Conference (MARAC) – Denbighshire
DS016351	100 - Multi Agency Risk Assessment Conference (MARAC) – Ynys Mon
DS016352	104 - Multi Agency Risk Assessment Conference (MARAC) – Conwy

THIS INFORMATION HAS BEEN PROVIDED IN RESPONSE TO A REQUEST UNDER THE FREEDOM OF INFORMATION ACT 2000, AND IS CORRECT AS AT 12/08/2026

NWSCB Practice Guidance

Professional Curiosity

1.0. Professional Curiosity

1.1. Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value.

1.2. This has been described at the need for practitioners to practice '**respectful uncertainty**' – applying critical evaluation to any information they receive and maintaining an open mind. In safeguarding the term 'safe uncertainty' is used to describe an approach which is focused on safety but that takes into account changing information, different perspectives and acknowledges that certainty may not be achievable.

1.3. Professional curiosity can require practitioners to:

- think 'outside the box', beyond their usual professional role, and consider families' circumstances holistically

- Show a real willingness to engage with children, adults and their families or carers.

1.4. Much has been written about the importance of curiosity during home visits and the need for authentic, close relationships of the kind where we see, hear and touch the truth of their experience of 'daily life' and are able to act on it and to achieve similar closeness with parents or carers.

1.5. Practitioners will often come into contact with a child, young person, adult or their family when they are in crisis or vulnerable to harm. These interactions present crucial opportunities for protection. Responding to these opportunities requires the ability to recognise (or see the signs of) vulnerabilities and potential or actual risks of harm, maintaining an open stance of professional curiosity (or enquiring deeper), and understanding one's own responsibility and knowing how to take action.

1.6. Children in particular, but also some adults, rarely disclose abuse and neglect directly to practitioners and, if they do, it will often be through unusual behaviour or comments. This makes identifying abuse and neglect difficult for professionals across agencies. We know that it is better to help as early as possible, before issues get worse. That means that all agencies and practitioners need to work together – the first step is to be professionally curious.

1.7. Curious professionals will spend time engaging with families on visits. They will know that talk, play and touch can all be important to observe and consider. Do not presume you know what is happening in the family home – ask questions and seek clarity if you are not certain. Do not be afraid to ask questions of families, and do so in an open way so they know that you are asking to keep the child or adult safe, not to judge or criticise. Be open to the unexpected, and incorporate information that does not support your initial

assumptions into your assessment of what life is like for the child or adult in the family.

2.0. Thinking the unthinkable

2.1. Safeguarding is everyone's responsibility and where practitioners are concerned each and every agency has a role to play in safeguarding children and adults.

2.2. The following factors highlight the need for all of us to strive to improve professional curiosity and professional courage:

- the views and feelings of children and some adults are actually very difficult to ascertain
- practitioners do not always listen to adults who tried to speak on behalf of a child or another adult and who may have important information to contribute
- parents or carers can easily prevent practitioners from seeing and listening to a child or another adult
- practitioners can be fooled with stories we want to believe are true
- effective multi-agency work needs to be coordinated
- Challenging parents or carers (and colleagues) requires expertise, confidence, time and a considerable amount of emotional energy.

3.0. Communication – the key to Good Multi Agency Practice

Top tips:

<u>Listen:</u>

- speak to other practitioners on a regular basis – don't wait for meetings
- when assessing and managing a case, input from two, three or four sources is better than one
- Sometimes the most important relationship to trust is yourself – if you feel there is a risk that is not being managed and no one is hearing you what do you do, how do you escalate this?
- try to be flexible with meetings to fit around all involved practitioners availability
- don't use jargon – talk to colleagues and families using language they understand and relate to
- include families in decisions about their own lives
- be mindful of personal optimistic bias (wishful thinking) when reviewing the families' progress
- make sure care plans are multi-agency and SMARTER
- self-assessments tools can promote honest discussion
- team managers should attend training for providing effective supervision and reflective practice in managing safeguarding
- Use quality assurance and audit framework such as quality standards to review case records to support good practice that keeps children safe and aids staff continuous professional development (CPD).

Information sharing:

- to support good communication, a formal information sharing arrangement should be in place between all agencies with the purpose and content about requesting and sharing information explicitly agreed
- fears about jeopardising the relationship with the family should not be a barrier to the sharing of information principles from 'the seven golden rules for information sharing' should be followed information should be shared in a timely manner and the family included where it does not increase risk
- all involved agencies should be given ample notice when invited to case review meetings to enable them to provide reports and feedback to contribute to ongoing assessment and review of family progress
- A group of practitioners should maintain contact with each other and make the times of meetings flexible to enable optimal attendance of practitioners.

4.0. Difficult Conversations with Parents/ Carers

4.1. Four factors to consider when preparing for a difficult conversation with a parent or carer are:

1. Principles – that underpin safeguarding children
2. Planning – how to plan or be prepared
3. The conversation – things to consider when having a conversation
4. Examples – open questions and suggestions.

5.0. Professional Curiosity and Culturally Competent Safeguarding Practice

5.1. It is important therefore that practitioners are sensitive to differing family patterns and lifestyles and to child rearing and caring patterns that vary across different racial, ethnic and cultural groups. At the same time they must be clear that child or adult abuse cannot be condoned for religious or cultural reasons.

5.2. All practitioners working with children, young people, vulnerable adults and their parents, carers or families whose faith, culture, nationality and possibly recent history differs significantly from that of the majority culture, must be professionally curious and take personal responsibility for informing their work with sufficient knowledge (or seeking advice) on the particular culture and/or faith by which the child, young person, adult and their family or carers lives their daily life.

5.3. Practitioners should be curious about situations or information arising in the course of their work, allowing the family to give their account as well as researching such things by discussion with other practitioners, or by researching the evidence base. Examples of this might be around attitudes towards, and acceptance of, services e.g. health; dietary choices; education provision or school attendance.

5.4. In some instances reluctance to access support stems from a desire to keep family life private. In many communities there is a prevalent fear that social work practitioners will 'take your children away'. There may be a poor view of support services arising from initial contact through the immigration system, and, for some communities – particularly those with insecure immigration status – an instinctive distrust of the state arising from experiences in their country of origin.

5.5. Practitioners must take personal responsibility for utilising specialist services' knowledge. Knowing about and using services available locally to provide relevant cultural and faith-related input to prevention, support and rehabilitation services for the child, young people or adults (and their family) will support practice.

5.6. This includes:

- knowing which agencies are available to access
- having contact details to hand
- Timing requests for expert support and information appropriately to ensure that assessments, care planning and review are sound and holistic.

6.0. Supervision Curiosity and Safeguarding Practice

6.1. For many agencies, the use of effective supervision is a means of improving decision-making, accountability, and supporting professional development among practitioners. Supervision is also an opportunity to question and explore an understanding of a case.

6.2. Group supervision and Reflective Practice Groups can be even more effective in promoting curiosity and safe uncertainty, as practitioners can use these spaces to think about their own judgments and observations. It also allows teams to learn from one another's experiences, and the issues considered in one case may have echoes in other workloads.

Tips for practice:

- play 'devil's advocate'
- present alternative hypotheses
- Present cases from the child, young person, adult or another family member's perspective.

7.0. Care Settings and Professional Curiosity

7.1. Care setting practitioners are perhaps best placed to notice how adults or children are because they have contact with the same adult or child on a regular basis. Practitioners can see changes in appearance, behaviour, alertness or appetite and provide a degree of monitoring of the adult or child's welfare; in effect, they can be the 'eyes' for other professionals working with them.

7.2. This will also apply to volunteers and workers who run groups and clubs for children, young people or adults.

7.3. There are many examples of good practice in care staff were alert to concerns and were able to demonstrate professional curiosity and awareness of possible maltreatment and cumulative risk.

7.4. Being professionally curious enables practitioners to challenge carers or parents and an adult or child's vulnerability or risk while maintaining an objective, professional and supportive manner. This is not an easy balance.

8.0. Domestic Abuse and Professional Curiosity

8.1. Many Domestic Homicide Reviews and Child Practice Reviews refer to a lack of professional curiosity or respectful uncertainty. Practitioners need to demonstrate a non-discriminatory approach and explore the issues to formulate judgments that translate into effective actions in their dealings with families.

8.2. In particular it is vital that professionals understand the complexity of domestic abuse and are curious about what is happening in the child, adult and perpetrator's life.

8.3. Professional curiosity is much more likely to flourish when practitioners:

- are supported by good quality training to help them develop
- have access to good management, support and supervision
- 'walk in the shoes' (have empathy) of the child and/or adult to consider the situation from their lived experience
- remain diligent in working with the family and developing the professional relationships to understand what has happened and its impact on all family members
- Always try to see all parties separately.

8.4. Working with families where there is domestic violence & abuse can be very challenging and practitioners should not take everything they are told at face value. This is particularly so when a victim is not being seen alone and we should also be alert to the following behaviours which should provoke our professional curiosity:

- the victim waits for her/his partner to speak first
- the victim glances at her/his partner each time they speak, checking her/his reaction
- the victim smooths over any conflict
- the suspected perpetrator speaks for most of the time
- the suspected perpetrator sends clear signals to the victim, by eye/body movement, facial expression or verbally, to warn them
- The suspected perpetrator has a range of complaints about the victim, which they do not defend.

8.5. If these signals are present, the practitioner should find a way of seeing the suspected victim alone. Practitioners must be mindful to the needs of young people who may be experiencing inequality and/or violence in their relationships. Practitioners, however curious, cannot protect children and adults by working in isolation. Domestic abuse requires a multi-agency response and families and communities also have a vital role to play in protecting children and adults.

9.0. Education and Professional Curiosity

9.1. Education staff are perhaps best placed to notice how children and young people are because they have contact with them on an almost daily basis. School staff can see changes – such as in appearance, behaviour, alertness or appetite – and provide a degree of monitoring of the child's welfare; in effect, they can be the 'eyes' for other practitioners working with the young person.

9.2. There are many examples of good practice in education where staff were alert to concerns and were able to demonstrate professional curiosity and awareness of possible maltreatment and cumulative risk.

9.3. Being professionally curious enables practitioners to challenge parents and explore a child's vulnerability or risk while maintaining an objective, professional and supportive manner. This is not an easy balance.

9.4. It can be difficult for children to express concerns about their own wellbeing, so practitioners have a responsibility to create an environment in which they can do so. Schools should be careful of 'organisational deafness' which minimises the chances of really hearing what young people are saying, for example in relation to concerns about their friends.

9.5. Professionals (particularly school staff) should be curious and give sufficient credence to occasions when information is shared by young people.

10.0. Health Practitioners and Professional Curiosity

10.1 Authoritative practice and professional curiosity are vital in responding to the often highly complex cases that are characteristic of Reviews, where multiple risks and vulnerabilities may extend over considerable periods of time.

10.2. An important aspect of authoritative practice is that every practitioner 'takes responsibility for their role in the safeguarding processes. Authoritative practice needs to be underpinned by a culture of supportive supervision and service leads and managers have a responsibility to foster such cultures and model authoritative practice in their own leadership by:

- encouraging all health practitioners to take responsibility for their role in safeguarding process, while respecting and valuing the role of others
- allowing practitioners to exercise their professional judgement in the light of the circumstances of a particular case

- Encouraging a stance of professional curiosity and challenge from a supportive base.

10.3. Tips for health professionals to **Be Curious!**

- know who the named professionals are for your area and that you fully understand their roles – promoting good professional practice and providing advice and expertise for fellow professionals
- ensure that safeguarding is addressed within your clinical supervision
- be aware of the relevant section in the Wales safeguarding procedures
- be aware of the need to always have 'professional curiosity'
- be prepared to be both challenged and challenging within your own professional sphere
- Ensure you know how to escalate safeguarding concerns.

11.0. Police and Criminal Justice Agencies and Professional Curiosity

11.1 Developing and maintaining an open stance of professional curiosity supports police (and other staff) to consider the possibility of maltreatment, and to challenge and explore issues while maintaining an objective and supportive approach.

11.2. Given that criminal justice agencies often deal with specific incidents, supervising individual offenders or investigating stand-alone crimes, there is a risk of seeing an individual or a family only through one lens. Protecting children, young people or vulnerable adults involves understanding their lives and experiences and making professional judgments.

11.3. Children, young people or adults are unlikely to readily disclosure abuse or neglect, this means practitioners have to be able to spot the signs and create a suitably safe and trusting listening environment.

11.4. There are examples of police and other professionals focusing on offender's behaviours and not their underlying vulnerabilities.

11.5. Children or Adults repeatedly going missing should trigger police officers' professional curiosity, it is vital to consider what is motivating their behaviour.

11.6. Practitioners and managers need to be curious, to be sceptical, to think critically and systematically but to act compassionately.

HEDDLU GOGLEDD CYMRU
NORTH WALES POLICE

PROCEDURAL RESPONSE TO UNEXPECTED DEATHS IN CHILDHOOD (PRUDiC) POLICY

POLICY

Governance:	**Strategic Management Board**		
Document Type:	**Policy**		
Policy Owner:	**Head of Crime Services**		
Department:	**Protecting Vulnerable Persons Unit**		
Policy Writer:	**DI**		
Policy Number:	**001**	**Version:**	**2.0**
Effective Date:	**18/07/2025**		
Recommended Review Date:	**18/07/2027**		

CHANGE HISTORY				
Version No	**Author**	**Changes**	**Ratification**	**Date**
1.1	16/08/22	DI	Addition to Para 4.2 re. use of BWV and para 4.8 re. Op Marshall	N/A
1.2	15/05/2024	DI	Amendments in line with all Wales PRUDIC procedures 2023. This was not amended on Force systems due to ongoing amendments.	N/A
2.0	12/5/2025	DI	Reviewed and amended in line with NPCC Practice Advice on Child Death Investigation 2024	

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1. WHY IS THIS POLICY REQUIRED?

1.1 Every child who dies deserves the right to have their sudden and unexpected death fully investigated to exclude homicide and have a cause of death identified. The vast majority of sudden infant deaths and some deaths of older children are the result of natural causes. However, all sudden child deaths need to be fully investigated,

- to exclude homicide,
- to reassure the families that the child's death has been fully investigated,
- to ensure that future children are protected,
- to satisfy wider public concerns.

The police have a key role in the investigation of infant and child deaths, and their prime responsibility is to the child, as well as to siblings and any future children who may be born into the family.

This policy is designed to support and enhance the NHS Procedural Response to Unexpected Deaths in Childhood (PRUDiC) 2023. It should also be read in conjunction with NPCC Practice Advice on Child Death Investigation 2024.

1.2 When dealing with the death of a child NWP along with all other agencies involved need to follow five common principles, especially when having contact with family members:

1. A Balanced approach between sensitivity and the investigative mind-set;
2. A multi-agency response;
3. Sharing of information;
4. Appropriate response to the circumstances;
5. Preservation of material and evidence.

1.3 Whilst investigating any child death, the following should be at the forefront of the Police Investigators mind:

- It is the responsibility of the SIO / Lead investigator to establish the cause of death and to identify contributory factors for that death.

- Other siblings may be at risk, through natural disease or unlawful action of a Parent or Carer. Steps must be taken to safeguard all those at potential risk by utilising 'Police Protection' powers if necessary and appropriate.

- Family / Carers will be in a state of shock and heightened distress. All investigations, whilst thorough, should be sensitively carried out. Support for the family should be a key consideration. Maintain a sympathetic and sensitive approach to the family, regardless of the cause of death.

- It is natural for a Parent / Carer to want to hold or touch the child. Providing this is done with a supportive professional (such as a police officer or nurse) present, it should be allowed in most cases, as it is highly unlikely that forensic evidence will be lost. In the case of an obvious suspicious death then the SIO should be consulted prior to any handling.

- Medical staff may be distressed at the loss of a child. An investigative mind-set may be seen as cold and officious. This could impact on the assistance and co-operation given during the early part of an investigation and therefore the need for sensitivity is paramount.

2. WHO SHOULD USE THIS POLICY?

2.1 This policy should be used by all members of the organisation involved in the initial response to unexpected deaths in childhood.

2.2 Investigative responsibility lies with:

- In hours: PVPU Detective Inspector or in their absence LPS Detective Inspector.

- Out of hours or weekends: CADRE Detective Inspector until 04:00 hours.

- After 0400 hours the SIO should be contacted. On a case-by-case basis, dependent on the circumstances, the SIO may delegate responsibilities which would normally fall to the CADRE DI to the CADRE DS. Thereafter the investigation and multiagency information sharing procedures will transfer to PVPU Detective Inspector.

2.3 PVPU will lead investigations for all child deaths, except those resulting from a Road Traffic Collision. For RTC child death's, a Collision Investigator will lead the investigation with the Roads Policing Unit Detective Inspector as SIO. In the event that the Road Policing Detective Inspector is not available the PVPU/CADRE DI will attend at the hospital and implement the PRUDiC process.

2.4 If the death is considered suspicious based on the presenting circumstances, the Duty SIO must be notified immediately.

2.5 The body of any deceased person, including a child belongs to the Coroner. This is until such time they have either determined the death as natural or where there is to be an inquest, they have opened and adjourned that inquest. The Coroner must be informed about any death that is sudden, violent, or unexplained or where there is reason to believe that it may be unnatural.

3. WHAT SHOULD I CONSIDER WHEN USING THIS POLICY?

3.1 The 'Procedural Response to Unexpected Deaths in Childhood' (PRUDiC), is implemented where a child, under the age of 18 years, dies in sudden, unexpected, and unexplained circumstances; where the death was not anticipated as a significant possibility (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.

3.2 The PRUDiC policy applies to all deaths, whether from natural, unnatural, known, or unknown causes, at home, in hospital or in the community. This includes accidental deaths, including 'Road Traffic Collisions', apparent suicides, and homicide.

3.3 The PRUDiC does not include still births (This is a birth on or after a gestation of 24 weeks (168 days), where the baby does not breathe or show any other signs of life). Nor does it include neonates, where the birth was at a hospital, attended by a professional and where the child has never been discharged into the community, where the death was expected.

3.4 The PRUDiC does not include children with a life-limiting condition known to the Palliative Care Team and where the death was expected. Children with a life-limiting condition may have an 'All Wales Paediatric Advance Care Plan' (PAC Plan) in place, which can be found on the Child's RMS Masterfile. The plan should facilitate multi-professional communication before and around the time of the death, in the event of a child dying in an expected way. Providing the plan is confirmed with the Consultant Paediatrician and they have no concerns surrounding the circumstances of the death, the PRUDiC principles will not apply. Some children who are expected to die may choose to have palliative care without a PAC plan. In these circumstances the Consultant in 'Children's Palliative Care' can be contacted for advice via University Hospital of Wales switchboard at any time (02920 747747).

3.5 When a child dies and a PAC plan is in place, or a MCDD (Medical Certificate Cause of Death) has been issued there may be occasion when the child is transported to rest on a cold mattress/cold cot at home or hospice so families can spend time with their loved one.

This movement can be facilitated in a private vehicle (anything other than Ambulance/Funeral Director) by the family. Under these circumstances the coroner does not need to be notified of the death or asked for permission to move the child as they have no legal jurisdiction when the death is not being investigated.

It is possible that the families wish regarding their child being taken by family home, or to a hospice has been discussed and documented in the PAC Plan. This may however not always be the case.

In these circumstances prior to the child being moved in case of incident on route i.e RTC or traffic stop, the control room will be notified with vehicle details, details of the child and who is travelling prior to the commencement of the journey. This will be done via 101 call to the control room and an ICAD created so the ICAD number can be given to the family in event of incident.

3.5 Factors common in most infant deaths

- Small quantities of gastric contents around the mouth. This does not mean that death was caused by inhalation of vomit. Often there is slight regurgitation immediately after death.
- Froth emerging from the nose and mouth. The froth results from the expulsion of air and mucus from the lungs after death. Sometimes the froth may be blood stained –this does not mean the death is unnatural.
- Purple discolouration of the lowest parts of the body. This may not be bruising and can be caused by the settlement of blood after death. For the same reason high lying parts may be very pale.
- Covering of the child's head by bedclothes. This has often been a feature of cot death in the past and may contribute to death through accidental asphyxia or overheating.
- Wet clothing or bedding (this is usually caused by excessive sweating before death)
- If the child looks as though he/she has been roughly handled, remember that this may be the result of attempts at resuscitation.

3.6 Indicators which may increase suspicion

The below is an aide memoir to consider & not an exhaustive or definitive list:

- Child older than 1 year (Deaths from 'Sudden Infant Death Syndrome' do sometimes occur at an older age but are unusual. There may be other natural causes)
- Unusual marks, bruises, or unexplained injuries to the child
- Previous and/or unusual presentations to medical staff
- History of recurrent cyanosis, apnoea, or other apparent life-threatening events (ALTE) whilst in the care of the same person
- Discovery of blood in infants' nose or mouth in association with ALTEs
- Presence of blood. Very occasionally found in cases of natural death (watery, frothy, blood-stained discharge is normal)
- Previous unexplained or unusual deaths in the family
- Information from other agencies (evidence of abuse or neglect)
- Reports of abuse/violence, failure to thrive.
- Previous child protection concerns (including siblings/children in household)
- Child Protection Register/Child Protection Plan (now/previous)
- Previous intelligence, information, or convictions of relevant Family / Carers / household
- Incidents of domestic abuse/history of abuse
- Drug/alcohol misuse in household
- Mental health issues
- Toxic Trio – Domestic Abuse, Drugs/Alcohol, Mental Health
- Inconsistent accounts
- Child dead longer than stated.
- Circumstances / mode of death
- Home environment/conditions
- Stressors e.g. financial debt
- Family dynamics / Interaction between Parents

3.7 **Factors at postmortem significantly associated with suspicious deaths**

- Presence of features sometimes referred to as the triad of injuries; RADI (rotational acceleration declaration impact injuries) subdural haemorrhages, brain swelling & retinal haemorrhages,
- Toxicological detection of drugs,
- Presence of fractures,
- Bruising at unusual sites, for example, torso,
- Post-mortem features indicating that the interval since death was significantly longer than stated by Parents or Carer.

3.8 Additional Resources

- NHS – Public Health Wales 2023 Procedural Response to Unexpected Deaths in Childhood
  https://phw.nhs.wales/services-and-teams/national-safeguarding-service/safeguarding-latest-policy/prudic-procedural-response-to-unexpected-death-in-childhood/

- NPCC 2024 Practice Advice on Child Death Investigations
  Practice-advice-child-death-investigation-2024.pdf

- College of Policing – Authorised Professional Practice Major Investigations and Public Protection
  Major investigation and public protection | College of Policing

- ACPO 2014 Guide to investigating Child Deaths
  https://library.college.police.uk/docs/acpo/ACPO-guide-to-investigating-child-deaths-2014.doc

- Proposed human tissue policy for police forces - GOV.UK (www.gov.uk)

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

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

4. THE PROCESS

Some of the appendices referred to within this section form part of the All Wales PRUDIC 2023. As such their numbering have been left the same.

It is recognised that this policy document covers a wide age range (0-17years) and the circumstances of death can also be very different. Some of the sections of the appendices may not reflect the ages of the child or circumstance. It is expected that the Detective Inspector overseeing these tragic incidents will apply their professional knowledge around complex investigations and golden hour principles.

4.1 Call handler

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

The call handler taking the initial call should:

Obtain as much information as possible about the incident. Information needed includes:

- Name and date of birth/age of the child (ask the child's name and use it throughout the call).
- Details of the child's parents.
- Where the child is at that moment.
- How the child was found (if asked correctly this should give you an account which you need to record, for example, 'I understand this is very difficult, but I need to ask what happened and who found (name of child)'.
- Ask the caller if medical assistance has been requested, if the report is made via ambulance control ask if they are on scene. If ambulance is required advise ambulance control and confirm to the caller that you will do this.
- Type as much information as possible straight onto the screen and listen to the call later to include more information if needed.
- Save the call as quickly as possible so that the dispatcher can begin to deploy officers.
- Allocate an immediate response.

4.2 Dispatchers' actions

- The dispatcher should deploy LPS officers as soon as possible as an immediate response incident to the place of death to liaise with ambulance staff.
- Notify relevant supervisors for the area and inform them who has been dispatched and request their attendance to the scene.
- FIM to be notified.
- During office hours, contact the PVPU DI immediately who will oversee the investigation.
- Out of hours, contact DI CADRE immediately who will oversee the investigation.
- Between 0400 and 0800 on-call SIO must be notified.

4.3 Ambulance and Police Initial response

- LPS officers will be deployed immediately.
- Take steps to preserve life, including administering first aid and requesting the attendance of an ambulance, unless ambulance is already present, or the child has already been taken to hospital for treatment.
- Be sensitive, compassionate, and professional.
- Sensitive use of BWV is encouraged to be able to capture evidence at scene, the behaviour and demeanour of people present, and any conversations or accounts provided. The use of BWV is by now common place when police attend most incidents and so it is likely that officers would be able to explain that the use of BWV as standard for most incidents. If queried, officers are encouraged to explain that gathering information helps investigators in identifying what could have happened to the child, to be able to present information to HM Coroner and to identify best practise to reduce incidents of child death.
- If a child dies other than at the hospital, NWAS will send an ambulance to the location. Where ambulance confirm life extinct, they will remove the child to the nearest Emergency Department (ED), unless the circumstances of the death present as suspicious and require for the child to remain at the location. The child should never be taken directly to the mortuary except where ED is not practical (e.g. Decapitation / Decomposition / Incineration); in such circumstances the ED paediatrician should be notified.
- It can be difficult to gather initial information at scene due to the shocking and traumatic nature of these incidents. Where possible please obtain an overview of circumstances from ambulance and family members at scene and update the control room.
- Record any comments made by those present which may be significant. Parents may disclose important information while searching for answers to what has happened.
- Attending officer(s) will communicate any immediate concerns to the DI. If Police/ Ambulance staff, consider there are suspicious circumstances they will not remove the body unless authorised by an SIO. The DI will notify the Duty SIO and will attend the place of death.

This will be determined by the DI from information given to them by attending officers, who have spoken with the attending ambulance staff. Clearly, this does not preclude the DI from visiting the location before the child is removed if there are no suspicious circumstances.

- A discrete scene log should be completed for incidents and the address controlled in a sensitive manner.
- If the circumstances are immediately suspicious, the place of death must be regarded as a crime scene and managed accordingly in line with scene preservation principles.
- If suspicious the SIO will make decisions in relation to forensic examination of the scene and in consultation with the Coroner, forensic examination of the child whilst in situ and the subsequent removal of the child from the place of death.
- If the circumstances are not suspicious and the child is being taken to ED, an LPS officer will accompany the child and remain with them to maintain continuity. If the child's parents want to travel with the child to hospital this should be allowed.
- Ensure that the needs of any siblings or other children left at the scene are met. If children are left in the care of nominated trusted adults, background checks must be made.
- There may be occasion where we believe that a child has passed away but have not recovered their body (ie suicide in the sea and their body not recovered). In these instances, the child's body may not be recovered for some time. The DI overseeing this investigation must from the outset give clear instruction for officers for when the child is located. It may not be appropriate for the child to be taken to A&E if decomposition has begun. If the child is taken straight to the mortuary for this reason an officer should accompany the child to the mortuary for continuity. Consideration and direction should also be given to if CSI are to attend the location they are located if possible.

4.4 **Background Checks**

The attending DI should gather as much information as possible prior to attending the hospital/ place of death, to enable information sharing with the paediatrician prior to the Joint History Taking /Medical Examination.

This should include details, circumstances, RMS, PNC, PND, Social Services / EDT checks.

4.5 Hospital Procedure

- A uniformed LPS officer will accompany the child to ED to maintain continuity and complete the following:
  - Formal identification including tagging the deceased.
  - Obtain details and circumstances for 'Sudden Death Notification' (CIVICA).
  - Obtain verbal consent from person in control of place of death for examination by CSM / CSI (DI will complete Appendix 3).
  - Observe the behaviour/demeanour of, and the dialogue between parents.
  - Record any comments which may be relevant to the investigation.
  - Provide an overview to the attending DI, including any initial accounts given to them by Parents / Carers and any concerns.

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

- Do not allow activities such as washing/wiping (unless part of the medical treatment), or other obvious interference with the child in areas (for example, around the mouth), which may provide forensic evidence. If this is unavoidable or has already happened, record details of who has done what, and why.

Ensure clothing is left on the child and not removed by medical staff unless required for medical treatment. Where clothing is removed, seize each item separately, and package and seal as separate exhibits. Consult a crime scene investigator (CSI) for policy if unsure.

- Be discreet when securing items which may be required for evidential purposes. Consult medical staff and ask that any disposable lines, tubes, masks or blood-stained bedding be retained. Each item should be seized, packaged and sealed as a separate exhibit.
- Any tubes, intravenous lines, cannula or similar should only be removed from the body after discussion between the lead investigator and lead health professional. It is of course preferable that parents do not view their child with these items still inserted if possible. However, the decision to remove them will need to be considered in the context of the surrounding circumstances including whether the death is being treated as suspicious at that time – in which case the lead investigator may decide that they are kept in situ until a forensic post-mortem examination is conducted.
- Ensure any relevant items from the ambulance, for example, the drainage bottle is seized, particularly where there is any suspicion that the child may have choked. The drainage bottle may contain an item which has caused an obstruction.
- The DI will debrief officers attending the hospital and scene.
- The DI will meet with Consultant Paediatrician and ensure a full briefing is given as to the circumstances and any past medical history, raising any concerns based on information to date.
- The DI will obtain signed consent from person in control of place of death for examination by CSM / CSI (appendix 3).
- The DI will obtain signed consent from Parents / Carers for voluntary blood / urine samples, if appropriate (appendix 8).
- The Custody Nurse will attend to take samples, if relevant and complete the ‘Health Professional Sample Record’ (appendix 9)
- The DI will obtain signed ‘Medical Records Authority’ from Parents / Carers (appendix 11)

- The Paediatrician will complete the examination of the child and take samples, including admission bloods. The DI and CSI / CSM will be present during the examination. Medical personnel will record findings / samples taken / body-mapping within the 'PRUDiC Medical Assessment Document' (appendix 3).
- A Copy of the completed 'PRUDiC Medical Assessment Document' will be provided to the DI prior to leaving hospital together with copies of medical / paramedic notes.

4.6 Joint History Taking (appendix 3)

- The DI and Consultant Paediatrician will meet the Parents / Carers to conduct the joint history taking. They should be informed that the police attend in such circumstances on behalf of the Coroner in order to establish the cause of death.
- The Paediatrician will complete the 'Joint History Taking' with Parents / Carers in the presence of the DI. Medical personnel will record responses within the 'PRUDIC Medical Assessment Document' (Appendix 3). A copy of which will be provided to the Police when complete, to minimise duplication and further distress to the family. Any outstanding police questions can be asked at the end of the procedure.
- Unless there are indications that the death is suspicious it will not be appropriate to separate the Parents / Carers to obtain the history, although a note should be made of who provides the information. If the death is suspicious the SIO will decide whether any interviews with the Parents / Carers need to be carried out under the Police and Criminal Evidence Act and how this may fit into the overall investigation plan.
- The DI will request consent for voluntary blood and urine samples from Parents / Carers who were present at time of death (appendix 8). Request for voluntary samples should be considered in all cases; except where the cause of death is obvious such as RTC / Suicide or where PACE powers are to be utilised. Think wider neglect, in addition to overlay relevant to Criminal, Coronial, Family court. Rationale should be documented where samples are not requested. Where

consent is given, request the attendance of the Custody Nurse (who will complete appendix 9). Be mindful of obtaining samples ASAP to enable effective analysis / back calculation. Where consent is refused, consider utilising PACE powers where necessary (to facilitate drawing of adverse inference).

- The Paediatrician will inform Parents / Carers that the death must be notified to the Coroner and that a post mortem examination will be required where tissue samples will be taken that may help to identify the cause of death.
- The DI will inform the Parents / Carers that a Coroners Officer will make contact during the next working day with a date and location for the postmortem and will continue liaison (unless suspicious in which case continued contact will be agreed by SIO). The Postmortem procedure will be fully explained to them by the Coroners Officer in relation to the ongoing handling and return of the samples.
- The postmortem will usually be carried out at a specialist hospital (normally Alder Hey Children's Hospital) by a Consultant Paediatric Pathologist. The child will normally return to the original hospital thereafter. Parents / Carers will usually be able to spend time with their child before and after the postmortem examination if they wish.
- The DI will explain to Parents / Carers that the home visit and examination by CSM / CSI is conducted as a routine part of any child death to help identify and understand the factors that may have contributed and provide information for the Pathologist, prior to the postmortem examination. This will require removal of items from the address (e.g. bottles containing last feeds, last used nappy, medication, child's red book and any other relevant items which may assist in establishing the cause of death). A list of items removed will be provided to Parents / Carers. Verbal consent should where practicable have already been obtained by the LPS officer in attendance. Signed consent must be recorded by DI (appendix 7)
- If at any time there are any concerns raised in relation to any other child or the death is of a suspicious nature then immediate safeguarding action should be taken in consultation with social services. Consideration should be given to a 'Child Protection Medical

Examination' of other sibling(s) in consultation with social services and named BCUHB Safeguarding Nurse.

4.7 Joint Physical Examination (Appendix 3)

Physical examination of the child's body will be completed by the Consultant Paediatrician in the presence of the DI and CSI to check for signs of abuse / neglect / injury. This examination will be recorded by a medical practitioner in the PRUDIC Medical Assessment Document (appendix 3).

CSI will photograph the child during the examination, taking scaled images of any marks / injuries. The child's nappy (and clothing – only if required) should be seized by the CSI. Medical equipment should be left in situ.

- After the examination the child should be re clothed in their own clothing unless there is a reason to seize. Should this be the case the hospital will provide alternative clothing for the child.
- The property receipt (appendix 18) must be provided with a list of items removed so families are aware of what has been taken and reassured of their safe keeping and return.
- Samples will be taken from the child by the Paediatrician during the examination which will be documented in appendix 3. Consent to obtain these samples will be obtained from Parents / Carers by the Paediatrician and documented using appendix 10. Admission bloods must be seized and stored appropriately (freezer). The DI must inform the Paediatrician about drugs / medication identified during the address examination / intelligence checks (enabling specific toxicology screening)
- The Paediatrician will consider whether the following need to be completed during the examination or delayed until Postmortem;
  - Kennedy Samples
  - Ophthalmology (examination of the eyes)
  - Full Skeletal Survey (X-ray of the full body) to check for any obvious fractures
  - CT scan to identify any injuries to the head

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

- If there are indications that the death is suspicious and an immediate forensic postmortem examination is to take place the examination of the child's body, skeletal survey and taking of samples may be deferred for the pathologist to carry out. This may also affect the way in which the history is obtained but this will be guided by the SIO.
- If at any point during the joint examination there are marks or injuries of concern always ask for an opinion as to possible causation. If medical staff are unable to offer an explanation to reasonably account for the injury/mark then this should be brought to the attention of the SIO. Ask questions of the consultant Paediatrician. Do not be afraid to query any information or opinions provided.
- Prior to leaving the hospital, please ensure that the 2Wish memory boxes and information leaflets have been shared with the family and consent is gained to refer them for ongoing support from 2Wish.

4.8 Examination of Place of Death / Home (Appendix 4)

- Arrangements for the visit will be considered by the Police in the context of the overall investigation and particularly the forensic strategy if deemed suspicious, where the SIO will set direction.
- The address examination should be done whilst Parents / Carers and family remain at the hospital and be completed as sensitively as possible.
- Consent must be obtained from the person in control of the location where child died / home address. Verbal consent given to the attending LPS officer will suffice to enable the examination to commence. However signed consent from the person providing permission must be recorded by the DI (appendix 7).
- The PVPU DS and DC or in their absence, LPS Detectives will attend the place of death / home address with a CSM / CSI. The attending

Detectives should ideally have 'Child Protection' experience, particularly in cases of suspected maltreatment. CSM / CSI will photograph and if required video record the entire address.

- CSI will undertake removal of any relevant items, in consultation with the attending DS / DC, such as the child's used bottles, cups, food or medication together with any used nappies will normally be taken as will the child's health record (red book). There is no need to retain clothing unless the child's death is considered suspicious. Bedding will only be taken if there are obvious signs of forensic value such as blood, vomit or another residue. The routine collection of bedding is neither necessary for any investigative purpose, nor appropriate for the family.
- The property receipt within the appendix must be provided with a list of items removed so families are aware of what has been taken and reassured of their safe keeping and return.
- Note will be taken of the following:
  - Empty alcohol beverage containers
  - Drugs / paraphernalia
  - Smoking in household
  - Prescription medication (patient/strength/quantity/location)
  - Location of cot/bed in room
  - Whether cot/bed appears to have been slept (evidence of co-sleeping)
  - Type of bedding where child was sleeping
  - Proximity of cot/bed to radiator
  - Heating (type /settings and timings/temperature of the thermostat setting)
  - Room temperature (recorded by CSI)
  - Ventilation in room (window's open / closed)
  - If bottle fed (type of food / adequate bottles / steriliser present)
  - General home conditions (sufficient provisions -food /clothing / toys)
  - Animals living at location

- In cases involving stillbirths, or a death immediately after birth, search objectives should include the presence of drugs that can terminate pregnancy such as misoprostol and mifepristone. Evidence that the drugs are present or have been used should be brought to the attention of the DI immediately.

4.9 Postmortem Examination

- This will be carried out at a specialist hospital by a Paediatric Pathologist (normally Alder Hey Children's Hospital, Liverpool). This will be arranged by the Coroners officer and should be conducted within 5 days.
- If there are concerns that the death may be suspicious, the Postmortem will be conducted in conjunction with a Home Office Pathologist. The SIO will attend and fully brief the pathologist about background, circumstances, medical records, and information gleaned during the 'Information Sharing and Planning meeting'. The CSM / Exhibits Officer and a Scribe will also be in attendance, together with any other Specialist Clinicians the Pathologist deems appropriate.
- Prior to the Postmortem, a full report on history / physical examination / samples taken / laboratory results / outstanding samples will be provided by the examining Consultant Paediatrician to the Pathologist and HM Coroner.
- If appropriate any Radiological investigations required will be instigated by the Pathologist prior to postmortem.
- A great deal of scrutiny surrounds the seizure, retention and disposal of human tissue and National policy must be followed. The link to this policy can be found on p.7 of this document.
- This policy document recommends while any human tissue samples that are retained during a postmortem examination conducted for criminal justice purposes and seized under police powers, are likely to be exempt from the Human Tissue Act 2004, the Home Office and the Human Tissue Authority ('HTA') recommend that the principles of the HTA 2004 and relevant codes of practice are followed. A new system has recently been introduced with NWP to ensure we are compliant with this.

- During the HO postmortem the Authority and Results report must be completed. This details exactly what samples have been taken, and where they are being stored. It is the responsibility of the SIO to ensure this form is completed. It is up to the SIO who completes it (scribe, exhibits officer, themselves etc). All samples should be exhibited, and a discussion should take place with the pathologist to guarantee all samples have been recovered appropriately. Upon completion this must be sent to the SIO and NWP Human Tissue Team (HumanTissueTeam@northwales.police.uk).
- The SIO must also discuss with the pathologist the future examination of these samples including who is taking responsibility for facilitating the examination and where they will be examined.
- Tissue Retention forms must be completed with the families following postmortem. If a standard PM has taken place the responsibility for this will fall to the Coroner's officers. If a HO PM has taken place a discussion should take place between SIO and Coroner's officer to identify who will complete this. It may be more appropriate for this to fall to the investigating officer but can be decided on a case-by-case basis. The most important thing is that they are completed but not duplicated causing the family distress.

4.10 Administration

- The Coroner must be notified and provided with full details of the circumstances of the death as soon as possible in accordance with Police procedures. The DI should make contact via phone in duty hours and also out of hours if suspicious.
- The Coroners Officer should be notified via completion of sudden death form (LPS).
- A Copy of the sudden Death Notification must be saved to RMS.
- Completed Appendices from this PRUDiC Guide must be scanned to RMS.
- Any Documentation obtained from the Hospital must be scanned to RMS.
- Add all family members including surviving siblings to RMS.

- Original paperwork and handover must be sent to the area PVPU DI
- Statements relating to the identification of the child's body should be forwarded to the Coroner's Officer as soon as possible to enable an Inquest to be opened (if required).
- Multi Agency meetings should be convened and chaired by PVPU within the appropriate timescales. Information Sharing & Planning (within 2 working days). Case discussion (within 28 days). Case Review (within 12 months) once PM results received.
- Its vital that communication takes place between the Coroner's officer and SIO to ensure that there is a clear understanding of responsibilities for actions and contact with the family. This is to be managed on a case-by-case basis depending on the circumstances and should be documented on RMS. It has been identified by 2Wish that this is often an area where we as a force fall short and it is of the upmost importance to manage families expectation around timeframes for investigations, and agree with them how and when they want updating.
- The investigation team/OIC should ensure Submission of Operation Marshall forms to the NCA (forms A,B and C as the investigation progresses) Operation Marshall is a national database to assist strategic analysis and inform future prevention and detection initiatives in relation to intrafamilial child homicide or suspicious death investigation. Each force has an Operation Marshall SPOC (DCI PVPU).

  To obtain a copy of the Operation Marshall forms, Data Request form or any other associated information, please contact the National Injuries Database team on:

  Tel: 01480 272620

  Email: childdeathinfo@nca.pnn.police.uk

4.11 Staff Welfare & Wellbeing

Child deaths will have varying degrees of impact upon staff.

Line Manager's responsible for all staff involved in the Procedural Response to Unexpected Deaths in Childhood, should ensure a de-brief is

undertaken, for the purpose of welfare and wellbeing, prior to the staff member going off duty and provide appropriate support as required.

The duty Patrol Inspector will be responsible for requesting a formal 'Critical Indecent De-brief'.

Recognising the impact PRUDIC can have on professionals 2Wish are now able to offer support to all professionals who involved in PRUDIC's or the meeting associated with them.

Sources of staff support can be found in appendix 2.

4.12 3 Phase Multi-Agency Meetings (applicable to PVPU Detective Inspectors only)

- **Phase one** (within 2 working days): The management of information sharing, including the Information Sharing and Planning Meeting, from the point at which the child's death becomes known to any agency until the initial postmortem examination has been completed.
- **Phase two** (within28 days): The management of information sharing, including the Case Discussion Meeting, once the preliminary results of the postmortem examination are available.
- **Phase three** (within 12 months): The management of information sharing, including the Case Review Meeting, when the final Postmortem 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 HM Coroner may consider certain information Sub Judice (i.e. under judicial consideration and therefore prohibited from public discussion elsewhere) or subject to continuing investigation which may preclude it being shared. In some circumstances this may include the preliminary and final results of the postmortem examination.

In these cases, the amount of information released from the Police investigation to these meetings must be 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. The paramountcy principle will apply. Any decision not to share information will be recorded by the Police Senior Investigating Officer in their Police Policy Book.

It is not usual practice to share meeting minutes with parents however on occasion parents have requested copies of meeting minutes. The decision to share minutes will be at the discretion of the Police who will be able to consider any necessary restrictions, given the circumstances of the case and the extent of any criminal or coronial investigations, which may be prejudiced by disclosure at that stage.

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 invitees within 5 working days of the meeting.

4.12.1 Phase 1: The Information Sharing and Planning Meeting (Appendix 12)

This meeting will be convened within two working days of the unexpected death and prior to the postmortem examination.

The Police will ensure that the family are informed about the PRUDiC process ideally prior to the Information Sharing and Planning Meeting or as soon as possible thereafter.

A Detective Inspector or Senior Protecting Vulnerable Persons Unit Officer or Public Protection Unit Officer will convene, chair, and minute an initial Information Sharing and Planning Meeting. As a minimum the Senior Police Officer (as defined above), Health Board Head of Safeguarding, Consultant Paediatrician who attended the child, and a Children's Social Care representative of appropriate seniority will attend. Other professionals will be included as deemed appropriate by the Chair (e.g. Education for a school aged child) whilst keeping numbers to a minimum and on a need to be there basis.

Commented [IR1]: The North Wales Safeguarding Board submitted a draft ISP to WASPI, for this purpose. WASPI seems to have dismissed it due to it being centred around a deceased person, however the policy suggests that details of family are shared, for potential safeguarding of siblings of the deceased, or to identify the cause of death. This should be reconsidered by the Safeguarding Board to proceed with an ISP for this purpose.

Commented [SS2R1]: I have made contact with Hannah Cassidy to ask its reconsidered.

It is desirable that the Pathologist is included in the meeting and may contribute by telephone. If the Pathologist is not attending the Information Sharing and Planning Meeting there will be a discussion between the Chair of the Information Sharing and Planning Meeting (usually a Senior Police Public Protection Unit Officer) and the Pathologist before the post mortem examination to identify outstanding or unsuspected issues and to ensure accurate understanding of information.

Minutes should be drafted and circulated to all invitees within 5 working days of the meeting.

The purpose of the Information Sharing and Planning Meeting is:

- To determine which professional is the most appropriate person to be the single point of contact for supporting the family.
- 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 reference to the environment and circumstances of the child's death. This would include details of previous or ongoing child protection or childcare concerns, history of previous unexplained injury, abuse or neglect, previous unexplained or unusual deaths in the family, medical conditions including any disability, parental substance misuse, parental mental ill health, domestic abuse, parental criminal convictions, previous hospitalisation and General Practice visits.
- To collate all relevant information to share with the HM Coroner and Pathologist prior to the postmortem 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 Regional Safeguarding Children Board for consideration of a Child Practice Review.
- 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.
- To make arrangements to convene the Case Discussion Meeting within five to twenty-eight days.

Where Child Protection concerns are identified, the Child Protection and PRUDiC processes will run in parallel. The Child Protection process will not be a substitute for the PRUDiC process, but one will inform the other and vice versa. If Child Protection concerns are identified a Strategy Meeting will be held; chaired by Children's Social Care, according to timescales and processes defined within the Wales Safeguarding Procedures (2019).

Appendix 5 the initial notification must completed and sent to both the Regional Safeguarding Children Board Business Manager and the Child Death Review Programme.

4.12.2 Phase 2: The Case Discussion Meeting (Appendix 13)

All professionals have a responsibility to ensure that any concerns they may have surrounding the death are passed to the Police Senior Investigating Officer as soon as possible.

A Case Discussion Meeting must be convened within 5 to 28 days. A Detective Inspector or Senior Protecting Vulnerable Persons Unit Officer or Public Protection Unit Officer will convene, chair, and minute the meeting. As a minimum the Senior Police Officer (as defined above), Health Board Head of Safeguarding, and a Children's Social Care representative of appropriate seniority will attend. The meeting should also include the Consultant Paediatrician and the Pathologist. Other

professionals will be included as deemed appropriate by the Chair whilst keeping numbers to a minimum and on a need to be there basis. With the agreement of HM Coroner, the preliminary results of the postmortem examination will be made available.

The purpose of the Case Discussion Meeting is to

- Receive any information which was not available at the Information Sharing and Planning Meeting.
- Discuss any further investigations which are ongoing.
- Discuss the preliminary results of the postmortem examination.
- Consider any safeguarding or child protection concerns.
- Consider any disclosure issues and any necessary restrictions according to the nature of the case and the extent of any criminal or coronial investigations.
- Consider the need for referral to the Regional Safeguarding Children Board for a SUSR (Child Practice Review).
- Ensure the right support is available to the family.
- Ensure appropriate support is provided to all professionals who attended the child and family.
- Consider and plan for any media interest in the death.
- Agree which agency will undertake each action and agree timescales (which may not exceed those set out in this PRUDiC) for doing so.
- Minutes will be circulated to all invitees within 5 working days of the meeting.
- The Chair (or their delegate) will provide available information to the Child Death Review Programme using the Child Death Notification Form (appendix 5).
- With the agreement of the Chair and depending on circumstances and on the course of any criminal investigation, the Consultant Paediatrician will write a letter to the parents offering to meet them to discuss the available information concerning the cause of their child's death, answer any questions, and offer future care and support.

- HM Coroner will be informed of any relevant new information shared at this meeting. This will be the responsibility of the Police Senior Investigation Officer.

4.12.3 Phase 3: The Case Review Meeting (Appendix 14)

The purpose of the Case Review Meeting is to provide assurance to the Regional Safeguarding Children Board that every unexpected child death has been thoroughly investigated and all learning identified.

A Case Review Meeting must be held as soon as possible once the results of all relevant investigations have been obtained. The final report of the postmortem examination will be necessary to inform this meeting. Sharing of the final report of the postmortem examination is at the HM Coroner's discretion and may not be possible until the Inquest or Trial has been concluded.

All relevant records will be available to this meeting, including the minutes and decisions of the Information Sharing and Planning Meeting and the Case Discussion Meeting. If this meeting is held after the Inquest, consideration should be given to applying to HM Coroner for the recording of the Inquest.

The meeting will be convened and chaired by a Detective Inspector or Senior Protecting Vulnerable Persons Unit Officer or Public Protection Unit Officer. The meeting will involve as a minimum, the Senior Police Officer (as defined above), Health Board Head of Safeguarding, a Children's Social Care representative of appropriate seniority and others if helpful to the process. Minutes should be drafted and circulated to all invitees within 5 working days of this meeting.

The Case Review Meeting will:

- Consider whether the family require any ongoing professional support.
- Consider any safeguarding or child protection concerns.
- Consider the need for referral to the Regional Safeguarding Children Board for consideration of a SUSR.

- Consider information about the cause of death and those factors that may have contributed to the death include
  ng;
  - Factors intrinsic to the child.
  - Factors in the social environment including family and parenting capacity.
  - Factors in the physical environment.
  - Factors in relation to service provision.
- Identify learning from any Health Board Child Mortality Review and any other single agency internal review process.
- Identify the learning from any Regional Safeguarding Children Board Child Practice Review or Multi-Agency Professional Forum.
- Share the family's views about the PRUDiC process and the care and support they have received where these have been shared with professionals.

At this meeting the Chair or their delegate will complete the Case Summary Template (Appendix 6) and forward it to the Regional Safeguarding Children Board Business Manager and the Child Death Review Programme.

Each agency will ensure that learning shared at the Case Review Meeting is disseminated within their agency and in particular to those involved with the child and family prior to or at the time of the child's death.

5. DECLARATION & LEGALITIES

5.1 In line with all Force policies, the overarching purpose of this document is to directly support the PCC police and crime plan objectives. Overall the intention of this policy is to make North Wales the safest place in the UK.

5.2 In the writing of this policy cognisance has been taken of the college of policing code of ethics (2014).

5.3 North Wales Police policies will be written in accordance with the approved corporate format and published on the Force Intranet, allowing access to staff and public, where appropriate, on the pages of the public facing Internet site under the Force publication scheme and Freedom of Information Act 2000.

5.4 The following main legal requirements have been identified within this policy:

- Equality Act 2010
- Human Rights Act 1998
- The Welsh Language (Wales) Measure 2011 and the Welsh Language Standards for the Chief Constable
- Data Protection Act 2018
- Freedom of Information Act 2000
- Health and Safety Act 1974

5.5 This policy has been written giving due regard to the above legislation and has considered the risk of unfair and/or disproportionate impacts on individuals or groups (actual or perceived) and has done so via an equality impact assessment (EIA).

5.6 New legislative requirements or changes in Force structure may necessitate a review of this policy document.

6. APPENDICIES

The appendices do not run in numeric order due to them being a mixture of NWP documents and All Wales documents taken from Procedural Response to Unexplained Deaths in Children 2023

Appendix 1 - Initial Information Recording Sheet.pdf
Appendix 2 - Sources of Family Support.pdf
Appendix 3 - Proforma for History and Physical Examination of the Child.pdf
Appendix 4 - Scene Examination Checklist for Infants and Children Under 24 Months.pdf
Appendix 5 - Child Death Notification Form.pdf
Appendix 6 - Case Summary Template.pdf
Appendix 7 - Address Examination Consent Form.pdf
Appendix 8 - Voluntary Blood and Urine Consent Form.pdf
Appendix 9 - Health Professional Blood and Urine Sample Record.pdf
Appendix 10 - Sample Consent.pdf
Appendix 11 - Medical Records Authority.pdf
Appendix 12 - PRUDIC Initial Information Sharing and Planning Meeting.docx
Appendix 13 - PRUDiC Case Discussion Meeting.docx
Appendix 14 - PRUDiC Case Review Meeting.docx
Appendix 15 - Police Response Flowchart.pdf
Appendix 16 - Legislation - Child Abuse Homicide Offences to Consider.pdf
Appendix 17 - Resources.pdf
Appendix 18 - Property Receipt.pdf