

HM Coroner Professor Fiona J Wilcox
HM Senior Coroner Inner West London
Westminster Coroner's Court
65, Horseferry Road
London
SW1P 2ED

15 May 2026

Dear HM Coroner Professor Wilcox,

Re: Regulation 28: Report to Prevent Future Deaths, Baby O.

Thank you for your report into the tragic death of Baby O. Please allow me to extend my condolences to the family and friends of Baby O and acknowledge the matters of concern set out in section 5 of your report, and our duty to respond.

I have outlined the matters of concern that appear to be related to the College of Policing, so that I can provide you with a comprehensive response for each.

- 1. That child death investigation teams are too easily reassured when they attend deaths and find a well-presented home environment with no overt signs of neglect or injury to the deceased child, such that the scene examination becomes perfunctory and forensic opportunities are lost.**

The College of Policing offers a national, Investigating Sudden Death in Childhood Course, which was reviewed and re-launched in 2025, and which is available to all Home Office forces. The programme has been developed for Lead Investigators who have the responsibility for conducting investigations following the sudden, unexpected death of a child. Those who attending the course should have previously completed Professionalising Investigation Programme (PIP) level 2 or level 3 learning and registration. The course reflects the 2024 National Police Chief's Council (NPCC) Practice advice on child death investigation and provides delegates with the knowledge to conduct thorough and impartial investigations. Referenced by the College of Policing, the national guidance also stresses the need to safeguard against bias, stereotypes, and assumptions, particularly in emotionally charged or ambiguous circumstances. The College of Policing also uses Authorised Professional Practice to underpin key facets of this approach, and more details, including the link to the current Practice Advice on Child Death Investigation can be found [here](#).

More widely, the College of Policing has developed a variety of tools and approaches to help officers and staff with decision making, promote professional curiosity, and to prevent or mitigate against biases, assumptions or stereotypes when dealing with an investigation or wider policing matter. The use of the **National Decision Model (NDM)**, and the **Code of Ethics**, which sits at the centre of the NDM, underline

the critical importance of making well considered and appropriately recorded decisions. First introduced in 2013 and updated in January 2024, the NDM supports officers to structure decisions, assess risk, consider alternative options, and ensure that decisions are lawful, proportionate, accountable, and ethical, particularly in complex and high-pressure situations where objectivity, challenge and reflection are essential.

These expectations are reinforced by guidance for conducting effective investigations (**Conducting effective investigations guidelines**, published in August 2023), Guideline 2, making good decisions, in particular, highlights the risks of confirmation bias and encourages open-minded hypothesis generation and reflective decision-making.

2. That feeding bottles and equipment are not routinely seized pending toxicology results.

The current NPCC **Practice Advice on Child Death Investigation**, stresses the need to “check throughout the house for feeding bottles (used or readymade),.....These items should be seized.” (P,30). The guidance also advocates wider good practice relating to scene management and the prevention of or disposal of potential evidence.

3. That insufficient consideration is given the potential role of poisoning in such deaths by the police.

In addition to the points made under Concern 1, the College’s Investigating Sudden Death in Childhood Course places emphasis on professional curiosity at the earliest stages of an investigation. The training highlights the need to keep an open mind and to actively consider whether poisoning or the ingestion of harmful substances, where no obvious cause of death, could have taken place. It provides clear guidance on relevant legislation, including Section 23 of the Offences Against the Person Act 1861, and outlines a range of substances that investigators should be alert to, such as oxygen, excessive salt, and incorrect dosages of medication (for example, insulin), all of which have the potential to cause serious harm to a child.

The Investigating Sudden Death in Childhood Course forms part of, and builds on the wider investigative skills programme. Beginning in 2003, **College’s Professionalising Investigations Programme** delivers a professional, ethical and effective investigation capacity for all levels, including those who would investigate unexpected and/or suspicious deaths; where consideration of poisoning and other criminal causes of death are covered.

4. That police training and guidelines may need to be updated.

While I am satisfied that current police training and practice advice do cover the crucial issues kindly raised. I would also like to reassure you that we will work closely with NPCC colleagues, to consider whether further strengthening of the approach advocated is required. This includes ensuring that both the practice advice and training are aligned in all areas.

The College of Policing has recently also launched a consultative period for our revision of **Child Abuse Authorised Professional Practice** (APP). I will ensure that the team proactively considers whether greater alignment between the practice advice on child death investigations and the APP on child abuse is required.

If you would like to explore any of the response areas provided above, or have any other questions or queries, please do not hesitate to contact my Crime and Criminal Justice Delivery Lead, DCS J [REDACTED] at [REDACTED]

Yours sincerely

[REDACTED]

Chief Executive Officer
College of Policing

[REDACTED]
Executive Assistant: Chris Hutchison

[REDACTED]