Child Death Review Process

(Incorporating the ALTE Process)

DURING THE CURRENT COVID PANDEMIC THE CHILD DEATH PROCESS WILL CONTINUE TO FUNCTION BUT ALL CONTACT WITH PROFESSIONALS AND FAMILIES WILL BE BY TELEPHONE.

A Joint Agency Protocol for Gloucestershire

Produced by CDOP on behalf of

Gloucestershire Safeguarding Children Board

Updated March 2020

Safeguarding Children

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

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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.

Amendments made to this document version

Date	Section	Page/s

Contents

Abbreviations

ALTE	Acute Life Threatening Event
CAIT	Child Abuse Investigation Team
CDOP	Child Death Overview Panel
CDR	Child Death Review
DDCD	Designated Doctor for Child Deaths
ED	Emergency Department
EDT	Emergency Duty Team (Social Care)
ESSUA	Executive Safeguarding Support Unit Administrator
FCR	Final Case Review
GP	General Practitioner
GSCB	Gloucestershire Safeguarding Children Board
GSCE	Gloucestershire Safeguarding Children Executive
ICD	Initial Case Discussion
LNCDR	Lead Nurse for Child Death Review
NCDR	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

Explanation of Category of death

An unexpected death is defined as the death of an infant or child (of more than 24 weeks gestation but less than 18 years old) which:

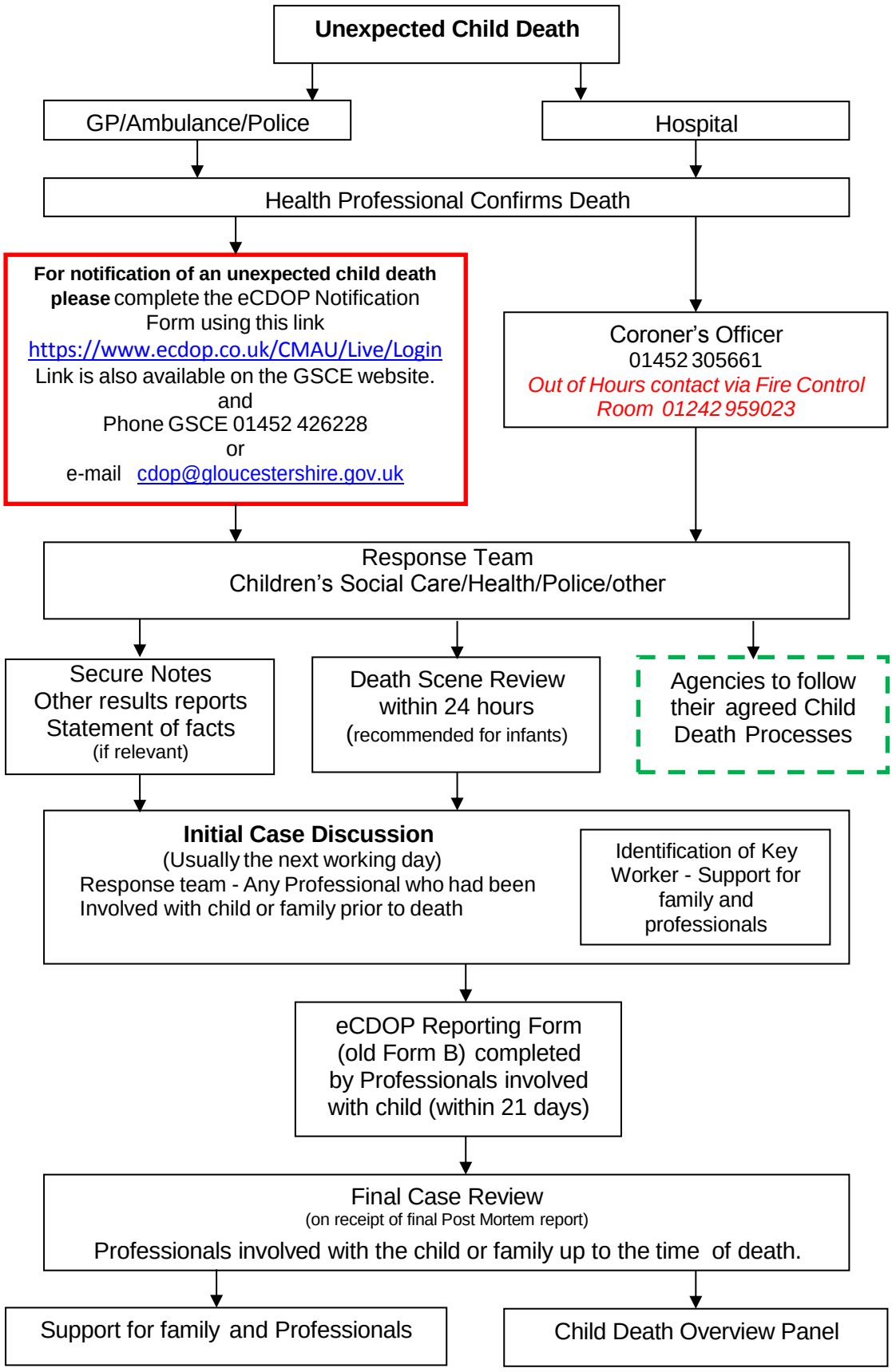
- was not anticipated as a significant possibility 24 hours before the death: or
- where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

This protocol:

- Relates to the county of Gloucestershire, covered by the Gloucestershire Safeguarding Children Executive (GSCE) and as such is to be adhered to by all agencies.
- Should be applied to all deaths in infancy (babies of more than 24 weeks gestation) and child young person less than 18 years old).
- Can be applied in other circumstances e.g. in dealing with a child who has suffered a life threatening event (ALTE).

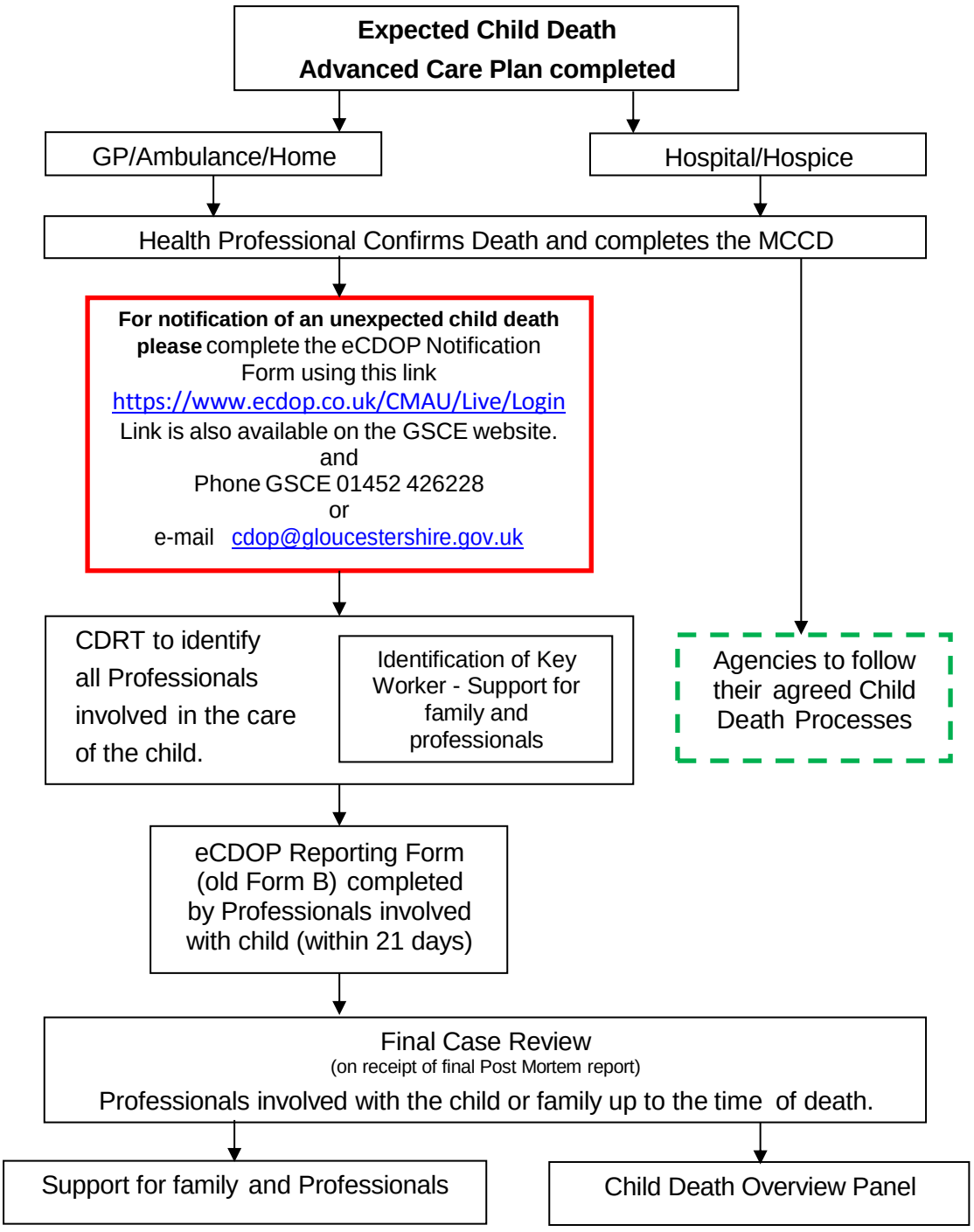
Flow Chart 1

Overview of the Child Death Process
Flow Chart for Unexpected Child Deaths



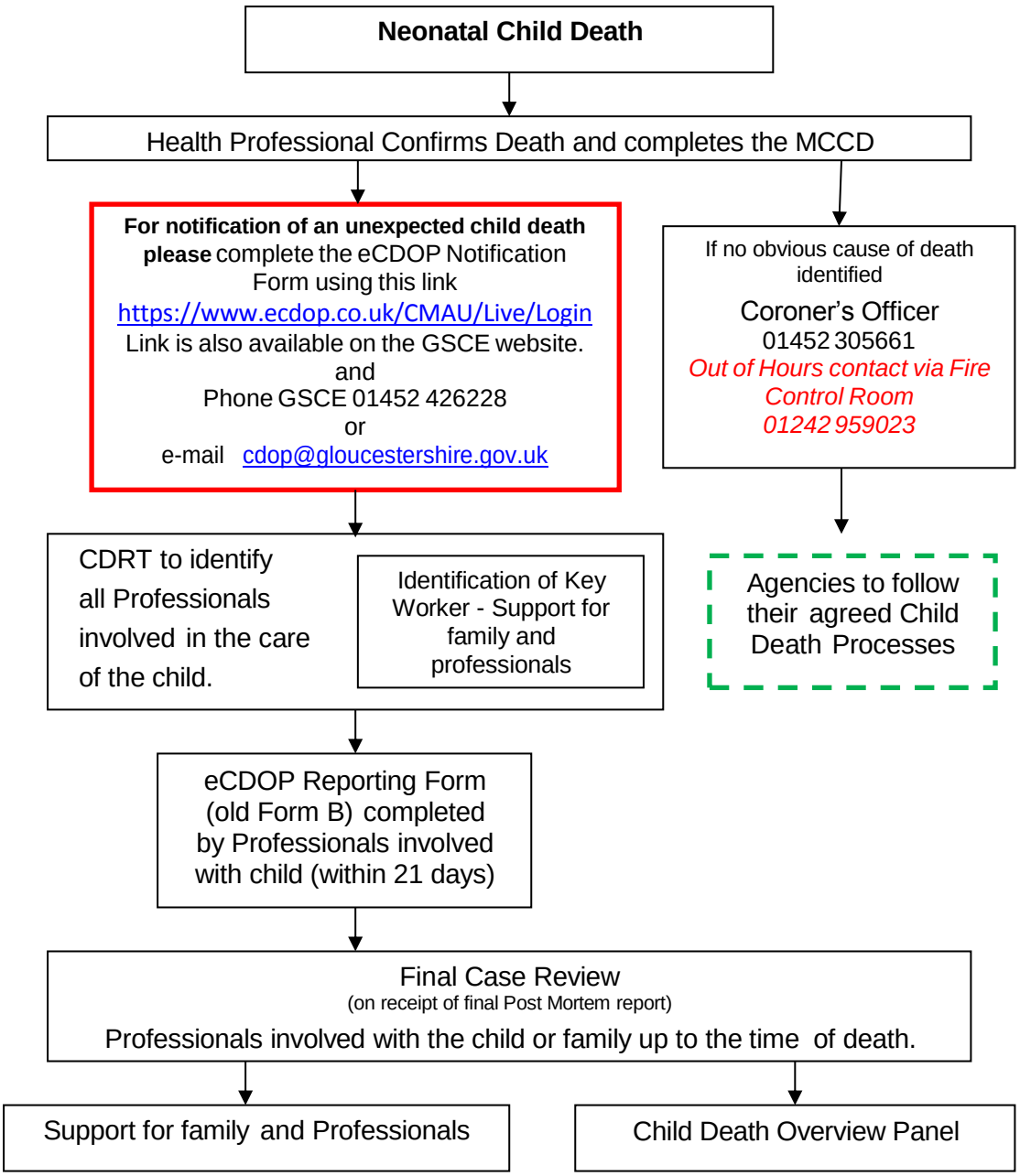
Flow Chart 2

Overview of the Child Death Process
Flow Chart for Expected Child Deaths



Flow Chart 3

Overview of the Child Death Process
Flow Chart for Neonatal Child Deaths



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, 2018*) 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

- The Child Death Review Process provides a systematic multi agency review of all deaths in childhood (from 24 weeks gestation to less than 18 years of age).
- The aim of the review is to:-
    a) establish the cause of death in conjunction with the coroner
    b) identify contributing factors,
    c) support the family.
- Deaths can be classified as Unexpected, Expected and Neonatal

All deaths in childhood are anonymized and reviewed at the multi-agency Child Death Overview Panel (CDOP). This enables any trends to be identified and learning to be disseminated.

Definitions

An **unexpected** child death is defined as the death of a child that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death. This includes children and young people with disabilities or life limiting illnesses, children and young people who die in road traffic accidents, by drowning etc. and children who are admitted to a hospital ward and subsequently die unexpectedly in hospital.

An **expected** death is defined as a child with a life limiting condition (Advanced Care Plan usually in place) or in a hospital/hospice and is anticipated to die after 24 hours of prognosis.

Neonatal deaths (for purposes of this process) are defined as a death of a baby from 24 weeks gestation to 28 days or a baby who has never left the hospital environment since birth.

Governance

The process is overseen by the Child Death Overview Panel and Gloucestershire Safeguarding Children Executive. If any safeguarding/suspicious concerns arise at any point during the process these will immediately be forwarded to Children's Social Care/Police as appropriate.

If a case is identified as a potential case for concern where there is more widespread learning or services have failed to meet the needs of the child or young person the case will be referred to the QIIP (Quality and Improvement In Practice).

ALTE (Acute Life Threatening Event)

An **ALTE** is defined as the unexpected collapse of a child where there is no known antecedent condition that might be expected to cause the collapse at any time. The child may, or may not, die imminently or subsequently. In these cases the same process that is used for a child death may be employed to discuss the background which has led to the ALTE as the child or young person may die to identify any learning from the case.

eCDOP

Since April 2019 GSCE have commissioned the use of eCDOP. This is an electronic system used for notification of child death and collation of all reporting forms replacing the old Forms A, B and C accessed via https://www.ecdop.co.uk/CMAU/Live/Login.

Forms: Notification, Reporting, Analysis

Three standard forms should be used in the child death review process:

- **Notification Form** (previously Form A) complete electronically via eCDOP for initial notification of a death to CDR partners; https://www.ecdop.co.uk/CMAU/Live/Login

- **Reporting Form** (previously Form B) complete electronically via eCDOP for gathering information from agencies or professionals who have information relevant to the case. Reporting forms should be completed by the relevant responsible officer and shared with the relevant CDOP.

- **Analysis Form** (previously Form C) initially drafted via eCDOP at the CDRM and finalised at CDOP for evaluating information and identifying lessons to be learned. This form is used to evaluated information and identify lessons to be learned. The Analysis is the final output of the child death review process.

These forms should **not be copied or stored in the child's record**, but will be retained electronically as part of the Child Death Review Process.

Top Tips for completing the reporting forms can be found at ***(Appendix 3)***.

For notification or reporting form queries please use the contact details below –

Child Death Review Service Administrator for eCDOP 0117 342 5277 email ubh-tr.cdop@nhs.net
(Lead) Nurse for Child Death 0300 421 8115 email childdeathnotification@ghc.nhs.uk
Executive Safeguarding Support Unit Administrator 01452 426228 cdop@gloucestershire.gov.uk

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 a life limiting or life threatening conditions needs to be referred to the Coroner's Officer by phoning 01452 305661 (via Fire Control Room if out of hours by phoning 01242 959023). Contact should also be made with Gloucestershire Safeguarding Children Executive Support Unit Administrator (ESSUA) via cdop@gloucestershire.gov.uk or by phoning 01452 426228 who will alert the Designated Paediatrician and the NCDR so that further investigation and management of the cases will follow a multi agency approach, as set out in this protocol.

Immediate Joint Agency Response. At the time of the sudden unexpected death the sharing of information between relevant agencies (primarily Police/Children's Social Care/Acute Paediatrician/Health) and Coroner's Officer 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. If concerns are raised, Police and/or Children's Social Care become the lead agency. 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 all agencies involved with the child and family. Leaflets are provided to the family (***Appendix 1***).

If no safeguarding concerns are raised, those professionals involved with the child who dies unexpectedly (before or at the time of death), will come together to enquire into and evaluate the child's death at an Initial Case Discussion. This usually occurs on the next working day to gather and discuss further information. The following professionals will be invited 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. This is separate to the Child Death Review Process. 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 Unit Team (PPU), the Police Supervisor, a Paediatrician or NCDR; 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 Public Health 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 of siblings, 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 Child Death Review 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 2)***. This meeting will be chaired by the L/NCDR or Designated Doctor for Child Deaths.

The purpose of this meeting is to

- share information,
- identify the Key Worker who will facilitate support for the family
- determine the need for a home visit if this has not already taken place (this visit should take place for infants who die unexpectedly).
- Identify key professionals with whom to share Post Mortem results
- Identify the health professional who will feed back to parents results of investigation or Post Mortem (if not the key worker)

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 with those professional identified as being involved with the child the next working day. Notes 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 meeting notes will **only** be retained by the CDRT for future access if necessary. The Key Worker 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 ESSUA will disseminate provisional results to the relevant professionals involved in the review and if deemed necessary the L/NCDR 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 the Coroner will have already shared the results with the family. The Key Worker or appropriately trained health professional should be available to discuss the findings with the parents at the earliest opportunity if requested, 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 ESSUA to relevant professionals as agreed with the Coroner.

General Guidance for Expected Deaths in Childhood – an Overview

For children who have been determined to have a shortened life expectancy it is good practice to complete an Advanced Care Plan (ACP) which should be shared with the Child Death Review Team cdop@gloucestershire.gov.uk and SWAST swasnt.Clinical-Alerts@nhs.net .

Notification of the death of the child should occur in the same way as for unexpected deaths and the professionals involved with the child will be expected to complete the eCDOP Reporting Forms https://www.ecdop.co.uk/CMAU/Live/Login .

A Final Case review will be convened as per unexpected deaths and the case will be anonymized and reviewed at CDOP Panel.

General Guidance for Neonatal Deaths (including infants who have not left the hospital) – an overview.

Notification of the death of the child should occur in the same way as for unexpected deaths and the professionals involved with the child will be expected to complete the eCDOP Reporting Forms https://www.ecdop.co.uk/CMAU/Live/Login .

The Final Case Reviews will be undertaken as part of the Morbidity and Mortality meetings where possible held within the Hospital Trust. The cases will then be anonymized and reviewed at CDOP Panel.

Role of Key Worker

The Key Worker is the person who acts as a single point of contact for the bereaved family, someone who they can turn to for information on the Child Death Review Process, and who can signpost them to sources for support. This person will usually be a healthcare professional but may be a Police Officer, teacher or other professional who may be close to the family. ***(Appendix 4)***

Final Case Review

Prior to the Final Case Review the Key Worker will be requested to obtain family feedback as to the provision of services to the child during their life and any issues which may have arisen since death.

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 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 2***) 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 child's file and also sent to the GP for information.
- Meeting notes will be retained by the Child Death Review Team.
- The Key Worker 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* (if required).

Outcomes of Final Case Reviews

Following the *Final Case Review* of a Child Death or the review of the case at 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 GSCE Support Unit to ensure appropriate implementation. Where any learning points or issues identified are raised these will be forwarded to the Clinical Governance Departments of all Health 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 Health 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 Children Executive. These will be implemented in the same manner as recommendations from Safeguarding Children Practice Reviews. The recommendations will be forwarded to the relevant Chief Executive of the Agency or Health Trusts with copies to the relevant Designated Leads. The Agency or Health Trusts will be expected to provide evidence of implementation to the CDOP Panel of what action has been taken to address the recommendations. The CDOP will then report to GSCE with regular updates.

Child Death Overview Panel (CDOP)

An overview through a comprehensive and multidisciplinary review of all child deaths in Gloucestershire will be undertaken by the Gloucestershire Child Death Overview Panel. 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 2018* 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 Learning 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 Safeguarding Children Executives of those concerns and advise the need for further enquiries under *section 47 of the Children Act*, or of the need for a Learning 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 child death review 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 GSCE 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. HSIB (Healthcare Safety Investigation Branch). Collation of data with other neighbouring CDOPs across the region – in order to identify lessons on the prevention of child deaths.

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 GSCE 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. The meeting will be quorate when there are representatives from each agency.

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 / Attendance Sheet before participating in the CDOP. Any ad-hoc or co-opted members and observers will also be required to sign this sheet.

The CDOP will be accountable to the Gloucestershire Safeguarding Children Executive (GSCE).

The CDOP is responsible for developing its work plan, which should be approved by the GSCE. It will prepare an Annual Report for the GSCE Support Unit, which is responsible for publishing relevant, anonymised information. The GSCE 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 GSCE 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 meet at 2 monthly intervals but may hold extra meetings if matters are identified by the GSCE 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
- Gloucestershire Health and Care NHS 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
- Education – Safeguarding Manager
- Early Years – Early Years Safeguarding Lead
- Children in Care – Strategic Lead for Children in Care
- GSCE – Executive Safeguarding Support Unit Business 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, timings of events and background information given by parents in as much detail as possible.

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 meeting notes will only be taken by the ESSUA. The exception to this is Police and Coroners Officers who are also permitted to take notes for investigation/inquest purposes.

Meeting notes 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 and not retained on the child's file.** The final agreed copy of the meeting notes **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 meeting notes will **only** be kept by the Child Death Review Team.

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 meeting notes of the meeting will be held securely.

Legislation underpinning this process is from the Children Act 2004 (Updated 2017) which 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 2018*) should be followed and Children's Social Care take the lead.

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

The CDRT will maintain a close link with the GSCE Delivery Board

Guidelines for Individual Agencies

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

At the time of the incident the SWASFT Clinical Hub will inform the Police of any unexpected death of a child or where paramedics are undertaking full resuscitation of a child.

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 or Coroners mortuary (16-18) 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. If the GP confirms death he/she should also notify CDRT or complete eCDOP Notification details

For notification of a child death please
Complete eCDOP Notification Form
using this link
https://www.ecdop.co.uk/CMAU/Live/Login

Phone GSCE 01452 426228
or
e-mail cdop@gloucestershire.gov.uk

Coroner's Officer
01452 305661
Out of Hours contact via Fire Control Room
01242 959023

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 CDT. 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 Senior Clinician must discuss the circumstances of the unexpected death with:

1. the Police 999
2. Children's Social Care Team / Emergency Duty Team (if out of hours)
3. the Coroners Officer or Fire Control if out of hours
4. the Child Death Review Team (CDRT)

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

For notification of a child death please
Complete eCDOP Notification Form
using this link
https://www.ecdop.co.uk/CMAU/Live/Login

Phone GSCE 01452 426228
or
e-mail cdop@gloucestershire.gov.uk

Coroner's Officer
01452 305661
Out of Hours contact via Fire Control Room
01242 959023

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 Resuscitation Area (for list of Kennedy Investigations see ***Appendix 5***). For all infants a skeletal survey and CT Head should be requested by the attending Paediatrician on ICE and should be carried out prior to Post Mortem. (***The Coroner's Officer must provide consent for this investigation by e-mail directly to Radiology***). Also see Skeletal Survey Body Flow Chart below. For older children, the Paediatrician should use their clinical discretion as to the investigations to undertake – always consider toxicology.

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 Police in the first instance (if involved) and parents and clearly documented in the notes. Any momentoes taken must be 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 remain in the ED until the police give consent that they may return home.

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 Officers) and that it will be several months for all investigations to be completed.

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 Superintendent, Public Protection Unit. 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 Flowcharts 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 (NAI) 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 Unit (PPU) 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 Flowcharts 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

The Coroner must be notified of all unexpected deaths in childhood and after the death is pronounced the Coroner has control of the body, mementoes and medical samples **(*Appendix 5)*.**

For sudden unexpected deaths in infancy/children who require radiological investigations post death, the Coroner's Officer must e-mail the GH Radiology Department providing appropriate consent for the investigation/s.

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/CDRT 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 Team, 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.

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 or where staff are undertaking full resuscitation of the 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/Coroner's mortuary 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).

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.
- If full resuscitation is required 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.
- Senior Medical Officer on-call, or Emergency Department Consultant determines when to stop resuscitation.
- Child pronounced dead.
- On confirmation of death the Senior Medical Officer 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 (good practice to discuss with family but Police/Coroners Officer can consent). For unexpected death in infancy ensure that a request for a full skeletal survey and CT Head is entered on ICE. SUDI investigation boxes (available in ED departments) should be completed.
    - Notify Coroner's Officer of case (01452 305661 or for out of hours Fire Control Room 01242 959023).
    - Notify the Child Death Executive Safeguarding Support Unit Administrator cdop@gloucestershire.gov.uk (01452 426228)
    - Make notification via eCDOP using the link

https://www.ecdop.co.uk/CMAU/Live/Login

- Explain the Child Death Review process and the need for a Post Mortem with the family. *Please inform family it may take several months before final reports are available.*
- Provide the family with the Gloucestershire Child Death Overview Panel Leaflet (***Appendix 1***)
- Provide a written report of the child's history and resuscitation as soon as possible for the Coroner, Pathologist and CDRT.
- 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.
- Senior Medical Officer/Paediatrician to meet with family to feed back results of investigations and post mortem if possible.
- Complete Reporting Form on eCDOP
- 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 Death Executive Safeguarding Support Unit Administrator cdop@gloucestershire.gov.uk (01452 426228)
- Make notification via eCDOP using the link https://www.ecdop.co.uk/CMAU/Live/Login
- Provide a written report of the child's history, resuscitation and clinical progress in hospital resulting in the child's demise for the Coroner, Pathologist and CDRT.
- 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.
- Complete Reporting Form on eCDOP
- 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 forward any resuscitation/DNAR/ACP policies for the child's expected death to The Child Death Review Team by emailing cdop@gloucestershire.gov.uk and to the Palliative Care Team by emailing ghn-tr.paediatricpalliativecare@nhs.net who will forward these to Ambulance Control.

On confirmation of the child's death:

- Notify the Trusts Clinical Risk Department.
- Make notification via eCDOP using the link https://www.ecdop.co.uk/CMAU/Live/Login
- Notify the Child Death Executive Safeguarding Support Unit Administrator cdop@gloucestershire.gov.uk (01452 426228)
- Continue to provide support for the family as appropriate.
- Complete Reporting Form on eCDOP
- 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.
- If the death was totally unexpected the Consultant Pediatrician may wish to discuss the death with the Coroner.
- Make notification via eCDOP using the link https://www.ecdop.co.uk/CMAU/Live/Login
- Notify the Child Death Executive Safeguarding Support Unit Administrator cdop@gloucestershire.gov.uk (01452 426228)
- Case to be discussed at Morbidity and Mortality meeting (where possible) arranged by Obstetricians/Neonatologists.

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

Gloucestershire Health and Care NHS Foundation Trust Staff (GHC)

a) Professionals who are informed of a child death must contact the Child Death Executive Safeguarding Support Unit Administrator cdop@gloucestershire.gov.uk (01452 426228) or (Lead) Nurse for Child Death Review 07954 179103 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 (Lead) Nurse for Child Death Reviews will review electronic records for the child.

c) The DATIX system is available for on-line incident reporting and will be completed by the (Lead) Nurse for Child Death in all cases.

d)

- 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.

e) The Specialist Public Health Nurse plays a crucial role in supporting the family following a 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 (Police) 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.

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 and CT Head, 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 at 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'.

a) Person(s) who saw the child last and at 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'.

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)**
The MASH	**EDT**
01452 426565	01452 614758
childrenshelpdesk@gloucestershire.gov.uk	
As soon as The Front Door or EDT are aware of a child death they must notify the Child Death Review Team	**For notification of a child death please** Complete eCDOP Notification Form using this link https://www.ecdop.co.uk/CMAU/Live/Login Phone GSCE 01452 426228 or e-mail cdop@gloucestershire.gov.uk

A referral will be made to The MASH, 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 same or 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 the Nurse for Child Death Review. 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 Executive Safeguarding Support Unit Administrator/(Lead) Nurse for Child Death as to the outcomes of any investigations during the Child Death process and as to the date of the *Final Case Review*.

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 (DD)

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 immediate Joint Agency 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.
- Once the initial Post Mortem report is available contact all the relevant agencies, to decide whether a second case discussion meeting is required.
- *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 QIIP sub group.
- Input provided to the CDOP Annual Report.
- Provide advice support and training as required to other professionals.
- Be a member of the National Designated Professionals Forum

Lead Nurse for Child Death Review (L/NCDR)

- Receive notification of child death.
- Contact the relevant professionals e.g. Health Visitors/School Nurses, GPs, Education via Safeguarding Manager 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.
- Identify the Key Worker to liaise with the family and provide support.
- Provide advice support and training as required to other professionals.

Additional roles of Lead Nurse

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

- To contribute to the Annual Report.
- Attend regional network meetings to discuss CDRP and CDOP.
- Support the Key Worker for the family

Executive Safeguarding Support Unit Administrator (ESSUA)

- Receive notification regarding a child death and record information appropriately.
- Notify Lead/Nurse for Child Deaths.
- Support the Lead/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 on the next working day following the Initial Case Discussion to ensure that contact between professionals can be made if required.
- Take meeting notes and summaries of these case discussion meetings and circulate reports within 10 working days; unless child protection/safeguarding concerns or other cause for concern are raised in which case they will be available the next working day to relevant professionals.
- Meeting notes to be checked by all professionals attending the meetings and corrections communicated to ESSUA to amend if necessary. The final agreed notes of these meetings will only be held on eCDOP. On completion and agreement of the Final Case Review discussion minutes a Summary Report is to be produced for selected distribution to professionals to be retained in the child's records and can be shared with the family if appropriate.
- Any Actions, Recommendations and Lessons Learned from Child Death Reviews are to be entered into the Child Death Review Team Action Plan.
- Action plans to be reviewed by the CDRT on a regular basis for updates and exception reports provided to the CDOP Panel for overview, or if requested at any time by the Panel.
- The CDRT will maintain a close link to the GSCE Delivery Board.
- To maintain the appropriate functions of eCDOP.
- To produce regular reports on child deaths and will contribute to the Annual Report.
- To ensure recommendations/outcomes following CDOP are regularly reviewed, monitored and completed.
- Liaise with the Designated Doctor for Child Deaths on all cases and communicate weekly review meetings with DD and L/NCDR.
- To facilitate the sharing of information between all agencies e.g. Health, Police, Social Care, Education and HM 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 and 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 ESSUA and CDOP.
- Minuting CDOP meetings and completing Final Reporting forms.
- Provide advice support and training as required to other professionals

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

MASH
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
https://www.gloshospitals.nhs.uk/contact-us

Police

Gloucestershire Constabulary
https://www.gloucestershire.police.uk/fo/feedback/tc/thanks-and-complaints/

Gloucestershire
Safeguarding Children
Executive

(Updated February 2020)

Appendix 1

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 Executive 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

The Bereavement Offices at Gloucestershire Royal Hospital and Cheltenham General Hospital 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:	ghn-tr.bereavement.service@nhs.net

Appendix 2

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.

MEETING NOTES W LL 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 CASE REVIEW WILL BE PRODUCED WHICH CAN 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 MEETING NOTES AND SUMMARY WILL BE REQUIRED.

ON RARE OCCASSIONS THESE MEETING NOTES MAY BE SHARED FOR THE PURPOSES OF A SAFEGUARDING LEARNING REVIEW.

By signing this document we agree to abide by these principles

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

Appendix 3

Top Tips to complete Reporting Form for eCDOP

(Prev. Form B)

STEP 1. Email from eCDOP no-reply@qes-online.com

You will receive an email requesting a reporting form to be completed, looking like below:

To respond please click on 'Link to Reporting Form'

Reporting Form Completion Required
Case: xxxx
CDOP Identifier: xxxxxx/xx/xxxx

Message:

It is with sadness that we are informing you that a child who may be known to you has died.
To assist with the review process we are required to collate all relevant information and I would be grateful if you would complete the agency form. We ask that the form is completed within 21 Working Days so that the review of this death is not delayed.
If for any reason you are unable to complete the form within this timescale please let us know as soon as possible.

LINK TO REPORTING FORM

STEP 2. Register with eCDOP

You will be sent details how to do this the first time - once registered with the one time passcode, please change password and complete the login process.
Login to your account:
Username: (YOUR EMAIL)
Password:

STEP 3. Reporting Form

Once you have registered the first time, you will be able to click directly onto the **LINK TO REPORTING FORM** in original email (STEP 1)
You may be asked to complete a 2 stage log-in process – with an authentication code sent in a separate email.

Top Tips:

- Some of the Reporting Form will be prefilled

- Any red asterisk field is mandatory and needs to be filled in – If you do not know the answer then please add 'not sure' or 'don't know' or 'not relevant' 'not applicable' etc. as appropriate.

- There are 7 categories on left hand side, all need to be completed as far as you are able (leave blank if relevant, or choose relevant pick list or add 'not sure') :

    - **SUMMARY –** basic demographics regarding child and family members / significant others. Cause of death may be unknown and there may well be other fields you cannot complete. Please either leave blank or choose 'not known' from pick list or free text 'not known' if appropriate
    - **SUDDEN UNEXPECTED DEATHS –** Predisposing risk factors / circumstances of death / Pathologist cause of death / Final Case Review. Again you may not know some of these answers so just please complete what you can
    - **CHILD –** Factors intrinsic to the child
    - **SOCIAL ENVIRONMENT –** Factors in the social environment including parenting capacity
    - **SERVICE PROVISION –** Factors in Service Provision / Key agency and hospital services involved
    - **REFERRER**
    - **DOCUMENTS**

- Please be aware there can be a 5 minute time out pop up which gives you the option of continuing the form - click Yes / No option

- You can part complete and come back to it when 'Save Draft'

- Once finished – click Save as Final to submit

For any queries completing these forms please contact:

Child Death Review Service Administrators
Tel: 0117 342 5277
e-mail: ubh-tr.cdop@nhs.net

Child Death Safeguarding Executive Support Administrator
Tel: 01452 426228 / 583629
e-mmail: cdop@gloucestershire.gov.uk

Lead/Nurse for Child Death Process
Tel: 07954 179103

Appendix Fifteen

KEY WORKER ROLE
(for Child Death Review)

Thank you for agreeing to be our keyworker. The Keyworker is the person who acts as a single point of contact for the bereaved family, someone who they can turn to for information on the Child Death Review Process, and who can signpost them to sources for support. This person will usually be a healthcare professional but may be a Police Officer, teacher or other professional who may be close to the family.

Main responsibilities

- be a reliable and readily accessible point of contact for the family after the death
- help co-ordinate meetings between the family and professionals as required
- be able to provide information on the Child Death Review Process and the course of any investigations pertaining to the child, including liaising with the Coroner's Officer and any Police Family Liaison Officer (FLO)
- represent the 'voice' of the parents at professional meetings, ensure that their questions are effectively addressed, and to provide feedback to the family afterwards: and
- signpost to expert bereavement support if required

HM Government October 2018
Child Death Review
Statutory and Operational Guidance (England)

Resources

- **Winston's Wish** is a charity supporting bereaved children, their families and the professionals who support them. Helpline 08088 020021 winstonswish.org
- **Child Bereavement UK** is a charity supporting bereaved children and families who have lost a child, and educating professionals: UK Helpline 0800 028 8840 childbereavementuk.org and (schools) elephantsteaparty.co.uk
- **The Lullaby Trust** charity provides advice on safer sleeping for babies and provides emotional support for bereaved families and support on SIDS. Helpline 0808 802 6868 lullabytrust.org.uk
- **Sands** is the stillbirth and neonatal death charity, offers support for parents and training for professionals. Helpline 0808 164 3332: sands.org.uk
- **Acorns Hospice** provides babies, children and young people aged 0 – 18 years who have life limiting or life threatening conditions and associated complex needs with a network of specialist palliative nursing care and bereavement support for those families that have been known to them.

Appendix 5

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 **or** Fire Control 01242 959023 (out of hours)
  b) Police on 999

- For all deaths, contact the Child Death Review Team on **01452 426228**.
  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.
- Notification via eCDOP must then be made using the link https://www.ecdop.co.uk/CMAU/Live/Login

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

Appendix 6

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
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 801 0388

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

Appendix 7

CHILD FUNERAL INFORMATION

This page is currently being updated

Appendix 8

CORONAVIRUS (COVID-19)

This page is currently being updated

Appendix 9

SCHOOLS

This page is currently being updated

Appendix 10

EDUCATIONAL PSYCHOLOGY SERVICES FOR SCHOOLS

This page is currently being updated