Child Death Review Process

A Joint Agency Protocol for Gloucestershire

Produced by CDOP on behalf of

Gloucestershire Safeguarding Children Board

August 2017

Child Death Review Processes – A Joint Protocol for Gloucestershire, Produced by CDOP on behalf of GSCB

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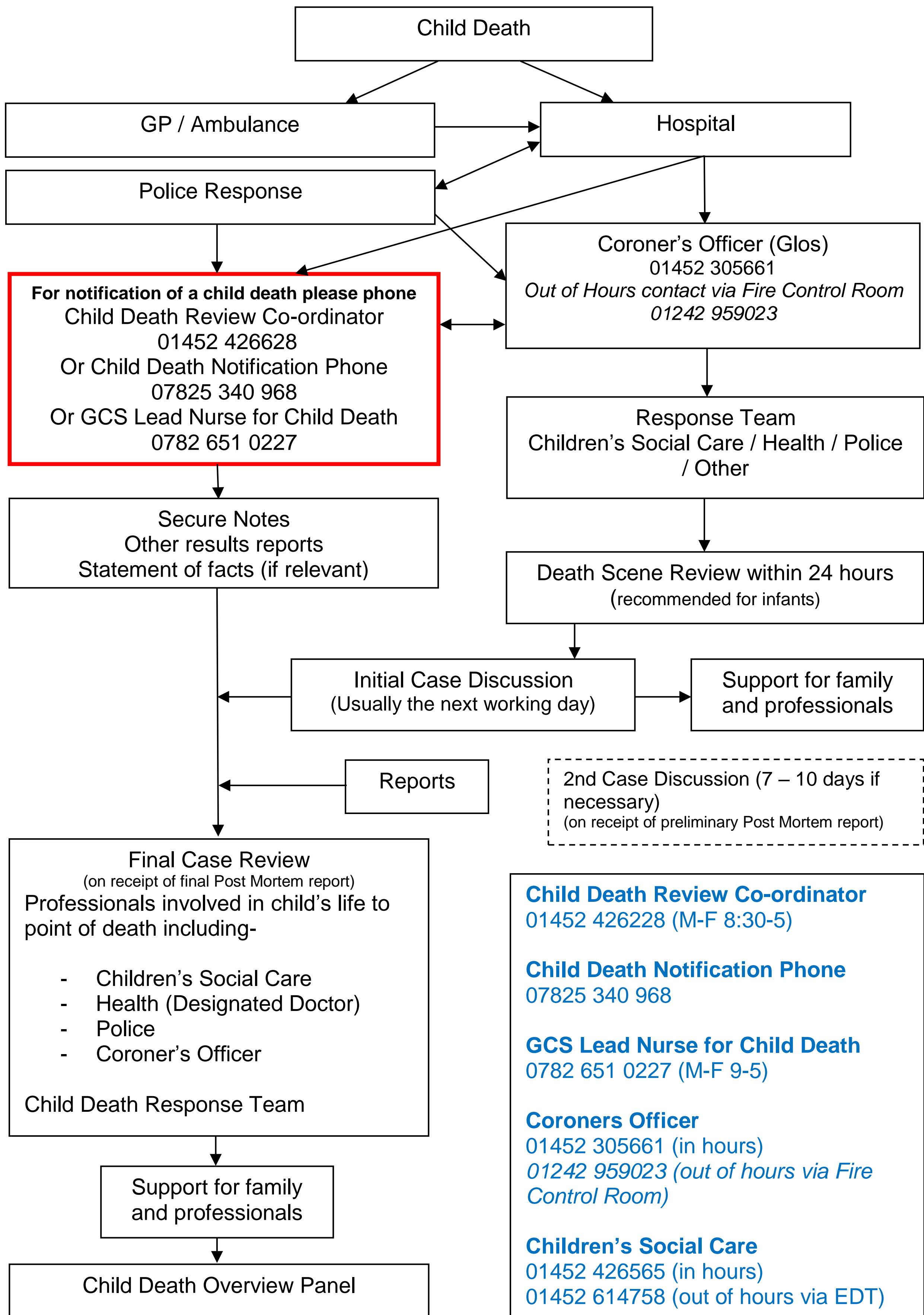
Acknowledgement
This protocol is based on a version produced by Dorset Safeguarding Children Board in 2007 and the version produced for Gloucestershire September 2008.

Abbreviations

CAIT	Child Abuse Investigation Team
CDOP	Child Death Overview Panel
CDR	Child Death Review
CDRC	Child Death Review Co-ordinator
DDCD	Designated Doctor for Child Deaths
ED	Emergency Department
EDT	Emergency Duty Team
FCR	Final Case Review
GP	General Practitioner
GSCB	Gloucestershire Safeguarding Childrens Board#
ICD	Initial Case Discussion
RRNCDR	Rapid Response Nurse for Child Death Review
L/RRNCDR	Lead Rapid Response Nurse for Child Death Review
ROLE	Record of Life Extinct
SIO	Senior Investigating Officer
SUDI	Sudden Unexpected Death in Infancy
SOCO	Scenes of Crime Officers
SWASFT	South West Ambulance Service Foundation Trust

Overview of the Child Death Process
Flow Chart



Child Death Review Processes

Introduction

Each death of a child is a tragedy for his or her family (including any siblings), and subsequent enquiries/investigations should keep an appropriate balance between forensic and medical requirements and the family's need for support. A minority of unexpected deaths are the consequence of abuse or neglect or are found to have abuse or neglect as an associated factor. In all cases, enquiries should seek to understand the reasons for the child's death, address the possible needs of other children in the household, the needs of all family members, and other children well known to the child. It should also consider any lessons to be learnt about how best to safeguard and promote children's welfare in the future.

This is a mandatory process (*Working Together to Safeguard Children, 2013 and revised 2015*) and has provided the opportunity to establish a standardised approach to the management of a child's death and to identify further support to the family.

General Principles

There are two interrelated processes for reviewing child deaths (either of which can trigger a multi agency Serious Case Review)

Child Death Review Process

- A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child.

Child Death Overview Panel (CDOP)

- An overview of all child deaths (under 18 years old) undertaken by the Gloucestershire Child Death Overview Panel (CDOP).

An unexpected death is defined as the death of an infant or child (less than 18 years old) which:

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

This protocol:

- Relates to the county of Gloucestershire, covered by the Gloucestershire Safeguarding Children Board (GSCB) and as such is to be adhered to by all agencies.
- Should be applied to all deaths in infancy and childhood (less than 18 years old).
- Can be applied in other circumstances e.g. in dealing with a child who has suffered a life threatening injury.

General guidance for Sudden Unexpected Deaths in Childhood – an Overview

Multi Agency involvement, Discussion and Assessment

All cases of sudden unexpected child death including the sudden demise of a child with life limiting or life threatening conditions needs to be referred to the Coroner's Officer (via Fire Control Room if out of hours). Contact should also be made with the Lead/ Rapid Response Nurse for Child Death Review (L/RRNCDR) and/ or the Child Death Review Co-ordinator (CDRC) who will alert the Designated Paediatrician and the L/RRNCDR so that further investigation and management of these cases will follow a multi agency approach, as set out in this protocol.

In the aftermath of a sudden unexpected death, professionals may need to fulfil several roles. At the time of death an evaluation of any safeguarding or child protection concerns should be made. If concerns are raised, Police and/or Children's Social Care (if there are other children in the home) become the lead agency. If no safeguarding concerns are raised, those professionals involved with a child who dies unexpectedly (before or at the time of death), should come together to enquire into and evaluate the child's death at an *Initial Case Discussion.* A balance must be kept between medical and forensic requirements and the need to support family members grieving for their child.

The parents of the child will be informed, at the earliest opportunity of the nature of the Child Death Review process and the need for multi agency information gathering and sharing, involving Health, Police, Children and Family Services, and the Coroner. Leaflets are provided to the family (***Appendix 2***).

At the time of the sudden unexpected death the sharing of information between relevant agencies (primarily Police/Children's Social Care/Acute Paediatrician) is vital. It will assist in assessing the level of any suspicions in relation to the death and in deciding upon any further safeguarding concerns for any siblings and aid the direction and level of investigation.

Not all relevant information will be available at this early stage and a formal *Initial Case Discussion* will usually occur on the next working day to discuss further information. The following will be invited, if available, or requested to send information if appropriate to the meeting:

- Paediatrician on-call (where possible) or senior representative
- Emergency Department /Ward representative
- Ambulance Staff
- Police
- Children's Social Care
- Any other key professional identified for family or siblings e.g. GP, Public Health Nurse, Midwife etc.
- Education representation
- Coroner's Officer

Where there are issues relating to other children in the family, or there has been previous relevant Children's Social Care involvement or, where there are suspicions requiring Child Protection (*Section 47*) enquiries, Children's Social Care will need to be more directly involved. Such concerns may be apparent at the outset, or may come to light at any stage during the investigation.

Where Children's Social Care have had no previous involvement with the child or family and are not needed to be involved in the investigation, they should still be notified of the outcome for future file reference.

Strategy Discussions

Where suspicious factors around the death have been identified and there are other children, there must be a formal child protection strategy discussion in relation to the other children led by Children's Social Care. The purpose of the strategy discussion is to identify if there are concerns about the circumstances of the death, and the safety of the other children. The strategy discussion will ideally be face to face, and should include a Senior Police Officer from the Public Protection Bureau Team (PPB), the Police Supervisor, a Paediatrician or L/RRNCDR; and a Social Worker from the relevant Children and Family Social Care Referral and Assessment Team or Emergency Duty Team (EDT). If the other children are at school or early years settings then a representative from Education / early years should attend and, if possible, it should also include a Health Visitor and/or School Nurse/GP. The prompt timing of the strategy meeting is essential and if key professionals are not able to attend, all relevant information should be sought from them by the Social Worker and brought to the strategy meeting.

The purpose of the strategy meeting is to:

- Share available information.
- Decide whether a *section 47* enquiry under *The Children Act 1989* should be initiated and undertaken.
- To decide whether there is a need for medical assessment, and if so who will carry out what actions, by when, and for what purpose.
- Determine what information from the strategy discussion will be shared with the family, without jeopardising the Police investigation or causing significant harm.
- Agree the conduct and timing of any criminal investigation.
- To decide whether a Joint Interview (JI) will take place, to agree who should be interviewed by whom, for what purpose and when.

If necessary, further multi agency discussions should be held with the same representatives to review the situation and plan accordingly.

Consideration should be given to the well-being and any potential risks to the care of other children in the family. This may require a medical examination, and enquiries under *Section 47 of The Children Act 1989*, the children to be temporarily cared for by members of the family network or in extreme circumstances, the children to be looked after in foster care. Wherever possible however, children should remain with their family, recognising that this is a particularly traumatic time for all family members.

Where there is the need for a core assessment led by Children's Social Care, this should be carefully planned through the multi agency meeting to ensure co-ordination with any Police investigation and ongoing Paediatric involvement.

Initial Case Discussion

All professionals who have been involved with the child in life or at the time of the death will be invited to attend an *Initial Case Discussion* in addition to representatives from Children's Social Care, Police, Health and the Acute Rapid Response Child Death Team. This will usually occur the next working day. At each meeting all participants will be required to sign an Attendance Sheet/Confidentiality Agreement - Form A2, confirming that they have understood the Confidentiality Agreement (***Appendix 5***). This meeting will be chaired by the L/RRNCDR or

Designated Doctor for Child Deaths.

The purpose of this meeting is to share information, facilitate support for the family and to determine the need for a home visit if this has not already taken place (this visit should almost always take place for infants who die unexpectedly).

Where a home visit is to take place, a decision should also be made about how soon (preferably within 24 hours) and who should attend. It is likely to be a Senior Investigating Officer from the Police and a healthcare professional experienced in responding to unexpected deaths. They may make this visit together or separately and then confer to discuss any additional information which may raise concerns about the possibility of abuse or neglect having contributed to the child's death.

Contact details of professionals who attended the *Initial Case Discussion* meeting will be shared by the next working day. The minutes of the meeting will be produced within 10 working days and sent to all present for agreement of accuracy. Once checked by the professionals any hard copies should be shredded and deleted as the master copy of the minutes will be retained by the CDRT **only** for future access if necessary. A professional will be responsible for keeping the family informed of the outcome of the meeting and any updates.

Following the preliminary results of the Post Mortem examination (usually 5 – 7 days after the death) the CDRC will disseminate provisional results to the relevant professionals involved in the review and if deemed necessary the RRNCDR may convene a multi agency case discussion to review any further information that has come to light.

On receipt of the final Post Mortem examination an appropriately trained health professional should be available to discuss the findings with the parents at the earliest opportunity, except in those cases where abuse is suspected or the Police are conducting a criminal investigation. In these situations the Paediatrician must discuss with Children's Social Care, Police, Coroner's Office and the Pathologist what information should be shared and when. The final Post Mortem will be disseminated by CDRC to relevant professionals as agreed with the Coroner.

Acute/Rapid Response team

This team will consist of specifically trained professionals from the Police, Children's Social Care and Health who are fully aware of the procedures and have received appropriate training. This will be lead by the RRNCDR.

The purpose of the acute response team will be:

- To participate in the initial information sharing and planning discussion.
- To determine in agreement with the other professionals involved in the case, the need for a home visit, the timing and by whom. It is expected a home visit is essential for all infant deaths but may not be necessary for older children. The home visit is likely to include the Senior Investigating Police Officer and a health care professional. Normally within the first 24 hours. A written report of the home visit will be shared with the Coroner and the Child Death Review meeting.
- To determine who will provide support for the family immediately and in the longer term.
- To determine who will be responsible for liaising with the family the outcome of any case discussions and Post Mortem report.
- To ensure feedback from the family in relation to service provision during the child's life or as a consequence of the child's death.

- To attend the child death *Final Case Review* meeting.

Final Case Review

The Designated Paediatrician for unexpected deaths or nominated representative will convene and chair a *Final Case Review* meeting following receipt of the final results of the Post Mortem examination. The meeting should include professionals who knew the child and family and those involved in investigating the death. The collection of the core data set should be completed. The purpose of this meeting is to share information to identify the cause of death and/or those factors that may have contributed to the death, and then to plan future care for the family. Potential learning points may also be identified. The meeting may also inform any Inquest being held. At each meeting all participants will be required to sign the Attendance/Confidentiality Agreement (***Appendix 5***) confirming that they have understood the document.

A Summary of the *Final Case Review* meeting will be produced within 10 working days and sent to all present to be retained in children's file and also sent to the GP for information. Formal minutes will be retained by the Child Death Review Team. The allocated named professional will contact the family and share this summary if the family wishes. The Coroner will be informed of the outcome of the *Final Case Review*.

Outcomes of Final Case Reviews

Following the *Final Case Review* of a Child Death Review (CDR) or the review of the case for the Child Death Overview Panel (CDOP), issues which may have contributed to the death of the child may be identified.

These will be classed as - Learning Points, Issues Identified and Recommendations

Learning Points & Issues Identified

These areas highlight development to improve services which could have impacted on the child's death. They will become part of the work program for the Child Death Team to ensure appropriate implementation. Where any learning points or issues identified are raised these will be forwarded to the Clinical Governance Departments of all Trusts and Agencies for action, if relevant. The CDR process will require evidence that actions have been completed to be overseen by the CDOP. An Annual Report of the learning points and issues identified will be shared with the CDOP and all Agencies and Trusts as per routes of communication below.

Recommendations

All recommendations will be reviewed at the CDOP and if approved will be accountable through the Gloucestershire Safeguarding Childrens Board. These will be implemented in the same manner as recommendations from Serious Case Reviews. The recommendations will be forwarded to the relevant Chief Executive of the Agencies or Trusts with copies to the relevant Designated Leads. The Agencies or Trusts will be expected to provide evidence of implementation to the CDOP Sub Group of what action has been taken to address the recommendations. The CDOP will then report to GSCB.

Child Death Overview Panel

An overview through a comprehensive and multidisciplinary review of all child deaths in Gloucestershire will be undertaken by the Gloucestershire Child Death Overview Panel (a sub group of the GSCB). This is a paper exercise, based on anonymised information available from those involved in the care of the child and other sources as appropriate. The panel aims to better understand how and why children in Gloucestershire die and use our findings to take action to prevent other deaths and improve the health and safety of our children.

The CDOP will meet the functions set out in *Chapter 5 of Working Together to Safeguard Children 2015* in relation to the deaths of any children normally resident in Gloucestershire. Namely collecting and analysing information about each death with a view to identifying –

(i) any case giving rise to the need for a Serious Case Review
(ii) any matters of concern affecting the safety and welfare of children in Gloucestershire
(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in Gloucestershire

Objectives of the panel

- To ensure, in consultation with the local Coroner, that local procedures and protocols are developed, implemented and monitored, in line with the guidance in *Chapter 5* of *Working Together* on enquiring into unexpected deaths.
- To ensure the accurate identification of and uniform, consistent reporting of the cause and manner of every child death.
- To collect and collate an agreed minimum data set of information on all child deaths in Gloucestershire and, where relevant, to seek additional information from professionals and family members.
- To evaluate data on the deaths of all children normally resident in Gloucestershire, thereby identifying lessons to be learnt or issues of concern, with a particular focus on effective inter agency working to safeguard and promote the welfare of children.
- To evaluate specific cases in depth, where necessary to learn lessons or identify issues of concern.
- To identify significant risk factors and trends in individual child deaths and in the overall patterns of deaths in Gloucestershire, including relevant environmental, social, health and cultural aspects of each death, and any systemic or structural factors affecting children's well-being to ensure a thorough consideration of how such deaths might be prevented in the future.
- To identify any Public Health issues and consider, with the Director of Public Health and other provider services how best to address these and their implications for both the provision of services and for training.
- To identify and advocate for needed changes in legislation, policy and practices to promote child health and safety and to prevent child deaths.
- To increase public awareness and advocacy for the issues that affect the health and safety of children.
- Where concerns of a criminal or child protection nature are identified, to ensure that the Police and Coroner are aware and to inform them of any specific new information that may influence their inquiries; to notify the Chair of the GSCB of those concerns and advise the Chair on the need for further enquiries under *section 47 of the Children Act*, or of the need for a Serious Case Review.

- To improve agency responses to child deaths through monitoring the appropriateness of the response of professionals to each unexpected death of a child, reviewing the reports produced by the rapid response team and providing the professionals concerned with feedback on their work.
- To provide relevant information to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family.
- To monitor the support and assessment services offered to families of children who have died.
- To monitor and advise the GSCB on the resources and training required locally to ensure an effective inter agency response to child deaths.
- To co-operate with any regional and national initiatives – e.g. the Confidential Enquiry into Maternal and Child Health (CEMACH). Collation of data with other neighbouring CDOPs across the region – in order to identify lessons on the prevention of child deaths.

The CDOP will gather and assess data on the deaths of all children and young people from birth (excluding those babies who are stillborn) up to the age of 18 years who are normally resident in Gloucestershire. This will include neonatal deaths, expected and unexpected deaths in infants and in older children. Where a child normally resident in another area dies within Gloucestershire, that death shall be notified to the CDOP in the child's area of residence. Similarly, when a child normally resident in Gloucestershire dies outside Gloucestershire, the Gloucestershire CDOP should be notified. For children not resident in Gloucestershire but have died in our county, Gloucestershire CDRT will assist the resident CDOP by holding an *Initial Case Discussion* to gather local information and forward all details to the CDOP of residence. In both cases an agreement should be made as to which CDOP (normally that of the child's area of residence) will review the child's death and how they will report to the other.

The Child Death Overview Panel will have a permanent core membership drawn from the following key organisations represented on the GSCB and from other relevant organisations: Designated Consultant Paediatrician, Designated Nurse, Coroner's Office, Midwifery, Lay Representative, Faith Representative, Children's Social Care, Police Public Protection Bureau, Bereavement Counsellor e.g. Winston's Wish, Administration Support.

CDOP core members will nominate a suitable deputy who will attend meetings in the absence of core members.

Other members may be co-opted to contribute to the discussion of certain types of death when they occur for example, Fire Services, Education, Obstetric staff etc.

The Chair has the discretion to defer the meeting if the appropriate representatives or deputies, with relevant skill mix are not available for a meeting or there are insufficient numbers for the meeting to be held effectively.

Information discussed at the CDOP meetings will be anonymised prior to the meeting, it is therefore essential that all members adhere to strict guidelines on confidentiality and information sharing. Information is being shared in the public interest for the purposes set out in *Working Together* and is bound by legislation on data protection.

CDOP members will all be required to sign a Confidentiality Agreement before participating in the CDOP. Any ad-hoc or co-opted members and observers will also be required to sign the Confidentiality Agreement. At each meeting of the CDOP all participants will be required to sign an Attendance Sheet, confirming that they have understood and signed the Confidentiality Agreement.

Any reports, minutes and recommendations arising from the CDOP will be fully anonymised and steps taken to ensure that no personal information can be identified.

The CDOP will be accountable to the Chair of the GSCB.

The CDOP is responsible for developing its work plan, which should be approved by the GSCB. It will prepare an Annual Report for the GSCB, which is responsible for publishing relevant, anonymised information. The GSCB takes responsibility for disseminating the lessons to be learnt to all relevant organisations, ensures that relevant findings inform the Children and Young People's Plan and acts on any recommendations to improve policy, professional practice and inter agency working to safeguard and promote the welfare of children.

The GSCB will supply data regularly on every child death as required by the Department for Education and Skills to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of these deaths.

The CDOP will in general meet at 2 monthly intervals but may hold extra meetings if matters are identified by the Chair of the panel or Chair of the GSCB which require an earlier response.

CONCLUSION

In all child deaths irrespective of any individual's background, job and other external factors, local protocols should be adhered to and the following principles should always be respected:

- Sensitivity
- Open minded/balanced approach
- Sharing of information
- Appropriate response to the circumstances
- Preservation of evidence
- Use of an appropriately skilled interpreter or communicator should always be considered

It must be remembered that all staff across the agencies involved in these sad events could potentially be distressed; each agencies' own counselling and post traumatic incident policies should be followed.

The following routes of communication to Agencies and Trusts are recommended.

- Police – Detective Inspector, Public Protection Bureau
- Social Care – Heads of Service, Children and Young People
- Gloucestershire Hospitals NHS Foundation Trust –Divisional Nursing & Midwifery Director, Women and Children, Head of Midwifery and Named Nurse for Safeguarding Children
- ²gether Foundation Trust – Named Doctor for Safeguarding Children
- Gloucestershire Clinical Commissioning Group – Executive Nurse Lead Head of Quality

- Ambulance Trust - Safeguarding Lead/Named Professional Clinical Standards Manager
- HM Coroner – HM Coroner / Coroner's Officers
- Gloucestershire Care Services – Director of Nursing
- Education – Safeguarding Manager
- Early Years – Early Years Safeguarding Lead
- Children in Care – Strategic Lead for Children in Care
- GSCB – Business Unit Manager
- Any other agency that may be relevant to the case.

Other Relevant Processes

Recording and Sharing Information in relation to the investigation of the child death

All professionals involved with the child at the time of death must record the history and background information given by parents in as much detail as possible. The initial accounts about the circumstances, including timings, must be recorded.

Staff from all agencies need to be aware that on occasions, in suspicious circumstances, the early arrest of the parents may be essential in order to secure and preserve evidence.

The Coroner and/or Police may require documentary information held by other agencies, which should be made available in the format agreed by individual agencies. Release of this information is permitted by Data Protection Legislation for the Prevention or Detection of Crime, or in pursuance of statutory functions. Professionals from all agencies must be prepared to provide statements of evidence promptly if required.

Recording and Sharing Information in relation to the child death case discussions

The information discussed at the *Initial Case Discussion* and *Final Case Review* is confidential and will be supported and minutes taken by the CDRC. Minutes will be produced and circulated within 10 working days of the meeting for accuracy to be agreed by each professional involved in the case discussion. They should then be destroyed as the agreed final copy of the minutes will only be retained by the CDR Team in accordance with the Child Death Protocol.

A Summary of the *Final Case Review* will be produced and circulated within 10 working days of the meeting. This Summary document can be retained in the child's notes and can/will be shared with the family (if appropriate). This will become the documented evidence of the discussions for all agency records. The full documented minutes will be kept by the Child Death Review Team **only**.

On occasions information may be discussed at the meeting which may not be relevant to include in the child death case summaries. For example; child protection concerns for previous children in the past or previous involvement with the Police. It is essential this information is shared at the meeting in order to fully assess all factors in the child's background. Occasionally further investigation may be required in order to document these elements of discussion and confidential minutes of the meeting will be held securely by CDRC.

The Children Act 2004 (Updated 2017) states-

(1) Any of the child death review partners for a local authority area in England may, for the purpose of enabling or assisting the performance of functions conferred by section 16M, request a person or body to provide information specified in the request to –
   (a) The Child Death Review partner or any other Child Death Review partner for the area, or
   (b) Another person or body.
(2) The person or body to whom a request under this section is made must comply with the request.
(3) The Child Death Review partner that made the request may enforce the duty under subsection (2) against the person or body by making an application to the High Court or

the County Court for an injunction.

(4) The information may be used by the person or body to whom it is provided only for the purpose mentioned in subsection (1) of the Act.

Statutory Role of the Child Death Review Process

If at any point in the investigation or review of the child's death there are safeguarding concerns about surviving children living in the household, the procedures set out in the South West Child Protection Procedures (*Chapter 5 Working Together Safeguard Children 2015*) should be followed and Children's Social Care take the lead.

The Police will be the lead agency for any criminal investigation.

The CDRC will maintain a close link with the SCR sub group of GSCB. A brief summary of the events leading to all unexpected child deaths will be presented to the SCR sub group for consideration. In addition, any concerns which arise as a consequence of the final CDR will also be presented. This will enable the GSCB to appropriately review all deaths in childhood and any safeguarding concerns.

Guidelines for Individual Agencies

South Western Ambulance Service Foundation Trust (SWASFT)
(See also - Detailed Agency Specific Information)

The Police will be informed or any unexpected death of a child by the SWASFT Clinical Hub at the time of the incident.

An Operational Commander will be informed of any incident involving the collapse, serious injury or death of a child.

An Operational Commander will be dispatched to any incident of presumed Sudden Unexpected Death in Infancy (SUDI).

The resuscitation management of cardiac arrest in any child under 18 will be delivered in accordance with the Resuscitation Council UK Guidelines.

Cessation of resuscitation and Recognition of Life Extinct must be undertaken by an appropriately qualified member of staff in accordance with the criteria detailed in Trust guidelines.

Cessation of resuscitation at scene outside of criteria may only occur if agreed by a Doctor or the Senior Clinical Advisor On-call.

All deceased children must be transported to Gloucestershire Royal Hospital Emergency Department, unless instructed otherwise by a Senior Police Officer. In cases where a child is left at the scene to facilitate a Police investigation, the Trust will transport the body to Gloucestershire Royal Hospital Emergency Department when subsequently requested to do so by the Police.

Following an incident involving a child death, an Operations Officer must meet with the Ambulance Clinicians involved and complete a detailed statement. The statement should include a description of the environment, interactions with relatives and professionals on scene, and any background history obtained.

General Practitioners

There are times when a General Practitioner (GP) attends the scene first. In such circumstances, they should adhere to the same general principles as for the Ambulance Clinicians (see above). In the majority of unexpected collapses/deaths in childhood, dial 999 for Ambulance and Police (if not already present). Begin CPR and facilitate the child and family being transported to GRH ED by Ambulance. Should the GP confirm death at the scene the GP should phone the Coroner's Officer (or Fire Control Room switchboard if out of hours) as soon as possible. ***See Flowchart (Appendix 1) for telephone numbers***

For all deaths in childhood, the child's GP will be invited to the *Initial Case Discussion* and *Final Case Reviews*. If they cannot attend, any relevant background health information for the child or family will be shared with the L/RRNCDR/CDRC. If there are any safeguarding or child protection concerns, it is essential this information is shared in a timely manner. Other information will be shared appropriate to the case and clinical discretion.

Hospital Staff in the Emergency Department
(See also - Detailed Agency Specific Information)

Immediate Action

On arrival in the Emergency Department (GRH), the child should be taken to an appropriate area either the resuscitation room or an area set-aside for such purposes. The Senior Paediatrician on call and the Senior Doctor in the Emergency Department should be notified immediately.

A Nurse should be allocated to look after the family. It is best practice that they should stay with the family at all times and keep them informed about what is happening.

The family should be provided with privacy and should be kept informed at all times. Staff should be particularly sensitive to the parents' needs and should handle the child with care and respect and refer to the child by name.

The child should immediately be assessed and death confirmed or appropriate resuscitation started.

Subject to the approval of the medical staff involved, the parents should be given the option of being present during resuscitation. The allocated Nurse should stay with them to explain what is going on, particularly procedures that may look alarming, such as cutting of clothes or intubation.

The Doctor in charge, whenever possible in consultation with the parents, should decide how long it is appropriate for resuscitation to be continued. It is usual to discontinue resuscitation if there is still no detectable cardiac output after 30 minutes (including prior resuscitation by paramedics).

Immediate responsibility for informing and providing appropriate care and support to the family rests with the Senior Clinician (in the absence of a Paediatric Consultant/team or Emergency Department Consultant).

The circumstances of the unexpected death must be discussed by the Senior Clinician with:

1. the Police
2. Children's Social Team / Emergency Duty Team (if out of hours)
3. the Coroners Officer or Fire Control is out of hours
4. the CDRC/L/RRNCDR child death notification phones available Mon–Fri 8am – 5pm.

See Flowchart (Appendix 1) for telephone numbers

The Senior Medical Officer will provide a written report of the circumstances leading to the child's death and any past medical/developmental history for purpose of the Post Mortem.

Assessment and investigation

A Senior Doctor (Consultant/Registrar level, preferably in paediatrics) should take a careful history of events leading up to and following the death of the child. This record may be used in the legal proceedings. It should be timed, dated and signed legibly.

The consideration should be given as to whether it is feasible to perform a joint meeting with the allocated Police Officer and Senior Doctor to obtain the history from the parent(s).

The child should be carefully examined, in particular noting any evidence of injury and the state of nutrition and hygiene of the child. Any injuries or rashes should be documented on a body chart. A rectal temperature should be taken immediately on presentation, using a low reading thermometer if necessary. The site and route of any intervention in resuscitation, for example venepuncture or intra-osseous needle insertion, needs to be carefully recorded. Full growth measurements (length, weight and, for children aged 2 years or under, a head circumference) if possible, should be taken and plotted on centile charts. The mouth, genitalia and retina should be examined for any signs of injury.

If any laboratory investigation samples are taken during resuscitation, these should be clearly labelled and documented. Once death has been pronounced then further specimens should only be taken in accordance with local agency protocols. For SUDIs further investigation boxes are available in each Emergency Department. For all infants a skeletal survey should be carried out prior to Post Mortem. (***The Coroner's Officer must request this investigation by e-mail directly to Radiology***)

It is usual practice for sudden unexpected deaths and very young children to take photographs of the child along with prints of the hand and foot and a small lock of hair as mementos for the family. If this is done it must be with the consent of the parents and clearly documented in the notes.

Clothing can be left on the child. If removed, it should be placed in labelled evidence bags. Any other item such as bedding brought in with the child should be placed in labelled evidence bags to be given to the Pathologist. The parents should be informed that this has been done. ***No items should be returned to the parents without consultation with the Senior Investigating Police Officer involved. Parents should also be warned as to the condition of the clothing prior to it being returned.***

The family should be allowed as much time and privacy as they wish with the child. Professional presence is vital at all times, but should be discreet.

The family should be informed of the Child Death Review Process, the need to notify the Coroner, and that a Post Mortem will be required for all unexpected deaths unless special circumstances are agreed by the Coroner's Officer.

The family should be given copies of available and appropriate bereavement support leaflets, booklets and contact details as well as local leaflets explaining the Child Death Review Process. (***Appendix 2***).

The Allocated Nurse should ensure that the family knows where their child will be before they leave the hospital, and that they have the contact details to enable them to arrange a visit if they wish.

The family should be offered help in contacting other family members or close friends, employers, the hospital chaplain or other faith representative if the parents wish.

If the infant was a twin, it will normally be appropriate to consider admitting the surviving twin to hospital for monitoring. You may wish to consider other young children in the household.

Where there are other children in the household and there are indications that the circumstances surrounding the child's death are suspicious, these concerns must be conveyed to the Senior Investigating Police Officer whose responsibility will be to consider the safety of the other children in conjunction with Children's Social Care.

Where the death occurred in a hospital the Trust's serious incidents protocol should also be followed.

Police
(See also – Detailed Agency Specific Information)

In Gloucestershire the responsibility for investigating unexpected child deaths lies with the Detective Chief Superintendent, Protective Services. Out of hours the Constabulary's on- call Senior Investigating Officer (SIO) or Detective Inspector will assume responsibility for the initial rapid response.

It is important for Police Officers to remember that for most sudden deaths, the death has been the result of natural causes. Police investigating unexplained but apparently natural deaths are acting on behalf of HM Coroner and it is important to stress this to the bereaved family. Police action therefore needs to maintain a careful balance between consideration for the bereaved family and the potential of a crime having been committed.

In all cases the Coroner's Officer must be notified as soon as possible, via Fire Control Room if out of hours ***See Flowchart (Appendix 1) for telephone numbers***. As well as the usual functions they perform, their experience in dealing with sudden deaths and bereaved families will be invaluable in explaining to the parents what will happen to their child's body and why. It may be useful for the Coroner's Officer to attend the scene, but it is not absolutely necessary. The Investigating Officer and the Coroner's Officer should continue close liaison throughout the investigation.

If the Police are the first professionals to attend the scene, they should request urgent medical assistance as the first priority (SWASFT). It is best practice for the child/young person and any family to be conveyed into Gloucestershire Royal Hospital Emergency Department.

Police should keep attendance to the minimum required. A single Police Officer should have the lead responsibility for interviewing the parents, who should not be subjected to repeated questioning by different people about the same events. The Detective Inspector or Senior Investigating Officer will determine this.

Police should exercise sensitivity in the use of personal radios and mobile phones etc. If possible, the Officers speaking with the family, whilst not being out of contact, should have such equipment turned off.

When a sudden unexpected child death occurs at home the child may still be there when the Police and other professionals attend. However, usually the child will already have been taken to the hospital. If this is the case, the principles remain the same. However, in such a situation, there may be two scenes and resources will need to be allocated accordingly. It is important to note that if the child has already been moved from the home, this does not negate the need for professionals to visit the home. All professionals should avoid referring to the home as the "death scene", or using other inappropriate phrases, which might be misunderstood, or distressing to the family.

The Senior Detective attending will be responsible for deciding on whether to request the attendance of a Crime Scene Investigator. If items are to be removed or Police photographs or a video are to be taken, their attendance will be essential.

The first Officer at the scene must make a visual check of the child and his/her surroundings, noting any obvious signs of injury. The Officer must establish whether the body has been moved and record the current position of the infant. All other relevant matters should also be recorded. Consideration must be given to evidencing factors of neglect that may have contributed to the death such as temperature of scene, condition of accommodation, general hygiene and the availability of food/drink. The Senior Detective attending is responsible for ensuring that this is done.

An early record of events from the parent is essential, including details of the child's recent health. This should normally be collected jointly or in close collaboration with healthcare professionals. If death is pronounced at a hospital then consideration should be given to performing a joint discussion interview of the parents with the Senior Doctor/Clinician (usually a Paediatrician).

The preservation of the scene and the level of investigation will be relevant and appropriate to presenting factors. In addition to the normal procedures surrounding a suspicious death (e.g. scene log, general preservation, photographs etc.) and in consultation with a Senior Detective, consideration must be given to:

- Retention of bedding and items such as the child's used bottles, cups, food, medication that may have been administered. This may be influenced by obvious signs of forensic value such as blood, vomit or other residues. Items should be retained only after the scene has been assessed and recorded by the Police
- The child's nappy and clothing should remain on the child but if removed arrangements should be made for them to be retained at the hospital
- Records of monitoring equipment used by the Ambulance Service which may be of evidential value; otherwise, this information may only be retained for 24 hours

The issues of continuity of identification must be considered. The child should be handled as if he/she were alive.

In general, avoid any disturbance of the environment around the place where the body was found until the Senior Investigating Officer has carefully assessed this. This will allow the best understanding of what may have happened and will also result, in those few cases where it is appropriate, in the preservation of the scene for forensic investigation. Non- forensic removal of bedding and other objects destroys the scene and prevents full investigation of what happened - both medical and forensic.

If it is considered necessary to remove items from the house, do so with consideration for the parents. Explain that it may help to find out why their child has died and that they will be returned later. Before returning the items, the parents must be asked if they actually want them back.

If articles have been kept for a while, try to ensure that they are presentable and that any official labels or wrappings are removed before return. Return any items as soon as possible after the Coroner's verdict or the conclusion of the investigation. The term investigation will include any possible trial or appeal process.

Police Officers have to be aware of other professionals' responsibilities, i.e. resuscitation attempts, taking details from the parents, examination of the child who has died and looking after the welfare needs of the family. Police Officers may have to wait until some of these things have happened and take details from these professionals before introduction to the parents. It is not helpful and may be distressing if the same questions are asked repeatedly.

Paediatricians may have already collected health and childcare information at the hospital and may be better able to obtain important details of the medical aspects of what happened. It is best to ask who was present when the child was fed, vomited, fell, etc. All comments should be recorded. Any conflicting accounts should raise suspicion, but it must not be forgotten that any bereaved person is in a state of shock and possibly confused. Repeat questioning of the parent(s) by different Police Officers should be avoided at this stage. Joint working with other agencies is essential.

There may be other children at the scene and their health and wellbeing is of paramount importance. Where there are other children in the household and there is immediate information or later findings which indicate non accidental injuries to the dead child, the information must be conveyed as soon as practicable to the investigating Police Officer, whose responsibility would be to consider the safety of the other children in consultation with Children's Social Care. If alternative arrangements for the care of the other children are deemed appropriate and if no other suitable accommodation is available consideration should be given to using Police Protection Powers or, in consultation with Children's Social Care, an Emergency Protection Order (EPO). These decisions should not be taken lightly and consultation with the Police Public Protection Bureau (PPB) and other agencies is essential. An urgent discussion initiated by Police within three to four hours to consider the information available should do this.

Police visits to the home should be kept to a minimum, and should be carried out by specially trained Officers in plain clothes, whenever possible.

Where the death occurred in a custodial setting appropriate liaison should occur with the investigator from the Prisons and Probations Ombudsman.

Where the Lead Investigator suspects that the death may be a result of homicide then this must be referred to a Senior Investigating Officer from the Major Crime Investigation Team who will then lead the crime investigation.

Children's Social Care
(See also – Detailed Agency Specific Information)

In all cases of sudden unexpected child death, Children's Social Care or if out of normal office hours, the Emergency Duty Team. will be contacted for any information they may hold about the child and/or family. A tripartite (Health, Children's Social Care and Police) discussion will always take place where there are other children of the family, or there is information held about the family or child who has died. ***See Flowchart – (Appendix 1) for phone numbers***

Children's Social Care may become more directly involved either where there are specific support needs if there are other children in the family, which cannot be met by other services, and always where there are child protection concerns arising from the circumstances of the death.

Where Children's Social Care have had no previous involvement with the child or family, and are not needed to be involved in the investigation, they should still be invited to the *Initial Case Discussion* meeting and be notified of the outcome for future file reference.

Where suspicious factors around the death have been identified and there are other children, there will be a formal child protection strategy meeting in relation to the other children lead by Children's Social Care. This meeting should ideally be face to face, and should include a Senior Police Officer; a Paediatrician and a senior representative from the relevant Children's Social Care team or Emergency Duty Team (EDT). It should also include other relevant professionals.

Coroner/Pathologist and Post Mortem

After the death is pronounced the Coroner has control of the body, mementoes and medical samples **(*Appendix 4*).**

The Pathologist is chosen by the Coroner, in consultation with Police and other relevant professionals.

The Post Mortem together with ancillary or additional investigations that become appropriate during the procedure should be performed to the current Royal College of Pathologists guidelines. If during the Post Mortem a Pathologist becomes at all concerned that there may be suspicious circumstances, s/he must halt the Post Mortem and a Home Office Pathologist must be contacted.

If the Coroner has any concerns, having been made aware of all the facts, that the death may be of a suspicious nature, then the Home Office Pathologist will be used in conjunction with a Paediatric Pathologist. In such circumstances, the agreed protocol will be followed in addition to any necessary forensic investigations.

Both the Coroner and the Pathologist must be provided with a full history at the earliest possible stage. This will include a full medical history from the Paediatrician, any relevant background information concerning the child and the family and any concerns raised by any agency. The Investigating Officer is responsible for ensuring that this is done.

The Coroner's Officer must ensure that all relevant professionals are informed of the time and place that the Post Mortem will be conducted as soon as it is known. A Crime Scene Investigation Officer must attend all Post Mortems conducted by a Home Office Pathologist.

Parents must be informed that small tissue samples will be retained for further investigation. They should be given the choice of whether samples are retained or returned to them once the Coroner has concluded their investigation.

Immediately following the completion of a Post Mortem, the interim or final findings should be provided to the Senior Investigating Officer and Coroner. The interim result may well be "awaiting histology/virology/toxicology" etc.

The final result must be notified in writing to the Coroner as soon as it is known.

The Coroner's Officer will forward copies of the Post Mortem report to the Investigating Officer and Child Death Review Co-ordinator, who will forward to the relevant health professionals involved in the case.

Final Post Mortem reports may be shared with the family by relevant health professionals unless criminal proceedings are continuing. The GP will receive a summary of the findings.

Appendix Two

CDOP Leaflet for Parents, Families and Carers

Gloucestershire Child Death Overview Panel

Information for Parents, Families and Carers

The death of a child is a very difficult time for parents, families and carers. As professionals working with the Gloucestershire Child Death Overview Panel, we recognise this and extend our sympathies to all bereaved families.

The following information helps to explain what has to happen following the death of a child or young person under 18 years of age, by way of a Review.

What is a review and why is it needed?

Government legislation requires that every Local Safeguarding Children Board has a Child Death Overview Panel to review the death of every child and young person from their area.

The review aims to try and identify any factors which may improve the health and wellbeing of children and families in the future.

How does a review happen?

Information about your child and how they died is collected and summarised in an anonymised report.

The information comes from records held by Hospitals, GP's, Health Professionals, Schools, Police, Children's Social Care, Education and other agencies who may have known your child.

The report also includes some information about your family circumstances so that the Panel can ensure you are being supported appropriately.

The Child Death Overview Panel includes Doctors, other Health Specialists, Children's Services, Police and Public Health.

They will look at the circumstances of your child's death and decide whether to recommend any changes and improvements to services for children or that might help to prevent similar deaths in the future

Recommendations are passed on to the organisations that are responsible for planning and managing services for children locally, as well as to other relevant agencies.

What happens when your child's death is reviewed?

Your Local Child Death Overview Panel (Gloucestershire) will be informed of your child's death and when all of the information has been collected they will be given anonymised information about what happened.

Sometimes it can take some months before all of the information is ready as the panel will wait until any investigations, for example Post Mortem results have been completed.

Parents are not invited to the panel meetings but you are asked to contribute any comments that you may have into the review of your child's death. The comments can be about anything related to their care or treatment. You will be contacted prior to the meeting to discuss this in more detail.

The information gathered is treated with the greatest respect and in the strictest confidence. We promise that none of our findings, recommendations or reports will name or identify your child or family.

Lessons learned and recommendations made will be included in our Annual Report.

If you have any questions in relation to this process please contact us on 01452 426228 or e-mail the Child Death Review Team on cdop@gloucestershire.gov.uk

Bereavement Advice

Opening Hours

The bereavement offices are open between 10am and 4pm to the public but staff are available from 8:30am Monday to Friday excluding bank holidays.

Contact details:

Gloucestershire Royal Hospital	0300 422 6742 or 0300 422 6982
Cheltenham General Hospital	0300 422 4753 or 0300 422 4235
e-mail:	Bereavement.Service@glos.nhs.uk

Compliments and Complaints

This review is about learning and improving services for children and families. It is not about attributing blame.

Respectfully, we advise that compliments and complaints are directed to the organisation involved.

Information and advice regarding compliments, feedback and complaints can be accessed:

Children's Services - Gloucestershire County Council
Children's Helpdesk Tel: 01452 42 6565
e-mail: childrenshelpdesk@gloucestershire.gov.uk

Education Services - Gloucestershire County Council

We advise parents and carers to contact the individual nursery, school or college.

Health
Gloucestershire NHS Foundation Trust
http://www.gloshospitals.nhs.uk/en/Contact-Us/Contact-Us

Police

Gloucestershire Constabulary
https://www.gloucestershire.police.uk/contact-us/give-us-feedback-or-make-a-complaint

Appendix Three

Notification of a Child Death to Trusts and Agencies

When a child dies in Gloucestershire, notification is made by the CDRC to the following professionals for dissemination throughout their trusts/agencies.

Head of Services - Safeguarding	Gloucestershire County Council
LADO	Gloucestershire County Council
Designated Doctor for Child Death and Community Paediatrician	Gloucestershire Hospitals NHS Foundation Trust
Head of Children's Services	Gloucestershire Care Services
Named Nurse	Gloucestershire Clinical Commissioning Group
Named Nurse for Safeguarding (October 2017)	Gloucestershire Care Services
MASH	
Safeguarding and Patient Experience Manager	NHS England
MASH Decision Maker	MASH
GSCB Business Unit Manager	Gloucestershire Safeguarding Children's Board
Paediatrics Information Assistant	University Hospitals Bristol NHS Foundation Trust
Named Nurse	2gether Foundation Trust
Director of Nursing	Gloucestershire Care Services
Head of Quality (Children and Young People)	Gloucestershire County Council
Lead Midwifery for Quality and Governance	Gloucestershire Hospitals NHS Foundation Trust
Consultant in Public Health and CDOP Chair	Gloucestershire County Council
Head of Clinical Governance	Gloucestershire Care Services
CHIS	
Named GP	Gloucestershire Clinical Commissioning Group
Director of Nursing	Gloucestershire Hospitals NHS Foundation Trust
Named Doctor	Gloucestershire Hospitals NHS Foundation Trust
Detective Inspector	Glos Police
Safeguarding Admin Support /Co-ordinator Community Paediatrics	GRH
Named Doctor	2gether Foundation Trust
Lead Administrator, CYPS	Gloucestershire Care Services
Children's Risk and Safety Manager	Gloucestershire Hospitals NHS Foundation Trust
CDOP Manager	University Hospitals Bristol NHS Foundation Trust
MASH Decision Maker	MASH
Deputy Medical Director	Gloucestershire Care Services
Child Death Review Co-ordinator	Gloucestershire Safeguarding Children's Board
Named Doctor	Gloucestershire Care Services
Interim Director of Children's Services	Gloucestershire County Council
Named Nurse for Safeguarding (Temp)	Gloucestershire Care Services
Secretary to Sarah Birmingham	Gloucestershire Care Services
Paediatric Liaison Health Visitor	Gloucestershire Care Services

Appendix Four

Investigations of sudden & unexpected death in infancy/childhood
Packs for the investigation will be found in the cupboards in the paediatric resuscitation bays.
It is recognised obtaining samples may be difficult and problematic. Attempt as best you can from a venous or arterial site (avoid cardiac puncture). CSF should only be taken from the spine (avoid the head).
List samples taken in notes and inform pathology of any samples not taken.
Once opened please return box to Tash/Kim.

Kennedy minimum standard recommendations are starred (July 2017)

Form	Investigation	Colour of Bottle	Tick if Taken	Test	Result
RED	*Blood (serum) (1-2 mls)	Red		Toxicology	
GREEN	Blood	Green		Electrolytes	
GREEN		Grey		Glucose	
GREEN		Green		LFT	
GREEN		Purple		FBC	
GREEN		Blue		Clotting	
BLUE	Blood (EDTA) (1-2 mls)			Meningitis (microbiology)	
BLUE	*Blood Culture (1 ml)			MC & S	
BLUE	*Blood Culture (Guthrie Card)			Inherited metabolic disease	
Chromosome Form	*Blood (lithium heparin) (1-2 mls)	Big Green		Chromosomes if dysmorphic (to genetics)	
BLUE	*CSF (few drops)			MC & S	
RED		Plain		Protein	
GREEN		Grey		Glucose	
BLUE	*Nasopharyngeal aspirate			MC & S	
BLUE				Viral culture immunofluorescence & DNA amplification	
BLUE	*Swab from any identifiable lesion			Culture & sensitivity	
BLUE	*Urine SPA if available	Pot		Toxicology	
	*Other - urine			Inherited metabolic disease	
BLUE	Viral	Green swab		Swine Flu	

Consider

Skeletal Survey	Mandatory for all unexpected deaths in infancy. Consider for older children whose death is unexpected, unexplained or not showing signs of infection.
Skin/Liver biopsy	For unexpected deaths where inherited metabolic disease is suspected (contact biochemistry)

The Child Death Process

Since 2009 it has been a Government mandatory process to fully investigate all deaths in childhood (<18 years). To facilitate Gloucestershire's Child Death Review Team on confirmation of the child's death please:-

- If death is unexpected contact is to be made to -
  a) Coroners Officer on 01452 305661 giving name of child, time of death, and NHS Number.
  b) Ambulance Control 01242 959023 (out of hours)

- For all deaths, contact the Child Death Phone on **07826 510 227** or **07825 340 968**.
  Please leave a message including child's full name , dob, dod, cause of death, where child died and your contact details. This team work Mon-Fri 9-5 and will respond as soon as possible.

If further advice is needed please contact CDOP by e-mail at cdop@gloucestershire.gov.uk or call PLHV on 07789 986 793

Appendix Five

Form A2 Initial/Final - Child Death Review Attendance Sheet and Confidentiality Declaration/Principles

Date:

The chair of the meeting will remind all attending of the confidential nature of the meeting.

INFORMATION DISCUSSED AND SHARED BY AGENCY REPRESENTATIVES IS STRICTLY CONFIDENTIAL AND MUST NOT BE DISCLOSED TO THIRD PARTIES OUTSIDE THE MEETING WITHOUT THE AGREEMENT OF THE CHAIR OF THE MEETING.

INFORMATION CAN BE DISCLOSED TO OTHER TEAM MEMBERS IF NECESSARY TO CARRY OUT SPECIFIC RESPONSIBILITIES OUTLINED IN THE ACTION PLAN.

THE FOCUS OF THE MEETING IS TO REVIEW THE UNXPECTED DEATH OF THE CHILD AND CLEAR DISTINCTIONS SHOULD BE MADE BETWEEN FACT AND PROFESSIONAL OPINION.

PUBLIC STATEMENTS ABOUT THE GENERAL PURPOSE OF THE CHILD DEATH REVIEW PROCESS MAY BE MADE, AS LONG AS THEY ARE NOT IDENTIFIED WITH ANY SPECIFIC CASE.

THE MINUTES OF THIS MEETING WILL BE CIRCULATED FOR ACCURACY TO THOSE ATTENDING FOR CONFIRMATION OF FACT BUT SHOULD NOT BE PRINTED OR STORED WITHIN THE CHILDS OR FAMILYS RECORDS.

A SUMMARY OF THE FINAL REVIEW WILL BE PRODUCED WHICH WILL BE MADE AVAILABLE TO THE FAMILY (IF REQUESTED) AND CAN BE SHARED ON CHILD'S FILE AND SHARED AS NEEDED. INDIVIDUALS ARE ASKED TO ONLY TAKE NOTES FOR ACTIONS REQUIRED OR INFORMATION NEEDED TO FOLLOW UP INQUIRIES AND MUST BE DESTROYED AND REPLACED BY THE AGREED SUMMARY.

CONFIRMATION OF ACCEPTING THE MINUTES AND SUMMARY WILL BE REQUIRED.

NAME	AGENCY	JOB TITLE	E MAIL ADDRESS	TELEPHONE NUMBER	SIGNATURE	COPY OF PM

Appendix Six

USEFUL CONTACTS

The Lullaby Trust
www.lullabytrust.org.uk
- 0808 802 6868

Stillbirth and Neonatal Death Society (SANDS)
www.uk-sands.org.uk
- 0808 164 3332 (National Helpline)

Miscarriage Association
www.miscarriageassociation.org.uk
- 01924 200799 (National Helpline – M-F 09.00-16.00)

Child Death Helpline
www.childdeathhelpline.org.uk
- 0808 800 6019 (National Helpline – M-F 10.00-13.00 & T&W 13.00 – 16.00 & 19.00-22.00)

Child Bereavement UK
www.childbereavementuk.org
- 01494 568900

Compassionate Friends
www.helpline@tcf.org.uk
- 0345 123 2304 (National Helpline – 7 days 10.00-16.00& 19.00-22.00)

CRUSE Bereavement Care
www.cruse.org.uk
- 0808 808 1677
- 01242 252518 (Local helpline)

Winstons Wish
www.winstonswish.org.uk
- General Enquiries: 01242 515157

Survivors of Bereavement by Suicide (SOBS)
www.uk-sobs.org.uk
- 0300 111 5065 (National Helpline 7 days)
- 01452-371945 (local support group)

Meningitis Trust
www.meningitisnow.org
- Helpline: 0808 80 10 388

The UK Sepsis Trust
www.meningitisnow.org
- Support Line: 0800 389 6255

Appendix Seven

Detailed Agency Specific Information.

(Please refer to the main protocol in the first instance)

Gloucestershire Hospitals NHS Foundation Trust

A For a child brought to the Emergency Department.

Expect two possible responses:

1

- 999 call to SWASFT triggers Paramedic response.
- Ambulance Service notifies Police of case (via control room).
- At home resuscitation started.
- Child and Family brought to the Emergency Department (ED) Gloucestershire Royal Hospital.
- Gloucestershire Royal Hospital alerted by Ambulance and Paediatric Crash Team call to ED raised.

2

- Child brought by family to ED (rare cases)
- Paediatric Crash call
- Resuscitation started

Procedures

- Resuscitation continued.
- Nurse allocated to the Family.
- Profoma commenced – brief history of events obtained and documented.
- Consultant Paediatrician on-call, or Emergency Department Consultant determines when to stop resuscitation.
- Child pronounced dead.
- On confirmation of death the Paediatric Consultant should;
  - Alert the Police if the child was brought into hospital and the Police are not already present.
  - Take a full detailed history of life of child including details surrounding events leading to child's demise preferably this will be performed jointly with a Police Officer. This should be accompanied by a full and detailed examination of the child noting evidence of haemostasis. If any suggestions of non-accidental injury urgently refer to Children's Social Care / Police.
  - Obtain consent for investigations. For unexpected death in infancy ensure that a full skeletal survey and SUDI investigation boxes (available in ED departments) are completed.
  - Notify Coroner's Officer of case (01452 305661 or for out of hours Fire Control Room 01242 959023).
  - Notify the Child's death to Child Death Review Co–ordinator (01452 426228) or Child Death Notification Phone (07825 340 968) or Rapid Response Nurse for Child Death Review (0782 651 0227).

- Explain the Child Death Review process and the need for a Post Mortem with the family.
- Provide the family with the Gloucestershire Child Death Overview Panel Leaflet (***Appendix 2***)
- Provide a written report of the child's history and resuscitation as soon as possible for the Coroner and Pathologist.
- Attend if possible or send a representative to the *Initial Case Discussion* / Strategy meeting.
- Determine/discuss the most appropriate health professional to continue to support the family.
- Attend if possible or send a representative to the *Final Case Review* meeting.

B For a Child who dies unexpectedly in hospital

On confirmation of a child's death the Paediatric Hospital Consultant should:

- Notify the Coroner's Officer (or 01452 305661 or if out of hours via Fire Control Room 01242 959023)
- Notify the Clinical Risk Department in hospital
- Notify the Child's death to Child Death Review Co–ordinator (01452 426228) or Child Death Notification Phone (07825 340 968) or Rapid Response Nurse for Child Death Review (0782 651 0227).
- Provide a written report of the child's history, resuscitation and clinical progress in hospital resulting in the child's demise.
- Attend if possible or send a representative to the *Initial Case Discussion*/Strategy meeting.
- Determine/discuss the most appropriate health professional to continue to support the family.
- Attend if possible or send a representative to the *Final Case Review* meeting.

C For a Child whose death is expected

Prior to the child's death, the Consultant Paediatrician working with the child's family should notify the plans for the child's expected death to Child Death Review Coordinator (01452 426228) and forward any resuscitation/DNAR policies (CDRC will forward these to Ambulance Control) cdop@gloucestershire.gov.uk

On confirmation of the child's death:

- Notify the Trusts Clinical Risk Department.
- Notify the Child's death to Child Death Review Co–ordinator (01452 426228) or Child Death Notification Phone (07825 340 968) or Rapid Response Nurse for Child Death Review (0782 651 0227).
- Continue to provide support for the family as appropriate.
- Attend if possible or send a representative to the *Final Case Review*.

D Babies who die and do not leave the hospital from birth

- Notify the Trust Clinical Risk Department.
- Continue to complete the relevant child death notification form.

- Notify the Child’s death to Child Death Review Co–ordinator (01452 426228), Child Death Notification Phone (07825 340 968) and/or Rapid Response Nurse for Child Death Review (0782 651 0227).
- Case to be discussed at Neonatal Child Death Review Meetings arranged by CDRC.

Appendix Eight

Detailed Agency Specific Information.

(Please refer to the main protocol in the first instance)

NHS Gloucestershire/ Gloucestershire Care Services staff

a) Professionals who are informed of a child death must contact the Child Death Review Co–ordinator (01452 426228) or Child Death Notification Phone (07825 340 968) or Rapid Response Nurse for Child Death Review (0782 651 0227) at the earliest opportunity and provide them with whatever information they have. The sharing of information at an early stage following the report of a child death is vital.

b) The Rapid Response Nurse will review electronic records for the child.

c) The DATIX system is available for on-line incident reporting and will be completed by the Rapid Response Nurse in the event of an unexpected child death and the Lead Nurse for Child Death in the case of an expected death.

d) The Primary Care Team plays a crucial role in supporting the family following a sudden child death. The Specialist Public Health Nurse, GP (or in some cases the Paediatrician/Lead Nurse for Child Death) will undertake an initial home visit for support within 24 – 48 hours to assist the family in coping with the loss of a child. There must be liaison with the Senior Investigating Officer prior to any contact to avoid duplicating visits and to ensure inappropriate questions are not asked about the circumstances of the child's death. This is normally arranged during the *Initial Case Discussion* meeting.

Appendix Nine

Detailed Agency Specific Information.

(Please refer to the main protocol in the first instance)

Ambulance Service

SWASFT operates a single unified approach to the management of child resuscitation and child death across the entire region of operations. Within Trust policy, a child refers to any person under the age of 18. As at the 1st August 2017, the current documents which outline the policies and procedures which Trust staff must follow are:

- Trust Clinical Guideline CG07, Cardiac Arrest, version 1.0, issued 1st October 2014.
- Standard Operating Procedure OP034, Child Death Information Statement, issued 24th April 2015.
- Clinical Hub Standard Operating Procedure CH010, Unexpected Death, issued 10th August 2011.
- Standard Operating Procedure OP006, Operations Officers, version 1.2, issued 25th October 2016.

Summary of key procedures:

1. The Police will be informed or any unexpected death of a child by the Clinical Hub (CH010) at the time of the incident.
2. An Operational Commander will be dispatched to any incident of Sudden Unexpected Death in Infancy (OP006).
3. An Operational Commander will be informed of any incident involving the serious injury or death of a child (OP006).
4. The resuscitation management of cardiac arrest in any child under 18 will delivered in accordance with the Resuscitation Council UK Guidelines (CG07).
5. Cessation of resuscitation and Recognition of Life Extinct must be undertaken by an appropriately qualified member of staff in accordance with the criteria detailed in Trust guidelines (CG07).
6. Cessation of resuscitation at scene outside of criteria may only occur if agreed by a Doctor or the Senior Clinical Advisor On-call (CG07).
7. All deceased children must be transported to an Emergency Department, unless instructed otherwise by a Senior Police Officer. In cases where a child is left at the scene to facilitate a police investigation, the Trust will transport the body to an ED when subsequently requested to do so by the Police (CG07).
8. Following an incident involving a child death, an Operations Officer must meet with the Ambulance Clinicians involved and complete a detailed statement. The statement should include a description of the environment, interactions with relatives and professionals on scene, and any background history obtained (OP034).

Appendix Ten

Detailed Agency Specific Information.

(Please refer to the main protocol in the first instance)

Police Service

Upon notification of a sudden unexpected death in childhood (U18) the police will:

- If first attenders, ensure that urgent medical assistance is requested as a priority
- Utilise the use of the Constabulary IT system "GCIS" to gather information and inform initial decision making (i.e. Domestic Abuse/Child Protection/Mental Health and Substance misuse information)
- In situations where an accident is the cause of death, consideration needs to be given to whether the accident reflected inadequate care of a child and therefore this protocol will apply. Supervisory attendance will be fundamental to that decision-making
- A Senior Detective of at least the rank of Inspector must make early contact with the on-call Paediatric Consultant to discuss their thoughts on whether or not the death could be suspicious. This will inform any subsequent Police action i.e. the seizure of bedding, declaration of potential suspects etc.
- Ensure the Senior Detective takes charge of the investigation and in conjunction with the Consultant Paediatrician meets with the family at the earliest opportunity
- Ensure that death is certified and the Coroner is notified if not already completed
- Consider the use of a Family Liaison Officer in accordance with national practice and guidance
- Evidence any apparent factors of neglect
- Designate potential crime scenes – including initial location of child, hospital, vehicles etc.
- Minimise the use of uniform staff
- Ensure that Children's Social Care are informed if not already done by medical staff
- Contribute to the multi agency Strategy meeting to determine further action
- If the child is not already at the hospital ensure that s/he is accompanied to the hospital casualty department by ambulance to ensure continuity.
- Complete with medical staff a physical examination recording observations in addition to use of photographs
- Consider the use of HQ photographic department to record digitally in 360 format the home address and or other relevant scenes. This is in addition to the use of Scenes of Crime Officers (SOCO)
- Consider requesting/obtaining blood and/or urine samples from carers where appropriate to investigation (as per ACPO 'A Guide to Investigating Child Deaths'). Agree suitable Paediatric Pathologist in conjunction with hospital Paediatric Consultant. If the death is obviously suspicious then a Home Office Pathologist will be requested to work with the Paediatric Pathologist
- Ensure that a full skeletal survey, if appropriate (Coroner's Officer to request directly to Radiology) and extensive toxicology tests are completed
- Consider relevant lines of enquiry dependent on the age of the child with the minimum information collected to include (ACPO guidance on Investigating Child Abuse and Safeguarding Children 2009):

a) Person(s) who saw the child last and the time
b) Any action taken prior to the arrival of the emergency services and who contacted the emergency services
c) Child's last feed, including time, food given and by whom, e.g., whether the child was breast or bottle fed
d) Who put the child to bed and where they were sleeping, e.g., in the same room or bed as the parent, in a cot, the sleeping position of the child
e) Who found the child and who else was in the house at the time
f) Child's condition when found, e.g., their colouring, breathing, level of consciousness
g) Temperature of the room where the child was found and details of clothing or wrapping on the child, e.g., whether bedding was tucked in, whether an electric blanket was used, how the room and house were heated
h) Whether an infant intercom was in place
i) Who was with the child in the 24 hours before the death
j) Child's behaviour and health 72 hours prior to death
k) Whether parents, carers or other members of the house smoke and whether there are any restrictions on smoking in the house
l) Details of any previous child deaths or acute life threatening events in that or the extended family
m) History of child abuse
n) Details of parents' or carers' previous relationships where they have had children and significant events in the lives of the children
o) Details of the child's birth, e.g., method of delivery, whether they were born prematurely and the birth weight, details of any special treatment required for the child and whether the child was discharged from hospital with their mother
p) Details of the child's health (and any other siblings) since birth, e.g., whether they have seen a doctor or been admitted to a hospital or clinic or received medical checks, including dates of appointments, history of injections and any details of unsuitable feeding
q) Details of advice received by parents from health care professionals with regard to the prevention of sudden infant death
r) Contents of the child health record detailing medical checks, examinations and development which is given to every parent and is also known as the 'red book'
s) Details of family members such as siblings and foster children, including history of illness and standards of care given by the parents
t) Any records of the family on PNC, INI, force intelligence systems, crime recording systems, command and control records, domestic abuse logs and whether the child is or has been the subject of a child protection plan.
u) Any records of the children, parents or carers held by Children's Social Care or other agency.

In cases where there is a suspicion that the death is unlawful, The Murder Investigation Manual (ACPO 2006) is to be followed, together with supplementary ACPO Guidance 'A Guide to Investigating Child Deaths'.

Appendix Eleven

Detailed Agency Specific Information.
(Please refer to the main protocol in the first instance)

Children's Social Care

When a child dies unexpectedly there will be an immediate information sharing and planning discussion between the lead agencies (i.e. Police, Health and Children's Social Care) to decide what should happen next and who will do what.

Single point of contact to Children and Family Social Care Services	**Single point of contact during out of hours (inc weekends and Bank Holidays)**
Childrens Helpdesk	**EDT**
01452 426565	01452 614758
childrenshelpdesk@gloucestershire.gov.uk	

As soon as Helpdesk or EDT are aware of a child death they must notify the Child Death Review Team on 01452 426228 or 07825 340 968 and/or e-mail cdop@gloucestershire.gov.uk

A referral will be made to the Customer Services Helpdesk, with the child and family details. Out of hours this will be actioned by EDT.

During these initial telephone discussions any safeguarding or child protection concern will be explored and appropriate actions taken if necessary for other children in the family. Children's Social Care will take the lead.

The sharing of information between relevant agencies at an early stage following the report of a sudden child death is vital. It will assist in assessing the level of any suspicions and in deciding upon the direction and level of investigation, practice, procedures, the timing and personnel involved in any home visits, ensuring appropriate support for the family, and in determining the overall strategy to be adopted.

In all cases of an unexpected child death, a formal *Initial Case Discussion* will be held on the next working day following the child's death and a representative from Children's Social Care will attend to participate fully in all discussions relevant to the child and family. This will be chaired by Health. If at any time safeguarding concerns are raised in relation to other children in the family, Children's Social Care will take the lead and a Strategy meeting arranged as appropriate.

Children's Social Care will be kept updated by the Child Death Review Co-ordinator/Lead/Rapid Response Nurse as to the outcomes of any investigations during the Child Death process and as to the date of the *Final Case Review*.

Appendix Twelve

Detailed Agency Specific Information.
(Please refer to the main protocol in the first instance)

Roles of the Child Death Review Team

Designated Doctor for child deaths

A role key to the whole process. This person will be expected to provide an overview of the whole process and ensure:

- Notification of all child deaths is received.
- The Acute Response Team is well co-ordinated.
- Relevant professionals are aware of the child's death e.g. Police, Coroner, GP etc.
- If the child is from a different county ensure liaison occurs with Local Designated professionals for child death.
- All relevant information is shared appropriately and outcomes from Child Death Reviews are actioned, implemented and audited.
- *Final Case Review* meeting (when final Post Mortem results are available) is chaired appropriately by him/herself/delegate.
- Attendance at Child Death Overview Panel (CDOP).
- Report to Director of Nursing, Gloucestershire Clinical Commissioning Group.
- Close liaison with the Chair of the Serious Case Review sub group of the GSCB.
- Input provided to the CDOP Annual Report.

Lead/Rapid Response Nurse for Child Death Review

- Receive notification of child death normally from CDRC or from holding the Child Death Notification Phone.
- Contact the relevant professionals e.g. Health Visitors/School Nurses, GPs, Education to inform them of the child death and obtain relevant background information.
- Contact the Police and Children's Social Care regarding the need for an *Initial Case Discussion* meeting (normally always held following an unexpected child death).
- Convene and chair the *Initial Case Discussion* meeting.
- All contacts with family including home visits need to be fully documented and information retained within the secure file held by the CDRC.
- Once the initial Post Mortem report is available contact all the relevant agencies, to decide whether a second case discussion meeting is required.
- Identify a professional to liaise with the family and provide support.

Additional roles of Lead Nurse

- Support staff involved in the process and to lead a debrief session for them if required.

- To produce regular reports on child deaths highlighting trends and to contribute to the Annual Report.
- Attend regional network meetings to discuss CDRP and CDOP.

Child Death Review Co-ordinator

- Receive initial contact regarding a child death and record information appropriately.
- Notify Lead/Rapid Response Nurse for Child Deaths.
- Support the Lead/Rapid Response Nurse to contact the relevant professionals e.g. Health Visitors/School Nurses, GPs, Education to inform them of the child death.
- Collate confidential and sensitive information for *Initial Case Discussion* and *Final Case Review* meetings.
- Co-ordinate and set up *Initial Case Discussion* and *Final Case Review* meetings liaising with professionals to ensure maximum attendance/representation at short notice.
- Send attendance list and contact details to all attendees the next working day to ensure that contact between professionals can be made if required.
- Take minutes and summaries of these case discussion meetings and circulate within 10 working days; unless child protection or safeguarding concerns are raised in which case they will be available the next working day.
- Minutes to be checked by all professionals attending the meetings and correction communicated to CDRC to amend minutes. Only the CDRC will keep the final agreed minutes. On completion and agreement of the Final Case Review discussion minutes a Summary Report is to be produced for selected distribution to professionals previously involved in the child's care for purpose of the child's records.
- Any Actions, Recommendations and Lessons Learned from Child Death Reviews are to be entered into the Child Death Review Work Plans.
- Work plans to be reviewed by the CDRC on a regular basis for updates and provided to the CDOP Panel bi-annually for overview, or if requested at any time by the Panel.
- Work plans to be provided to the Rapid Response Nurses for regular actioning and updating
- Details of all cases of unexpected child deaths to be prepared and reviewed at SCR Sub group
- To set up and manage a database and filing system for all CDRP & CDOP correspondence.
- To produce regular reports on child deaths highlighting trends and will contribute to the Annual Report.
- To ensure recommendations/outcomes following CDOP or the CDRP are regularly reviewed, monitored and completed.
- Liaise with the Designated Doctor for Child Deaths on all cases and attend weekly review meetings with DDCD and Lead Nurse for Child Deaths.
- To assist with the preparation of reports relating to child deaths for the CDRP and GSCB liaising with the Coroners Office, the Registrar Service and GSCB partners as appropriate including the CDOP Annual Report.
- To facilitate the sharing of information between all agencies e.g. Health, Police, Social Care, Education and Coroner's Office.
- As a named Professional on the support leaflets given to families/professionals following a death, be prepared to receive contacts from families wishing to discuss the deaths of their children.
- Attend regional network meetings to discuss CDRP and CDOP and to host one meeting per year on a rotational basis for the South West Region.
- Maintain and/or create links into National Network and Annual CDOP, South West network meetings as well as national CDOP offices.
- Maintain close links with University of Bristol and CDOP Manager for the South West.
- To provide resources and actively promote Child Accident Prevention Week reflecting learning and recommendations from reviews of child death's locally and nationally.
- To provide strong and accurate administrative link between CDR and CDOP.