Bedford Borough
Safeguarding Children Board

Central Bedfordshire

Local Safeguarding Children Board

Luton
Safeguarding
Children
Board

Central Bedfordshire, Bedford Borough and Luton

Child Death Overview Panel

Processes and Procedures

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1. INTRODUCTION

1. STATUTORY BASIS OF CHILD DEATH OVERVIEW ARRANGEMENTS

1.1.1 The Local Safeguarding Children Board Regulations 2006 places a requirement on the Central Bedfordshire, Bedford Borough & Luton LSCBs to include within its function, in relation to the deaths of children normally resident in Bedfordshire and Luton;

(a) Collecting and analysing information about each death with a view to identifying—

(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e) [*Serious Case Review*];

(ii) any matters of concern affecting the safety and welfare of children in the area of the authority; and

(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

(b) Putting in place procedures for ensuring that there is a co-ordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

1.1.2 In this connection an unexpected death is one which was not anticipated as a significant possibility 24 hours before the death or where there was similarly unexpected collapse leading to or precipitating the events which led to the death. This definition is adopted throughout this procedure.

1.1.3 Statutory guidance on the fulfilment of this requirement is contained in Chapter 5 of Working Together to Safeguard Children (2015) and these procedures are consistent with that guidance.

1.1.4 Within Central Bedfordshire, Bedford Borough and Luton the functions specified in the regulations and guidance will be undertaken by the Child Death Overview Panel (CDOP) on behalf of the LSCBs. CDOP will meet approximately every 6 weeks.

2. CHILD DEATH OVERVIEW ARRANGEMENTS

2.1 Notification of deaths (Expected or unexpected)

2.1.1 The CDOP Manager is the Single Point of Contact (SPOC) and will be notified of the death of any child, from 0 to 18 years, normally resident in Central Bedfordshire, Bedford Borough or Luton by:

- The senior police officer in Bedfordshire or Luton attending the unexpected death of a child or similarly unexpected event consequent to which a child had died, wherever the death occurred
- The medical practitioner or paramedic confirming the fact of death of a child in Bedfordshire or Luton, whether the death was unexpected or not, unless the Police are involved in the investigation of that death
- The coroner's officer should be informed for all unexpected deaths, there has been a fracture within the last year, or concerns are raised by the family or they have not seen the Dr within 14 days.
- Any professional made aware of the death, outside of Bedfordshire or Luton, of a child normally resident in one of the authorities. (This is particularly relevant to children receiving medical treatment at specialist centres, in out of county respite hospice or foster care placements or on holiday, including abroad)

- Any other professional or member of the public learning of a relevant death who suspects that it may have not been previously notified to the CDOP
- The Registrar of Births and deaths are required to send information to the LSCB no later than 7 days from the date of registration of the death
- The Child Health Records Department on receipt of notification that a child has died from the Registrar of Births and Deaths

2.1.2 The CDOP Manager will also be informed of deaths of children occurring in Central Bedfordshire, Bedford Borough or Luton who normally reside elsewhere. Notification of a child death should be made within 48 hours to the CDOP Manager and confirmed in writing, by email, if this cannot be sent and the sender needs to send a fax, they must telephone the CDOP Manager and advise that a fax is being sent, and include the information specified in **Appendix 1**.

2.1.3 These procedures along with the notification form for notifying a child death to the CDOP is available for downloading on Bedford, Central Bedfordshire & Luton LSCBs' websites www.bedfordlscb.org.uk ; www.centralbedfordshirelscb.org.uk; or www.lutonsafeguarding.gov.uk

2.1.4 On receipt of notification that a child has died the CDOP Manager will;

- Record the child's details on the secure database (Excel spreadsheet)
- Inform the relevant Child Health Department in Bedford or Luton
- If the child was not resident in Bedfordshire or Luton the CDOP manager will contact the CDOP manager in the area where the child was resident by telephone, secure email or secure fax
- If the child's death is unexpected the CDOP manager will inform the Designated / Lead Paediatrician for the area where the child has died & the Designated / Lead Paediatrician will advise of her availability for a Rapid Response/Information Sharing meeting as soon as possible (usually within 2 working days)

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2.2 DATA SET COLLECTION
(Appendix 1 and 2 - data collection Forms A & B)

2.2.1 All deaths whether expected or unexpected will be notified to the CDOP manager via a Form A. This form is available within the Accident and Emergency Department of Bedford and Luton & Dunstable Hospital, in the Maternity Units, on the paediatric wards of both hospitals and at the local children's hospice. The police also have access to this form if required. If the child dies at home and the death is certified by the GP a form will be sent to him/her for completion.

2.2.2 If the child normally resident in Central Bedfordshire, Bedford Borough or Luton has died outside the area, the CDOP manager will normally be informed of the child's death by the CDOP manager/administrator in the area where the child has died.

2.2.3 The Department for Education is responsible for maintaining a list of contact details which is readily accessible to CDOP managers/administrators

2.2.4 The CDOP manager is responsible for requesting further information from all professionals who knew the child and family via a Form B

2.2.5 Supplementary forms as described on data collection form B can be downloaded if required from www.bedfordlscb.org.uk

3. UNEXPECTED CHILD DEATH RESPONSE ARRANGEMENTS

3.0 Introduction

3.0.1 The following procedures details the CDOP multi-agency response to the sudden or unexpected death of a child. They should be followed by all professionals in conjunction with any relevant policies, procedures and protocols of their own agency.

3.0.2 These procedures are applicable to the sudden or unexpected death of a child, aged 0 to 18 years, of any natural, unnatural or unknown cause, at home, in hospital or in the community.

3.0.3 A sudden unexpected death is defined as one which 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 which led to the death. This includes the death of a child with an existing medical condition or disability whose death at the time it occurred was not expected as a natural consequence of that condition (e.g. died at a time or of a cause or event not normally associated with the medical condition).

3.0.4 Where there is any doubt about whether a death is unexpected these procedures should be followed.

3.0.5 It is advised that professionals responsible for end of life care to children with terminal conditions identify, document and regularly review the circumstances to be able to ascertain when death occurred, was it unexpected for the purpose of this procedure. It should be ensured that the child's family and all staff involved in the care are aware of these actions.

3.0.6 These procedures are applicable to deaths occurring in Central Bedfordshire, Bedford Borough or Luton but will also be applied to deaths occurring elsewhere consequent to a sudden unexpected event in Bedfordshire or Luton.

3.0.7 Similarly, it will normally be appropriate for the initial response to a death occurring in Central Bedfordshire, Bedford Borough or Luton following a sudden unexpected event of a child from elsewhere to be provided by the CDOP, under these procedures, with the further management of the response being undertaken by the CDOP for the area where the event occurred.

3.0.8 In such cases close liaison and cooperation between the child death response arrangements of the respective CDOP is essential to ensure a coordinated approach and agree appropriate management of the response. The place where the child is normally resident and any agreement between the respective Coroners on jurisdiction should be considered in deciding which CDOP should have primacy.

3.0.9 These procedures contain general guidance for all professionals involved in the response to the sudden or unexpected death of a child, information about individual agency responsibilities and details of the multi-agency arrangements for the longer term management and assessment of the death.

3.0.10 Multi-agency working will always involve at least HM Coroner, Police, Health and Social Care professionals. Other agencies involved with the family also have a contribution to make.

3.0.11 Each professional must be fully conversant with both their own agency's responsibility and the responsibilities of the other agencies. There should be collaborative and coordinated working at all levels from the earliest call to the emergency services.

3.0.12 The events described in these procedures are:

- Transfer of the child to an Accident and Emergency Department unless the child has been dead for some time (e.g. days) so that the need for resuscitation is clearly out of the question. In latter cases transfer of the child's body will be transferred to the mortuary.
- Initial response and early investigation
- Hospital procedures
- Lead Consultant Paediatrician/ Child Death Review Nurse (only Luton Cases) /Police home visit
- Rapid response/information sharing meeting
- Liaison with HM Coroner and Post Mortem examination arrangements

4. RAPID RESPONSE/ INFORMATION SHARING MEETING

4.0.1 The CDOP manager will be responsible, following discussion with the Designated or Lead Paediatrician responsible for unexpected deaths in childhood, Responsible Paediatrician and the Police Investigating Officer, for arranging a Rapid Response/Information Sharing meeting. This should take place as soon as possible once the unexpected death has been notified, ideally within 2 working days. The CDOP manager will be responsible for taking notes at the meeting

4.0.2 Any professional/agencies who knew the child or family will be invited to attend. It is acknowledged that it may be difficult for the GP to attend due to clinic commitments but where possible any relevant information should be obtained.
Children's Social Care should be invited even if the child/family were not previously known to them.
Where possible the ambulance crew transferring the child to the hospital should be invited

4.0.3 The purpose of the rapid response/information sharing meeting is to:

- Share all currently available information on circumstances leading to the death
- Review of records held at the hospital
- Discuss if there are any suspicious circumstances surrounding the child's death
- Review professionals/agencies previous involvement with the child and family
- Discuss if there are any safeguarding concerns for other children in the family
- Plan any actions to be undertaken by health and police
- Review provision of care and support to the family
- Review what is done and what else needs to be done at the hospital
- Any other action following conclusion of hospital involvement
- If clear indicators of abuse or neglect discuss with social care representative about course of action e.g. s47 Strategy meeting.
- Plan a visit to the home address or other place where the child died if appropriate

4.0.4 There should be a clear agreement in each case on specific roles and responsibilities.

4.0.5 If there are indications that the death is **suspicious** the police will arrange for a forensic post mortem examination to take place, the examination of the child's body,

skeletal survey and taking of samples should be deferred for the Pathologist to carry out. In such cases the on call Consultant Paediatrician will need to brief the Pathologist on whatever information has been obtained up to that point.

4.0.6 At the conclusion of their actions at the hospital the Responsible and Designated / Lead Paediatrician, Police Investigating Officer and, if present, Social Worker should agree a record of what has been done, what actions are outstanding and who is responsible for their completion.

5. AGENCY NOTIFICATION AND INFORMATION GATHERING

5.0.1 The sharing of information between agencies at an early stage following the report of a sudden unexpected child death is vital to the planning of the multi-agency response.

5.0.2 The following should be notified by the CDOP Manager of the child's death, requested to check their records for relevant information relating to the child or other family members and to ensure that any appointments for the deceased child are cancelled:

- Child Health Department
- Health Visitor/midwife if appropriate
- Named Nurse for Safeguarding Children if there are known safeguarding concerns within the family
- Social Care for the area where the child is normally resident, or Out of Hours Team (who will notify and obtain information from the Bedfordshire or Luton Review and Conference Service)
- Other relevant health professionals involved in the previous care of the child
- Police Child Abuse Investigation Unit (to include all Police databases)
- Education establishments, if relevant (including any nursery or other provision attended by the child)

5.0.3 Where the child is normally resident outside of Central Bedfordshire, Bedford Borough or Luton the CDOP manager will inform the CDOP Manager/Administrator in that area who will ensure relevant agencies/professionals are aware of the child's death

5.0.4 All records held by the hospital in respect of the child and any siblings should be obtained and reviewed by the Responsible Paediatrician. The original records will be required by the pathologist and a copy should therefore be produced for retention by the hospital. Additional copies will be required by the Designated / Lead Paediatrician and may be requested by the Police.

5.0.5 As a minimum any relevant information held by Social Care and the hospital should be obtained whilst the child and family are still at the hospital. The urgency with which checks of other records should be requested will be dependent upon the circumstances of the death. They should however be completed as far as is possible prior to the post mortem examination taking place.

6. RELATIONSHIP TO OTHER PROCEDURES

6.0.1 These procedures are complimentary to and will operate in parallel with or contribute to a number of other processes. These may include:

- Coroner's inquests
- Guide to Coroners Services
- Criminal investigations
- Serious Case Reviews
- Child Protection (Section 47) investigations

- Health and Safety Executive Investigations
- Health Service Serious Incident investigations
- Provision of Social Care services to family members
- Provision of primary care and/or hospital treatment to family members
- LSCB Child Death Overview arrangements
- Prison Service investigations
- Independent Police Complaints Commission investigations

6.0.2 Following the sudden or unexpected death of a child the Police, acting on behalf of HM Coroner or in the investigation of a crime have primacy in the investigation. Notwithstanding this, all professionals should work within these procedures and ensure that the interface between them and other processes is appropriately managed.

6.0.3 The unexpected death of a child is a traumatic time for everyone involved. The family will be experiencing extreme grief and shock. Professionals will need to support the family and although the time spent with them may be brief, actions may greatly influence how the family experiences the bereavement for a long time afterwards.

6.0.4 It is the right of every child to have their death properly investigated. Families also want to know what happened, how the event could have occurred, what the cause of death was and whether it could have been prevented. If another child death occurs in the family, a carefully conducted investigation of an earlier death is extremely helpful.

6.0.5 The majority of child deaths occur as a result of natural causes or accidents. Some of these will however have medical implications for other family members or have been contributed to by potentially avoidable factors. In addition, a minority of child deaths are the consequence of, or associated with, abuse or neglect.

6.0.6 The response of all agencies to the death of a child must therefore keep a sensitive balance between a sympathetic and supportive approach to the family and maintaining professionalism towards the investigation.

6.0.7 When the Police are concerned that a death may be due to intentional harm, it is important that these procedures are still applied and that all agencies co-operate closely and jointly to determine how best to proceed with the investigation and support of the family.

6.0.8 All professionals must record any information provided by parents, carers or other family members in as much detail as possible. The initial accounts about the circumstances, including timings, must be recorded accurately, contemporaneously and preferably verbatim.

6.0.9 Where the use of any recording equipment is contemplated to assist in the later recall and documenting of information provided by the family, this should only be carried out with the knowledge and agreement of all persons present and the Police Investigating Officer. Any recordings made must be preserved and once used for their primary purpose retained by the Police.

6.0.10 All entries on medical records and other documents relating to the deceased child must be legibly signed, timed and dated, include role or designation and be and clearly attributable to their author.

7. FACTORS THAT MAY AROUSE CONCERN

7.0.1 Certain factors in the history or examination of the child may give rise to concern

about the circumstances surrounding the death. If any such factors are identified, it is important that the information is documented and shared with senior colleagues and relevant professionals in other key agencies involved in the investigation. The following list is not exhaustive and is intended only as a guide.

- Previous child deaths in the family. Two or more unexplained child deaths occurring within the same family is unusual and should raise questions both about an underlying medical or genetic condition as well as possible unnatural events
- Inconsistent information. The account given by the parents or carers of the circumstances of the child's death should be documented verbatim. Inconsistencies in the story given on different occasions or to different professionals should raise suspicion, although it is important to be aware that inconsistencies may occur as a result of the shock and trauma of the death
- Inappropriate delay in seeking help
- Evidence of drug, alcohol or substance misuse, particularly if the parents are still intoxicated or sedated
- Evidence of parental mental health problems
- Previous episodes of unexplained illness, such as cyanotic episodes or acute life threatening events Acute Life Threatening Event (ALTE).
- Previous and current child protection concerns within the family relating to this child or any siblings.
- Neglect. Observations about the condition of the accommodation, cleanliness, adequacy of clothing, bedding and the temperature of the environment in which the child is found are important. A history of previous concerns about neglect may be relevant.
- Evidence of physical abuse/unexplained injuries, e.g. unexplained bruising/burns/bite marks. However, it is very important to remember that a child may have serious internal injuries without any external evidence of trauma.
- Presence of Blood. The presence of blood must be very carefully noted and recorded. It is found occasionally in cases of natural death. A pinkish frothy residue around the nose or mouth is a normal finding in some children whose deaths are due to the Sudden Infant Death Syndrome. Fresh blood from the nose or mouth is less common, but does occur in some natural deaths. Bleeding from other sites is very uncommon in natural deaths.

7.0.2 However the following should be noted and are present in many infant deaths:

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

8. AGENCIES/PROFESSIONALS ROLES & RESPONSIBILITIES FOLLOWING AN UNEXPECTED CHILD DEATH

8.1 AMBULANCE STAFF

8.1.1 This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies.

8.1.2 Following receipt of a call to the Ambulance Control Centre the nearest available emergency response will be sent to the scene, supported by a second emergency response if appropriate

8.1.3 The recording of the initial call to the ambulance service should be retained in case it is required for evidential purposes.

8.1.4The Ambulance Control Centre will immediately notify the Police Force Control Room when there is a call to the scene of an unexpected child death or this is reported by the attending ambulance staff. The member of staff calling should specify that the child death response procedures are being initiated and provide details of the child and circumstances.

8.1.5 Ambulance staff should not assume death and unless clearly inappropriate they should clear the airway and apply full cardiopulmonary resuscitation except for situations where the child is found dead hours or days later, in which case the child could be taken straight to the hospital mortuary.

8.1.6 All children should be taken to the Accident and Emergency Department, unless they have obviously been dead for some time and the circumstances of death preset a clear and compelling reason for the body to remain at the scene for forensic examination.

8.1.7 The Accident and Emergency Department should be informed, giving an estimated time of arrival and the child's condition (and the mortuary where relevant).

8.1.8 The family should also be taken to the hospital to ensure receipt of appropriate medical and social support.

8.1.9 The first professional on the scene should note the position of the child, the clothing worn and the circumstances of how the child was found.

8.1.10 Any persons remaining at the scene should be asked not to disturb or move items around where the child was found until it has been seen by the Paediatrician and/or Police. It should be stressed that this can be extremely important in helping the family to understand why the child has died.

8.1.11 If the circumstances allow, any comments made by the carers or others present, any background history, any possible drug misuse and the conditions of the living accommodation should be noted.

8.1.12 The patient clinical record is to be completed in full as a record of attendance and treatment of the patient. Printouts from any monitoring equipment used should be retained with the record. All information from the scene and any concerns should be reported directly to the Police and to the receiving doctor at the hospital as soon as possible.

8.1.13 If the child's body is to remain at the scene the ambulance staff should await the arrival of the Police Investigating Officer.

8.1.14 there will be times when a GP, Health Visitor or Community Nurse is the first professional to attend. In such circumstances that professional should adhere to the same general principles as the ambulance staff and an ambulance should be called as an emergency.

8.1.15 A representative of the Ambulance Service will always be invited to the rapid response/information sharing meeting.

8.2 POLICE RESPONSIBILITIES

8.2.1 In respect of the sudden or unexpected death of a child the Police have a number of inter-related responsibilities:

- To investigate the circumstances of the death on behalf of HM Coroner
- To establish if a crime has been committed and if so, to investigate that crime
- To participate in the CDOP response to the death as described in these procedures including contributing to any action required to protect other children in the family from any identified child protection risks.

8.2.2 Procedures detailed here relate to:

- Investigative Responsibility
- Receipt of call and deployment
- Child deaths at hospitals outside of Bedfordshire and Luton
- Initial attendance
- Inter-agency liaison and planning
- Agency notification and information gathering
- Care of the child's family
- History taking from the child's family
- Examination of the child's body and obtaining samples and x-rays
- Identification
- Home visit
- Reporting the death to HM Coroner
- Post mortem examination
- Multi-agency arrangements

8.2.3 These should be followed in conjunction with and additional to any other procedures applicable to the circumstances of the death (e.g. Road Traffic Collision SOP; ACPO Murder Investigation Manual).

8.2.4 If any child protection concerns arising from the circumstances of the death are identified, the appropriate Social Care professional should be requested to attend the hospital and a formal Strategy Meeting should be held under LSCB Safeguarding procedures.

8.2.5 If there are indications that the death is suspicious and a forensic post mortem examination will take place and the examination of the child's body, skeletal survey and taking of samples should be deferred for the Pathologist to carry out. This may also affect the manner in which the history is obtained and the briefing of the Pathologist by the Responsible Paediatrician.

8.3 GENERAL PRACTITIONERS / HEALTH VISITORS / COMMUNITY NURSING STAFF RESPONSIBILITIES

8.3.1 This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies

8.3.2 Occasionally the GP, Health Visitor or Community Nurse will be the first professional to attend the scene of the unexpected death of a child. In general the same guidance applies to these professionals as the Ambulance Service.

8.3.3 Primary healthcare professionals should not assume death and unless clearly inappropriate they should clear the airway and apply full cardiopulmonary resuscitation. An emergency ambulance should always be called to the scene. It is important that if a health professional is the first at the scene that they take responsibility for contacting the Police. They should specify that the child death response procedures are being initiated and provide details of the child and circumstances.

8.3.4 The professional should ensure that ambulance staff take the child to the Accident and Emergency Department rather than to the mortuary, even when the fact of death has been confirmed at home or elsewhere. It is preferable that verification of death is deferred until the child is transferred to the local Accident and Emergency Department.

8.3.5 Primary healthcare staff are very important in supporting the family following the death of a child. They should visit the family at home as soon as is convenient and will be involved in providing ongoing advice, support and counselling for the family, in collaboration with other professionals. This process will be coordinated as detailed below in the inter-agency working section of these procedures.

8.3.6 Additional guidance for primary healthcare staff, particularly in relation to the longer term care of the family, is available from the Foundation for the Study of Infant Deaths.

8.3.7 Primary healthcare staff should make notes available to the professionals involved in the investigation of the child's death.

8.3.8 Those involved with the family will always be invited to the rapid response/information sharing meeting and final case discussion where possible

8.4 RESPONSIBLE PAEDIATRICIAN / DESIGNATED/LEAD PAEDIATRICIAN/ OTHER HEALTHCARE STAFF RESPONSIBILITIES

8.4.1 Following the arrival of the child at the hospital, the initial response will be from hospital staff. Thereafter, others will take over. For the purpose of clarity the term '**Responsible Paediatrician**' is used for Consultant Paediatrician on call who would attend the child at the hospital. Subsequently, the '**Designated** / **Lead Paediatrician**' with wider remit, who would be a Community Paediatrician will take over and will remain connected with the process.

8.4.2 These procedures will be followed when a child dies unexpectedly within a hospital in Bedfordshire or Luton or is brought to an Accident and Emergency Department having died in the community. In addition to procedures for hospital staff, there are those which may be undertaken by other health service staff in the initial response to the death of a child.

8.4.3 Procedures detailed here relate to:

- The initial hospital response to the death of a child
- Inter-agency liaison, discussion and planning

- Agency notification and information gathering
- Care of the child's family
- History taking from the family
- Examination of the child's body and obtaining early samples and x-rays

8.4.4 The management of the health service response to the death of a child must be undertaken by a Consultant Paediatrician. In case of an unexpected death occurring outside or within the hospital, a Consultant Paediatrician on call on that day will assume the role of 'Responsible Paediatrician' under this procedure that will make initial response. Later, at an appropriate time the case will be handed over to the 'Lead Paediatrician' who will be another Consultant Paediatrician specifically designated for this role.

8.4.5 The on-call Consultant Paediatrician undertaking the Responsible Paediatrician role at the hospital and the nurse allocated to support the family will be invited to the rapid response/information sharing meeting and final case discussion where possible

8.4.6 On arrival at the hospital the child should be taken to an appropriate area in the Accident and Emergency Department. Should the unexpected death of a child occur elsewhere in the hospital (e.g. in a children's ward or maternity unit) these procedures should be followed at that location.

8.4.7 The family should be provided with privacy. A nurse should be allocated to look after the family and to keep them informed about what is happening. The nurse should record any medical or other information provided by the family.

8.4.8 The child should immediately be assessed and unless it is clear that the child has been dead for some time (for example when rigor mortis or blood pooling are evident), resuscitation should always be initiated and death confirmed when appropriate.
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 happening.

8.4.9 The On Call Consultant Paediatrician should be immediately notified who will assume the role of 'Responsible Paediatrician' and will thereafter be responsible for management ensuring that procedures are followed. .

8.4.10 At the same time the Police will be notified, if already not involved, by telephone call to the Police Control Room. The member of staff calling should specify that the unexpected child death response procedures are being initiated and provide details of the child and circumstances. Initially uniformed officers will attend the hospital and will liaise with the Responsible Paediatrician.

8.4.11 Once the fact of the child's death has been confirmed, any IV cannulae, ET tubes and other equipment may only be removed from the child after checking with the Coroner's office. This should be documented clearly in the medical notes and necessary investigations with chain of evidence and X-rays organised.

8.4.12 any clothing removed and any items of clothing or bedding brought in with the child should be placed in labelled specimen bags and given to the Police Investigating Officer. The clothing may assist the pathologist and occasionally be required for forensic examination. A record must be made of who removed the items and handed them to the Police. Clothing may not be returned to the parents until the Coroner agrees.

8.4.13 the child's body should not be washed or "cleaned up" as this may interfere with the pathologist's investigation. The child may be wrapped in a clean blanket. Where

cleaning of the child's body is considered essential the Police Investigating Officer and Responsible Paediatrician must be consulted as it may be appropriate for the body to be photographed and / or swabbed before being cleaned.

9. WORKING PRINCIPLES

9.1 History taking from the child's family

9.1.1 Initial history would be taken by the Responsible Paediatrician at the time of presentation at the hospital. The identity of the people present and their relationship to the child needs to be ascertained and detailed records made of who was present and what was said.

9.1.2 Following the confirmation of the death there will be joint history taking with the Responsible Paediatrician and the police.

9.1.3 Unless there are indications that the death may be suspicious it will not be appropriate to separate the parents / carers to obtain the history from them, although note should be made of who provides the information. If the death is suspicious the Police Investigating Officer will take this into account when planning the taking of the history.

9.1.4 Appendix 3 is provided as a guide to samples to be taken in the event of a sudden unexpected death.

9.1.5 Discretion is needed as to the amount of detail that should be sought in the first instance and the immediate history should be obtained first. If a visit to the home address is planned, a lot of the background information can be obtained from the medical records or during that visit. If, however, such a visit is not feasible, it will be necessary to cover as much ground as possible whilst at the hospital.

9.1.6 Encouraging the parents to talk spontaneously with prompts about specific information is likely to be better than trying to collect a structured history. In recording the accounts of parents / carers it is important to use their own words as far as possible. Ideally, information should be recorded verbatim.

9.1.7 Much of the information is very sensitive. Parents may feel very vulnerable when asked about their sleeping arrangements, alcohol intake or drug use, so great skill is needed in asking the questions in a non-threatening way, with no implication of value judgement or criticism.

9.2 Examination of the child's body

9.2.1 Unless there are indications that the death is suspicious and an immediate forensic post mortem examination is to take place, the Responsible Paediatrician should undertake a full general examination of the child's body. A consultant in emergency medicine may also need to be involved and for children over 16 years, may be more appropriate.

9.2.2 This examination should be conducted with the Police Investigating Officer present.

9.2.3 Any marks and injuries should be documented on a body chart. This should include the site and route of any intervention in resuscitation, for example, venepuncture or intra-osseous needle insertion.

9.2.4 The examination should include the genitalia for any signs of injury and fundoscopy for retinal haemorrhage (preferably by a Consultant Ophthalmologist).

9.2.5 An ear temperature should be taken immediately on presentation, using a low reading thermometer if necessary. Care should be taken to examine the ear and record the findings before the temperature is taken.

9.2.6 Full growth measurements (length, weight and head circumference) should be taken and plotted on centile charts if possible. The child's general appearance, cleanliness and descriptions of any blood or secretions around nose or on clothes should also be noted.

9.2.7 The child's body should not be washed or "cleaned up" as this may interfere with the pathologist's investigation. Any visible marks and injuries should be photographed by a Police Forensic Investigator.

9.2.8Any clothing removed should be placed in labelled specimen bags and given to the Police Investigating Officer. The clothing may assist the pathologist and occasionally be required for forensic examination. A record must be made of who removed the clothing and handed it to the Police. Clothing may not be returned to the parents until the Coroner agrees.

9.3 Obtaining samples

9.3.1 If any laboratory investigations were taken during resuscitation, these should be clearly documented.

9.3.2 Unless there are indications that the death is suspicious and an immediate forensic post mortem examination is to take place, samples for medical investigations should be taken routinely as soon as possible after death. The recommended samples are detailed in Appendix 3.

9.3.3 Unless there are indications that the death is suspicious and an immediate forensic post mortem examination is to take place a full skeletal survey needs to be performed in all children under 2 year age and a clinically targeted X-rays in older children. It should be reported before the post mortem examination by a consultant Radiologist experienced in interpreting paediatric X-rays. If the surveys have to be performed and reported out of hours, the X-rays should be reviewed by a specialist Paediatric Radiologist before the post mortem examination. This x ray is usually performed as part of the post mortem

9.3.4 For children under the age of 2 years a full skeletal survey will be undertaken. The British Society of Paediatric Radiology, have developed standards for skeletal surveys in suspected non-accidental injury (NAI) in children and these should be followed.

9.4 Care of the child's family

9.4.1 When the child has been pronounced dead, the Responsible Paediatrician should break the news to the parents, having first reviewed all the available information. The interview should be in the privacy of an appropriate room. The allocated nurse should also be present.

9.4.2 The family should be treated with respect and honesty. They should be allowed to ask questions at any stage. Unless there is an obvious cause of death, it is usually best

to say that an opinion cannot be given at that stage.

9.4.3 Parents should, in all but exceptional circumstances, be allowed to hold and spend time with their child. Professional presence should be discreet but vigilant during parents' time with their child.

9.4.4 Mementos should be offered routinely. If there are marks on the child's body which might be masked by taking mementos these areas must be avoided. Details must be recorded in the medical notes (e.g. lock of hair cut or palm or sole prints taken).If mementos are not taken in the Accident and Emergency Department the Coroner's Officer should be notified and a request made to arrange these after the post mortem examination.

9.4.5 The family should be informed that the death must be notified to HM Coroner (if reportable case to coroner) and that formal identification of the child's body to the Police and a post mortem examination may be required. It should be sensitively explained to the family what this involves and that tissue samples may be taken for examination under the microscope. They should be told as soon as possible where this will be done and that if it is to be at a specialist centre what will happen afterwards. They will usually be able to spend time with their child after the post mortem examination.

9.4.6 The family should also be informed that to ensure that the investigation into the death of a child is as effective as possible and that the family are properly supported a number of agencies, including the Police, Health Service, Social Care, Education will be involved and will meet to plan any further actions that each will take. Details should be provided of any action planned, including any visit to the home address and of the need to obtain a comprehensive history from the family.

9.4.7 If the child is a twin the other twin should be assessed immediately and admission or a period of observation and investigation should be considered. It may also be appropriate for other children in the family to be seen and examined by a Consultant Paediatrician

9.4.8 Further support for the family should be provided in accordance with existing hospital policies.

9.4.9 Before they leave the hospital the family should know where their child will be, and the contact details for the relevant co-ordinator whom they can contact if they wish to visit their child.

9.4.10 They should also be provided with contact details for the Lead Paediatrician, the Police Investigating Officer (or Family Liaison Officer if appointed) and the Coroner's Officer.

9.4.11 The Department for Education leaflet entitled 'The Child Death Review' will be given to bereaved families by a professional known to the family when deemed most appropriate.

9.5 Secure Children's home *(chapter 5, page 87, para 21 working together to safeguard children 2015)*

9.5.1 .For any child who dies in a secure children's home, the Prisons and Probation ombudsman will carry out an investigation. In order to assist the Ombudsman to carry out these investigations, secure children's homes are required to notify the ombudsman of the deaths and to comply with requirements at regulation 40(2) of the Children's Homes (England) Regulations 2015 to facilitate that investigation.

9.6 Home Visit

9.6.1 Consideration will be given to a joint visit to the home address (or to the place where the child collapsed / died if different) by the Designated / Lead Paediatrician (or alternative senior health professional experienced in responding to unexpected child deaths) and the Police Investigating Officer. Where it is not possible for Designated / Lead Paediatrician to accompany the Police on a home visit, any medical query could be put to the Responsible Paediatrician who would have attended the child in the hospital at the time of death and would have collected preliminary information.

9.6.2 Where the death is considered suspicious at the outset, the arrangements for the visit will be considered by the Police in the context of the police investigation and particularly the forensic strategy for the scene.

9.6.3 Arrangements should be made to ensure that the scene of the child's collapse and / or death is left undisturbed and the Police Investigating Officer may have visited the scene of death immediately and be maintaining a presence there.

9.6.4 If it is not possible for the Designated / Lead Paediatrician to undertake the visit at this stage, the Police or the Responsible Paediatrician will fully brief the Designated / Lead Paediatrician as soon as possible afterward who may arrange to visit if feasible.

9.6.5 It must be explained to the family that this is a routine part of the investigation to help identify and understand the factors that have contributed to the death and provide information for the pathologist, prior to the post mortem examination.

9.6.6 The purpose of the visit is to:

- Explore the circumstances of the death, relevant events and previous history, filling any gaps in and supplementing the information which was obtained at the hospital or from agency records.
- Carry out a systematic examination of the site of the child's death
- Ensure that the family are fully informed about the multi-agency approach to the death of the child and the support available to them
- Give the booklet 'The Child Death Review' if appropriate

9.6.7 The Police Investigating Officer will arrange for the scene to be photographed by a Police Forensic Examiner. This should normally take place towards the end of the home visit when the Police Investigating Officer is in a position to set parameters for the Forensic Investigator.

9.6.8 There may also be a need to remove items from the scene. This will be undertaken by the Police Forensic Investigator and the decision to take items will be made by the Police Investigating Officer in conjunction with the Responsible Paediatrician.

9.6.9 The home interview and visit to the place where the child died can be very difficult, but may also be of great value in understanding the sequence of events leading to the death. Parents commonly find this home interview, whilst stressful and sometimes painful, very helpful. The fact that the Paediatrician is willing to spend this time with them, helping to understand what has happened to their child may in itself be very important to the family.

9.7 Reportable deaths to the Coroner

9.7.1 If the death occurs in hospital the Responsible Paediatrician in the Hospital is responsible for informing in writing, by fax or secure email, to the Coroner of a child death.

9.7.2 If the death occurs at home either the attending Dr, usually a GP or the Police can advise the coroners' office.

9.7.3 Reportable deaths:

- The cause of death is unknown
- It cannot readily be certified as being due to natural causes
- The deceased was not attended by the doctor during their last illness of was not seen within the last 14 days of viewed after death
- There are any suspicious circumstances of history of violence
- The death may be linked an accident (whenever it occurred)
- There is a question of self-neglect or neglect by others
- The death has occurred or the illness arose during or shortly after detention in police custody (including voluntary attendance at a police station)
- The deceased was subject to a Deprivation of Liberty (DOL) order
- The deceased was detained under the mental health Act
- The death is linked with an abortion
- The death might have been contributed to by the actions of the deceased (such as history of drug or solvent abuse, self injury or overdose)
- The deceased suffered a fracture within the last twelve months
- The death could be due to industrial disease or related in any way to the deceased's employment
- The death occurred during an operation or before full recovery from the affects of an anaesthetic or was in any way related to the anaesthetic (in any event of a death within 24 hours should normally be referred)
- The death may be related to a medical procedure or treatment whether invasive or not
- The death may be due to lack of medical care
- There are any other unusual or disturbing features to the case
- The death occurred within 24 hours of admission to hospital
- It may be wise to report any death where there is an allegation of medical mismanagement
- Any maternal death relating to pregnancy of childbirth
- Any stillbirth

9.7.4 The coroner will establish if an investigation is required;
If yes they will investigate to establish the identity of the person who has died, how, when and where they died and any information required to register the death; and uses information discovered in the investigation to assist in the prevention of further deaths where possible.

9.7.5 The coroner may decide, as part of the investigation to hold an inquest. If the coroner decides to investigate the death, the registrar of births and deaths must wait for the coroner to finish the investigation before the death can be registered.

9.7.6 The Coroner decides whether or not a post-mortem examination is needed and what type of examination is most appropriate. Further details regarding the Coroners Service can be obtained from www.gov.uk/moj

10. CORONER & PATHOLOGIST INVOLVEMENT

10.0.1 If he/she deem it necessary (and in almost all cases of an unexpected death it will be) the Coroner will order a post mortem examination to be carried out as soon as possible by the most appropriate pathologist available (this may be a paediatric pathologist, forensic pathologist or both) who will perform the examination according to the guidelines and protocols laid down by the Royal College of Pathologists.. Information gathered by the lead paediatrician at the rapid response/information sharing meeting should be forwarded to the Coroner so this can be shared with the pathologist conducting the post mortem in order to inform the process. Where the death may be unnatural or the cause of death has not yet been determined the Coroner will in due course hold an inquest

10.0.2 All information collected relating to the circumstances of the death including a review of all relevant medical, social and educational records must be delivered to the Coroner within 28 days of the death unless some of the crucial information is not yet available

10.0.3 The Police Investigating Officer should, where possible, attend the post mortem. A Police Photographer will also be present. If this is not possible, then they must send a representative who is aware of all the facts of the case. A Forensic Investigator must attend all post mortem examinations conducted by a Home Office pathologist. The Responsible Paediatrician may also attend. Where this does not occur there must be adequate discussion between the Paediatrician and the Pathologist both before and after the post mortem examination.

10.0.4 Lists of inquests held are on the Central Bedfordshire Website, and it is the coroners' responsibility to inform the press of any inquests, inquests are almost always held in public

10.0.5 The coroner will speak to all families about the results of the post mortem. Once the post mortem has been carried out the Coroner will determine when the body can be released for burial.

11. DESIGNATED / LEAD PAEDIATRICIAN RESPONSIBILITIES

11.0.1 The Designated / Lead Paediatrician for Child Deaths will be notified by the CDOP Manager or the Responsible Paediatrician, of the death of a child in hospital or who has been brought to an Accident and Emergency Department having died in the community.

11.0.2 The Designated / Lead Paediatrician will also be notified by the Police Investigating Officer if the body of a child who has died is not removed to hospital and by the Coroner's Officer if the body of a child has been conveyed directly to the mortuary. In such cases the Designated / Lead Paediatrician will liaise with the Police Investigating Officer to coordinate a subsequent response which complies with these procedures as closely as possible.

11.0.3 The Designated / Lead Paediatrician will, if appropriate, either conduct the joint visit to the home address (or to the place where the child collapsed / died, if different) with the Police Investigating Officer, or arrange for an alternative senior health professional experienced in responding to unexpected child deaths to do so.

11.0.4 The Designated / Lead Paediatrician will obtain from the 'Responsible Paediatrician' (on call Paediatrician) a full report on the initial response to the child's

death. This should include details of any outstanding actions and the Designated / Lead Paediatrician should, in conjunction with the Police Investigating Officer, arrange for these to be completed.

11.0.5 The Responsible Paediatrician would have reviewed available hospital records and summarised that in a report. The Designated / Lead Paediatrician will receive Responsible Paediatrician's report and add information from reviewing other available health records.

11.0.6 Copies of the original records should be retained by the Designated / Lead Paediatrician to facilitate management of the investigation and review process and provided to the original record holder and the Police Investigating Officer.

11.0.7 The Designated / Lead or Responsible Paediatrician will, in conjunction with the Police Investigating Officer, fully brief the Pathologist and should include all information obtained during the initial investigation, a full medical report based on the history given by the parents in hospital, examination of the child immediately after death, information obtained during the home visit and examination of all relevant medical and social records. In very young babies this might include obstetric records. Any photography of the scene or of the child at presentation or in the Accident and Emergency Department should be provided to the Pathologist prior to starting the post mortem.

11.0.8 The final report on the post mortem examination will be provided to the Designated / Lead Paediatrician, via the CDOP Manager, by the Coroner when the inquest has been concluded.

12. FINAL CASE DISCUSSION

12.0.1 A multi-agency Final Case Discussion will be convened by the CDOP Manager on behalf of the Designated / Lead Paediatrician as soon as possible after the inquest. The Coroner's officer will advise the CDOP manager when this has taken place and will then release a copy of the post mortem, if a post mortem has taken place. In some circumstances this can take many months.

12.0.2 The type of professionals involved in this meeting depends on the age of the child. The meeting should include those who knew the child and family and those involved in investigating the death for example the GP, health visitor or school nurse, paediatrician, pathologist, senior investigating police officers and where appropriate social workers

12.0.3. The meeting should be chaired by the Designated / Lead paediatrician and the main purpose of the final case discussion is to share information to identify the cause of death and those factors which may have contributed to the death and then to plan for future care for the family.

12.0.4 There should be an explicitly discussion on the presence or not of concerns about abuse and neglect causing or contributing to the death. If there is no evidence of maltreatment this should be documented

12.0.5 Equally consideration should be given as to whether there are any unaddressed safeguarding concerns for siblings or other children in the household and if so what action should be taken and by whom and decide whether the circumstances should be referred to the LSCBs for consideration of holding a Serious Case Review if this has not already happened

12.0.6 The results of the post mortem examination, with the consent of the Coroner,

should be discussed with the parents at the earliest opportunity except in those where abuse or neglect is suspected. This discussion with the parents is usually part of the role of the Coroner's officer involved in the investigation of the child's death and he/she will have the responsibility for initiating this meeting. If possible a member of the primary health care team should usually attend this meeting.

12.0.7 Where the child was normally resident in and / or the event leading to the death took place in another CDOP area, consider the information needs of the CDOP and how these will be addressed. This will normally be through providing copies of the documents prepared for the CDOP.

13. SERIOUS CASE REVIEWS

13.0.1 Regulation 5 of the Local Safeguarding Children's Boards Regulations 2006 sets out the function of LSCBs. This includes the requirements of the LSCB to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

13.0.2: 5(1)(e) undertaking reviews of serious cases and advising the authority and their board partners on lessons to be learned.
For the purpose of paragraph (1) a serious case is one where:

(a) Abuse or neglect of a child is known or suspected; and

(b) Either – (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their board partners or other relevant persons have worked together to safeguard the child. (p75 Working together to safeguard children, 2015)

14. CHILD DEATH OVERVIEW PANEL MEETINGS

14.0.1 The Panel will meet approximately every 6 weeks. Meetings will be supported and minuted by the CDOP Manager. The confidential minutes of Panel meetings will be circulated to all core members of the Panel and to any co-opted members attending the relevant meeting providing they have secure e mail addresses.

14.0.2 The CDOP Manager will meet with the Designated / Lead Paediatricians at regular intervals to discuss on going cases and determine which cases are to be presented at the next CDOP panel meeting.

14.0.3 In agreement with the Designated / Lead Paediatrician and where there is a complete data set of information on a child's death, the CDOP Manager will, one week in advance of the Panel meeting send copies of these cases using the agreed data analysis proforma, to all members attending the meeting. This information will be sent via secure nhs.net/ gcsx e-mail or posted using recorded delivery.

14.0.4 At the CDOP panel meeting the Designated / Lead Paediatrician will present the child death cases to the panel describing any medical terminology and answering questions raised by panel members.

14.0.5 The Panel will categorise the child deaths according to the pre determined list and complete an assessment of factors that contributed to the death and determine if any modifiable factors were present.

14.0.6 The panel will also consider:

- Issues identified in the review
- Learning points
- Recommendations
- Follow up plans for the family

The panel is responsible for defining factors where if actions could be taken through national, or local interventions, the risk of future child deaths could be reduced. (Chapter 5, page 85, para 11 Working Together 2015)

14.0.7 It will be agreed by the panel who will be the lead person to act on the recommendations and follow up plans for the family

14.1 CDOP reporting arrangements

14.1.1 The chair of the Panel is responsible for referring to the chairs of the Bedford Borough, Central Bedfordshire & Luton LSCB's any matter as agreed by the Panel and for monitoring completion of any other action agreed by the Panel within their terms of reference.

14.1.2 The Panel will decide on a case by case basis the information that should be shared with the family of each child whose death is reviewed and the means by which this will be provided.

14.1.3 An annual report from the Panel will be provided to Central Bedfordshire, Bedford Borough and Luton LSCBs in a format that will not reveal the identity of individuals in the case but contain a summary outlining trends, comparative data, and main issues emanating from cases reviewed in-depth that year.

14.1.4 The CDOP Manager is responsible for the compilation of any data returns required by the Department for Education or the bodies operating on behalf of that Department.

14.1.5 Information on individual cases will only be provided to any body outside of the CDOP as specified in these procedures or with the explicit agreement of the Panel.

14.2 CDOP administrative arrangements

14.2.1 The CDOP child death database is managed by the CDOP Manager. This needs to be compliant with relevant legislations such as the Data Protection Act, Freedom of Information Act etc.

14.2.2 Complaints received regarding the actions of an individual professional or agency will be directed to the relevant agency and dealt with under that agency's complaints procedure. Any other complaints regarding the application of these procedures by the CDOP or a professional operating on their behalf will be referred to the chairs of the LSCBs.

APPENDIX 1

Form A - Notification of Child Death

Notification to be reported by secure email to CDOP Manager at:

Bedfordshire-cdopmanager@nhs.net
Capability House
Wrest park
Silsoe
MK45 4HR
Tel: 01525 864430 ext 5878
Fax: 01525 864425

The information on these forms and the security for transferring it to the CDOP Co-ordinator should be clarified and agreed with your local Caldicott guardian.

If there are a number of agencies involved, liaison should take place to agree which agency will submit the Notification.

Child's Details

Full Name of Child		
Any aliases		
DOB / Age	days/months/years	NHS No.
Address		
Postcode		
School/nursery etc		
Date & time of death	/ / Time	
Other significant family members		

Referral details

Date of referral	/ /
Name of referrer	
Agency	
Address	
Tel Number	
Email	

Details of the death:

Location of death or fatal event (Give address if different from above)				
Death expected?	☐	Expected	☐	Unexpected†
Reported to Coroner		Y / N / NK / NA	Date: / /	
			Name:	
Reported to Registrar		Y / N / NK / NA	Date: / /	
			Name:	
Has a medical certificate of cause of death been issued?		Y / N / NK / NA	Date: / /	
Post mortem examination:		Y / N / NK / NA	Date: / /	
			Venue:	

† An unexpected death is defined as the death of an infant or child (aged under 18 years) where there is no prior condition that might be expected to cause the death at that time, and the child dies either immediately or subsequently from the consequences of the precipitating event or collapse.

Notification Details:
Please outline circumstances leading to notification. Also include if any other review is being undertaken e.g. internal agency review; any action being taken as a result of this death.

Agency	Name, Address & Tel No.
GP	
Midwife/ Health Visitor/ School nurse	
Paediatrician	
Police	
Children's Social Care	
School/ nursery etc	
Others (list all agencies known to be involved)	

Are the parents related? **Yes/No/ Not Known**

If yes please specify

APPENDIX 2

Agency Report Form B

This form to be returned to CDOP Manager at:

Bedfordshire-cdopmanager@nhs.net
Capability House
Wrest park
Silsoe
MK45 4HR

The information on these forms and the security for transferring it should be clarified and agreed with your local Caldicott guardian.

Please complete this form based on the information you have and return it quickly to the CDOP manager. If in doubt about what information to provide, please discuss with your manager.

Completing the form: The form is sent out to all agencies involved with a child and family. As such you are not expected to complete all of the form. **You are asked to complete only those sections and questions on which you hold information**. Some information is collected in tick box or yes/no format to allow collation and comparison of data, but in each section there is space for more narrative/qualitative information which will help the CDOP to more fully understand the nature of each child's death. If you do not have information for any particular item, please either circle NK (Not Known) or NA (Not Applicable) or leave the item blank. It is preferable to circle not known as this indicates to the CDOP that you have considered the question but have no information.

The form consists of six sections, A to F, along with supplementary forms B2 – B12 to be completed where appropriate according to the type of death. **Please note: If the death concerns the death of a neonate please complete form B2 first.**

Purpose: Form B is designed to gather information about each child's death. Its primary purpose is to enable the local CDOP to review all children's deaths in their area in order to understand patterns and factors contributing to children's deaths and ultimately to take steps to prevent future child deaths.

Confidentiality: The information requested on this form will be used for the purposes of child death review as outlined in chapter 5 of Working Together to Safeguard Children. All bereaved parents are informed of these processes. The nature of the information collected means it is likely that some of the information is personal/sensitive data and therefore CDOPs should be mindful of their obligations under the Data Protection Act (DPA) 1998 when processing that information. All cases will be anonymised prior to discussion by the CDOP. All information gathered will be stored securely and only anonymised data will be collated at a regional or national level.

This page may be removed for the purposes of anonymisation prior to discussion at the CDOP

A: Identifying and Reporting Details

Full name of child			Date of birth
NHS No.			Date of death
Gender	Male		
	Female		
Address (including postcode if known)			

Agency Report Provided by

Agency	Name
Address	
Postcode	
Tel No	Email

B: Summary of Case and Circumstances leading to the death
This section provides information on the nature and manner of the child's death. Please complete any information which you hold on the case.

The 'Details of the Death' section is to be completed by the treating doctor involved with the child at the time of death – other professionals can complete this section if they have the information.

Details of the Death		
What is your understanding of the cause of death? (complete registered cause of death, if known, below)		
What was the mode of death?	☐	Planned palliative care
	☐	Witholding, withdrawal or limitation of life-sustaining treatment
	☐	Brainstem death
	☐	Failed Cardiopulmonary resuscitation
	☐	Witnessed event
	☐	Found dead
	☐	Not known
Has a medical certificate of the cause of death been issued?	Yes / No / Not Known *Please circle as appropriate*	
Was this death referred to the coroner?	Yes / No / Not Applicable / Not Known *Please circle as appropriate*	
Was a post-mortem examination carried out?	Yes / No / Not Applicable / Not Known Date of PM if known / / Place of PM if known	
Has an inquest been held?	Yes / No / Not Applicable / Not Yet/ Not Known Date of Inquest if known / /	
Registered cause of death if known (for children over 28 days)	**Ia** **Ib** **Ic** **II**	
Registered cause of death if known (for neonatal deaths)	(a) main diseases or conditions in infant (b) other diseases or conditions in infant (c) main maternal diseases or conditions affecting infant	

	(d) other maternal diseases or conditions affecting infant (e) other relevant conditions

All – please complete

Where was the child at the time of the event or condition which led to the death?	☐	Acute Hospital	☐	Emergency Department
			☐	Paediatric Ward
			☐	Neonatal Unit
			☐	Paediatric Intensive Care Unit
			☐	Adult Intensive Care Unit
			☐	Other
	☐	Home of normal residence		
	☐	Other private residence		
	☐	Foster Home		
	☐	Residential Care		
	☐	Public place		
	☐	School		
	☐	Hospice		
	☐	Mental health inpatient unit		
	☐	Abroad		
	☐	Other (specify)		
	☐	Not known		

Where was the child when the death was confirmed?	☐	Acute Hospital	☐	Emergency Department
			☐	Paediatric Ward
			☐	Neonatal Unit
			☐	Paediatric Intensive Care Unit
			☐	Adult Intensive Care Unit
			☐	Other

	☐	Home of normal residence	
	☐	Other private residence	
	☐	Foster Home	
	☐	Residential Care	
	☐	Public place	
	☐	School	
	☐	Hospice	
	☐	Mental health inpatient unit	
	☐	Abroad	
	☐	Other (specify)	
	☐	Not known	

Were any of the following events known to have occurred?		
☐	Neonatal Death	Complete B2 - Please complete form B2 before continuing to complete the rest of this form, as you may not be required to provide any further information through Form B.
☐	Death of a child with a life limiting condition (to be completed by the lead clinician or designated member of the palliative care team)	Complete B3
☐	Sudden unexpected death in infancy (to be completed by the SUDI paediatrician or designated deputy, and will almost always be completed at or immediately after the local case review meeting. In those rare instances in which there is no local case review meeting the SUDI paediatrician or designated deputy should complete this form at the conclusion of the investigation)	Complete B4
☐	Road traffic accident/collision	Complete B5
☐	Drowning	Complete B6
☐	Fire/burns	Complete B7
☐	Poisoning	Complete B8
☐	Other non-intentional injury/accidents/trauma	Complete B9
☐	Substance misuse	Complete B10
☐	Apparent homicide	Complete B11
☐	Apparent suicide	Complete B12

Circumstances of Death: Please provide a narrative account of the circumstances leading to the death. This should include a chronology of significant events (e.g. contact with service; changes in family circumstances) in the background history, and details of any important issues identified. **Consider**: Events leading to the death; Early family history; Pregnancy and birth; Infancy; Pre-school; School years; Adolescence

C: The Child

This section provides information about the child and any known conditions or factors intrinsic to the child that may have contributed to the death. Please complete any information which you hold on the case.

Birth weight (gm or oz / lb)	gms lbs oz	Gestational age at birth (completed weeks)	
Last known weight (gm or oz / lb) Date	gms lbs oz / /	Last known height (ft/in or cm) Date	cm ft in / /

Any known medical conditions at the time of death? Yes / No / Not known

If yes, please provide details below

Was the child fully immunised?	Yes / No / Not known Date of last immunisation / /
Any known developmental impairment or disability at the time of death? If yes, please provide details below	Yes / No / Not known
Any medication at the time of death? If yes, please provide details below	Yes / No / Not known

Education/Occupation	☐	Not yet in education		
	☐	Nursery		
	☐	School		
	☐	College		
	☐	Not in education		
	☐	Left education	☐	Employed
			☐	Unemployed

If employed, please provide occupation			
Ethnic group	☐	White	☐ English/Welsh/Scottish/Northern Irish/British ☐ Irish ☐ Gypsy or Irish Traveller ☐ Any other White background (please specify)
	☐	Mixed/ multiple ethnic groups	☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Any other mixed/multiple ethnic background (please specify)
	☐	Asian or Asian British	☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Any other Asian background (please specify)
	☐	Black/ African/ Caribbean/ Black British	☐ African ☐ Caribbean ☐ Any other Black/African/Caribbean background (please specify)
	☐	Other ethnic group	☐ Arab ☐ Any other ethnic group (please specify)
	☐	Not known/ not stated	
Religion (please state)			

Factors in the child:
Please provide a narrative description of any relevant factors within the child that have not already been covered. Include any known health needs; factors influencing health; growth parameters development/educational issues; behavioural issues; social relationships; identity and independence; any identified factors in the child that may have contributed to the death. Include strengths, as well as difficulties.

D: Family and Environment

This section provides details of the child's family and close environment. Please complete with any information known to you.

Please circle your responses

	Age	Gender	Relationship to child and/or family	Occupation	Living in primary household?[1]
Mother		F	Mother		Y / N / NK
Father		M	Father		Y / N / NK
Other significant others *(e.g. Mother's partner; significant carer. Please number and complete any information known; further adults can be added below)*					
1					Y / N / NK
2					Y / N / NK
3					Y / N / NK
4					Y / N / NK
Siblings (*Please number and complete any information known; further siblings can be added below, please include step and half siblings)*					
1					Y / N / NK
2					Y / N / NK
3					Y / N / NK
4					Y / N / NK
6					Y / N / NK
7					Y / N / NK

Was the child/family an asylum seeker	Yes / No / Not known

Further family information

(In relation to the primary household or other household where the child spends a significant amount of time)

Please circle your responses

	Mother	Father	Other adult 1	Other adult 2
Smoker	Y / N / NK	Y / N / NK	Y / N / NK	Y / N / NK
Any Known:				
Disability, including learning disability?	Y / N / NK	Y / N / NK	Y / N / NK	Y / N / NK
Physical health issues?	Y / N / NK	Y / N / NK	Y / N / NK	Y / N / NK
Mental health issues?	Y / N / NK	Y / N / NK	Y / N / NK	Y / N / NK
Substance misuse?	Y / N / NK	Y / N / NK	Y / N / NK	Y / N / NK
Alcohol misuse?	Y / N / NK	Y / N / NK	Y / N / NK	Y / N / NK
Known to police	Y / N / NK	Y / N / NK	Y / N / NK	Y / N / NK

Any known domestic violence in the household? (please provide details below)

[1] If the child is living in more than one household, for example where the parents have separated, the primary household is where the child spends most of his/her time; please provide any relevant details in the narrative section.

Yes / No / Not known

Factors in the family and environment: Please provide a description of any relevant factors known to you that have not been covered elsewhere. **Consider**: family structure and functioning; wider family relationships; housing; employment and income; social integration and support; community resources. Include strengths and difficulties

E: Parenting Capacity

The purpose of this section is to understand factors in relation to the care of the child that may have been of relevance in any way to the child's death, and also factors that may have contributed to support and nurture of the child. Please complete any information known to you.

Where was the child living at the time of their death or the event leading to their death?	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Parental home Other relatives Foster carers Private fostering Residential unit Long stay hospital Hospice Other
Who was directly looking after the child at the time of their death or the event that led to their death? (please tick all that apply)	☐ ☐	Mother Father
	☐	Other adults (please list and give adults relationships to the child)
	☐	Child/young person (please list and give age and relationships to the child)
	☐ ☐	Health care staff Others (please list below)

Was the child subject to a child protection plan?	☐ ☐ ☐	At the time of death Previously Not at all
Category of most recent child protection plan:	☐ ☐	Physical abuse Neglect

	☐ Emotional abuse ☐ Sexual abuse ☐ Not known
Was the child subject to any statutory orders?	☐ At the time of death ☐ Previously ☐ Not at all
Category of most recent statutory order:	☐ Police Powers of Protection ☐ Emergency Protection Order ☐ Interim Care Order ☐ Care Order ☐ Supervision Order ☐ Residence Order ☐ Section 20 (Children Act 1989) ☐ Antisocial behaviour order ☐ Other court order, please specify:
Had the child been assessed as a child in need under section 17 of the Children Act 1989?	☐ At the time of death ☐ Previously ☐ Not at all
Were any siblings subject to a child protection plan?	☐ At the time of death ☐ Previously ☐ Not at all
Were any siblings subject to any statutory orders?	☐ At the time of death ☐ Previously ☐ Not at all

Factors in the parenting capacity:
Provide a narrative description of the parenting capacity with any relevant factors known to you and not already covered elsewhere.
Consider issues around provision of basic care; health care (including antenatal care where relevant); safety; emotional warmth; stimulation; guidance and boundaries; stability. Include strengths as well as difficulties.

F: Service Provision

The purpose of this section is to obtain a profile of the services being offered to the child and family; the effectiveness of those services in supporting the child and family; and to identify any unmet needs or gaps in services. Please complete any information you are able to on your agency.

Details of agency involvement

Please indicate whether any of the services listed were involved with the child, or in neonatal deaths, with the mother. Where any service was involved, please provide details in the narrative section below.

Please circle your responses

Agency / professional	Involved at time of death or in relation to the final illness[2]	Involved previously
Primary Health Care	Y / N / NK / NA	Y / N / NK / NA
Secondary / Tertiary Hospital Services	Y / N / NK / NA	Y / N / NK / NA
Secondary / Tertiary Community Health Services	Y / N / NK / NA	Y / N / NK / NA
Hospice Services	Y / N / NK / NA	Y / N / NK / NA
Child & Adolescent Mental Health	Y / N / NK / NA	Y / N / NK / NA
Police	Y / N / NK / NA	Y / N / NK / NA
Local Authority Children's Services	Y / N / NK / NA	Y / N / NK / NA
Education	Y / N / NK / NA	Y / N / NK / NA
Connexions	Y / N / NK / NA	Y / N / NK / NA
Probation	Y / N / NK / NA	Y / N / NK / NA
Other (please specify)	Y / N / NK / NA	Y / N / NK / NA

If no professionals involved at the time of death, what was the last known contact of a professional from your agency?	Professional Date of last known contact / / Nature of contact ☐ No known contact from this agency ☐ Not known

Were there any identified unmet needs / gaps in services? (if yes, please provide details below)	Y / N / NK / NA
Were there any identified difficulties in family engagement with services? (if yes, please provide details below)	Y / N / NK / NA

[2] Include all those providing services at the time of death or in relation to the final illness, even if not present at the time of the death; e.g. child on school roll; planned out patient follow up; active social work case; palliative care.

Factors in relation to service provision

Please complete any information known to you in relation to service provision that has not been covered elsewhere. **Consider** any identified services both required and provided; the nature and timing of any services provided; any gaps between child's or family member's needs and service provision; any issues in relation to service provision or uptake, positive/negative in relation to bereavement care.

Was there a formal Critical Incident investigation – if yes, please state which specific agency	Y / N / NK / NA

Any other internal agency investigation (please specify)

Is this child death the subject of a serious case review	Y / N / NK / NA

Issues for discussion Include any action or learning you consider should be taken forward as a result of the child's death; issues that require broader multi-agency discussion

APPENDIX 3

Samples to be taken when a child dies unexpectedly

Sample	Send to	Handling	Test	Special comments
Throat swab	Microbiology	Normal (standard operating procedure as for any other sample) by clinician	Culture and sensitivity	
NPA	Virology	Normal by clinician	Viral culture, immunofluorescence and DNA amplification techniques	
Peripheral blood	Microbiology	Normal by clinician	M,C and S	Please do **not** attempt cardiac puncture to obtain blood samples as this interferes with post mortem findings.
Peripheral blood	Haematology and Biochemistry	Normal by clinician	FBC, U and Es	If not already taken during resuscitation
Urine (from in out catheterisation, not SPA)	Biochemistry	Normal by clinician	Organic acids	Post mortem sample not informative. Therefore helpful to do in hospital if possible.
CSF	Microbiology	Normal either by clinician or pathologist	Microscopy , culture and sensitivity	The pathologist can take this sample at post mortem if the clinician feels it is out of their area of expertise.
Blood or urine for Toxicology	Toxicology	If you have clinical grounds to believe that toxicology is warranted, you **MUST** inform the **Police officer** who will make the necessary arrangements for **FORENSIC** processing of the sample. PACE		Toxicology samples are used as evidence for criminal proceedings and should not therefore be taken by clinicians without discussion with the Police, nor should they be sent to the routine hospital laboratory.

		(Police Criminal Evidence Act)		
Guthrie card	Biochemistry	Standard operating procedures		See comments below. If sample not available in A and E, it is routinely taken by pathologist unless trauma is clearly cause of death.
Skin Biopsy	Biochemistry	By Pathologist, standard operating procedures.	Carnitine profile, growth of skin fibroblasts	The pathologist routinely sends the following samples for metabolic screening: Skin Biopsy Solid tissue (liver, kidney, skeletal and cardiac muscle) Guthrie card. Unless there is a clear traumatic cause of death.

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