DOCUMENT TITLE	**Calderdale and Kirklees - Child death review policy**
VERSION	1
AUTHOR(S) CONTACT NAME AND JOB TITLE	Abdul Shameel Mattara SUDIC Paediatrician
TARGET AUDIENCE	Paediatrics Neonates Emergency department Obstetrics and midwifery services
RATIFYING GROUP & DATE RATIFIED	Paediatric forum Neonatal forum ED forum
RATIFICATION AT MEDICINES MANAGEMENT COMMITTEE (if medicine-related)	
IMPLEMENTATION DATE	11/05/2021
REVIEW DATE	01/05/2024
WHERE AVAILABLE	Policies and Documents Library

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1. Overview

The death of a child is a devastating loss that profoundly affects all those involved. The process of systematically reviewing the deaths of children is grounded in respect for the rights of children and their families, with the intention of learning what happened and why, and preventing future child deaths. Every family has the right to have their child's death sensitively reviewed in order, where possible, to identify the cause of death and to learn lessons that may prevent future deaths.

Most child deaths in England arise from medical causes. Enquiries should keep an appropriate balance between forensic and medical requirements and supporting the family at a difficult time.

1.1 Background to statutory child death review in UK

The UK has a long tradition in expertly reviewing children deaths. In 2007,*Working Together to Safeguarding Children* outlined the duties of Local Safeguarding Children Board to identify patterns of death in a community by setting up Child Death Overview Panel (CDOP)to review all child death under 18 years of age and via a standardised approach to multiagency review of unexpected child deaths.

In 2017, the Children and Social Work Act revised arrangements for child death review in line with Wood's recommendation (HM Government - The Children and Social Work Act 2017). Child Death Review Partners were established representing the local authority (LA) and any clinical commissioning group that fell within LA area and the shift of lead responsibility for child death from Department for Education to Department of Health and Social Care

In the Calderdale and Kirklees areas the 'child death review partners' are:

- Calderdale Metropolitan Borough Council;
- Calderdale Clinical Commissioning Group;
- Kirklees Council;
- Greater Huddersfield & North Kirklees Clinical Commissioning Groups

Definition of child
A child is defined in the Children Act 1989 as a person under 18 years of age

Unexpected death is defined as death of a child 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

A child death review must be carried out for all children regardless of the cause of death. This includes the death of any live-born baby where a death certificate has been issued.

In the event that the birth is not attended by a healthcare professional, child death review partners may carry out initial enquiries to determine whether or not the baby was born alive. If these enquiries determine that the baby was born alive the death must be reviewed.

For the avoidance of doubt, this does not include stillbirths, late fetal loss, or terminations of pregnancy (of any gestation) carried out within the law.

- Stillbirth: baby born without signs of life after 24 weeks gestation;
- Late fetal loss: where a pregnancy ends before 24 weeks gestation.

Cases where there is a live birth after a planned termination of pregnancy carried out within the law are not subject to a child death review.

Population Covered

- All children and young people under the age of 18 years
- All of the above resident within the geographical boundaries of Calderdale and Greater Huddersfield

Children normally resident in another LSCP area

The Paediatrician (or Consultant in Emergency Medicine) must still notify the local SUDIC Paediatrician about the death.

The task of handing over responsibility to the SUDIC Paediatrician in the area of the child's usual residence lies with the local SUDIC Paediatrician in the area where the death takes place

Responsibilities of CDR partners'

The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified. Where 'the partners' find action should be taken by a person or organisation, they will inform them.

In addition, 'the partners' will prepare and publish an annual report on:

- What they have done as a result of the child death review arrangements in their area; and
- How effective the arrangements have been in practice.

The wider child death overview process has been agreed by Calderdale, Kirklees and Wakefield local authority areas to provide a combined child death overview panel (CDOP). This has been to satisfy the child population such that CDOP will typically review at least 60 child deaths per year. It also takes into account networks of NHS care, and agency and organisational boundaries in order to reflect the integrated care and social networks of the area. In order to fulfil this, the CDOP will be divided into two geographical areas based on the Calderdale and Huddersfield Foundation Trust (CHFT) and Mid-Yorkshire Hospitals Trust (MYHT) footprints.

The Partners' have established designated doctors for child deaths for CHFT and MYHT who are senior paediatricians who have a lead role in the review process. The appropriate designated doctor for child deaths is notified of each child death within their hospital trust and is sent relevant information.

The partners may request a person or organisation to provide information to enable or assist the reviewing and/or analysing of a child's death. The person or organisation to whom a request is made must comply with such a request and if they do not do so, the partners may instigate legal action to enforce.

The partners may choose to review the death of a child in their local area even if that child is not normally resident there. Potential 'out of area cases' will be brought to the attention of the designated doctor for child deaths and the CDOP Chair who will decide whether it is useful for CDOP to review an out of area case. In particular, the partners will consider this for the deaths of Children in Care placed within the area.

Responsibilities of other organisations and agencies

- All local organisations or individual practitioners that have had involvement in the case should co-operate, as appropriate, in the child death review process and should also have regard to any guidance on child death reviews issued by the government.

- Organisations have a responsibility to share relevant information with the child death review partners. It is expected that this will be through completion of relevant information requests, and attendance at Child Death Review Meetings.

- There is a specific requirement on registrars of births and deaths to supply child death review partners with the particulars of the death entered in the register in relation to any person who was or may have been under the age of 18 at the time of death. A similar requirement exists where the registrar corrects an entry in the register.

- The registrar must also notify child death review partners if they issue a Certificate of No Liability to Register (where a death is not required by law to be registered in England or Wales) where it appears that the deceased was or may have been under the age of 18 at the time of death.

- The information must be provided to the appropriate child death review partners (which cover the sub-district in which the register is kept) no later than seven days from either the date the death was registered, the date the correction was made or the date the certificate was issued.

- The Coroner has a duty to notify the child death review partners for the area in which the child died or where the child's body was found within three working days of deciding to investigate a death or commission a post-mortem. The Coroner has a duty to share information with the relevant child death review partners.

1.2 Scope

This policy sets out the processes to be followed when a child or young person under 18 years dies in the Calderdale and Greater Huddersfield Geographical area as set out in Working Together to Safeguard Children.

Aims and objectives

The aim of this specification is to outline the procedures CHFT will follow during the management of all Child Deaths including Sudden Unexpected Death in Childhood (SUDIC) resulting in coordinated response by the Health, Police ,Social care and other relevant persons, as recommended by Child Death Review Statutory and Operational Guidance (England) 2018

The objectives of the policies are:

- To respond quickly to the child's death in accordance with the locally agreed procedures
- To maintain a rapid response protocol with all agencies, consistent with the Kennedy principles and current investigative practice from the Association of Chief Police Officers
- To ensure 'Joint Agency Response' is instigated of the criteria is met
- To maintain overarching respect for the child and his/her family
- To ensure the family are supported and have a nominated key worker to coordinate communications and ensure the parents/carers voice is incorporated into the child death processes

1.3 Evidence

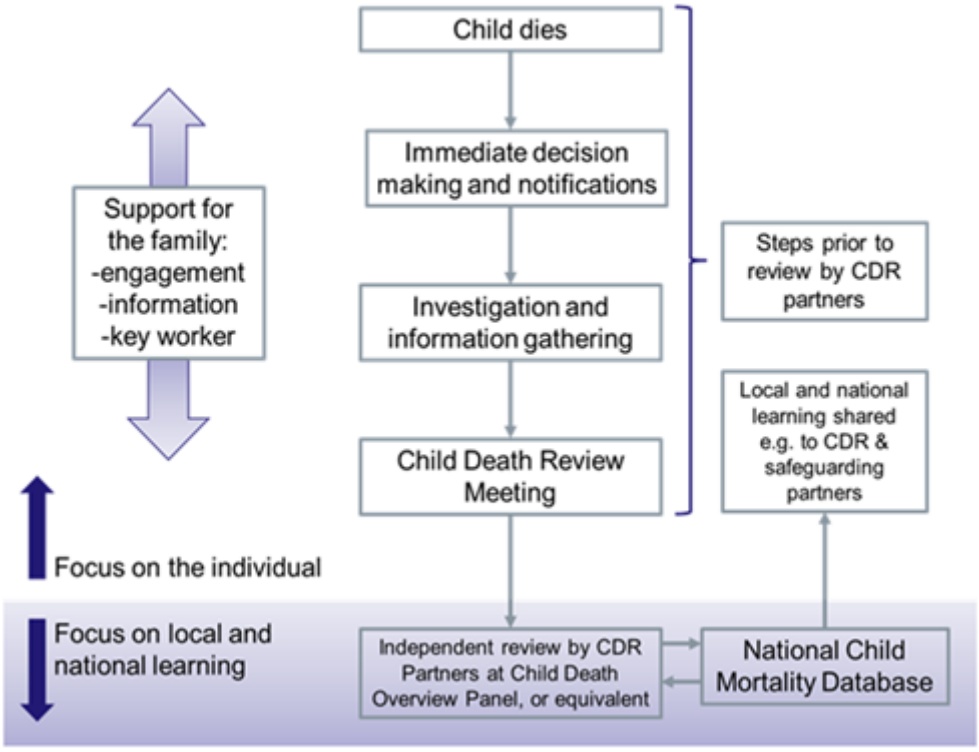
- Children Act 2004 (the Act), as amended by the Children and Social Work Act 2017.
- Sudden unexpected death in infancy and childhood: Multi-agency guidance for care and investigation (Royal College of Pathologists endorsed by Royal College of Paediatrics and Child Health 2016)
- Working Together 2018
- West Yorkshire Consortium Safeguarding Children Procedures
- Child Death Review Statutory and Operational Guidance (England) 2018

CHFT Child death team

- **SUDIC Paediatrician - Dr Abdul Shameel Mattara**
- **Designated doctor for child safeguarding - Dr Pamela Ohadike**
- **Child health safeguarding team**
- **SUDIC Administrator - Diane Crodden**
- **Key worker (To be appointed)**

2. Responding to the Death of a Child: The Child Death Review Process

Process to follow when a child dies:



There are 3 steps that precede the child death review partners' independent review (CDOP) in the immediate aftermath of a child's death. These include:

- Immediate decision making and notifications
- Investigation and information gathering
- Child Death Review Meeting/Final case discussion

The information gathered throughout this process should be fed into the independent review at the Child Death Overview Panel (CDOP).

2.1 Immediate decision making and notifications

A number of notifications must be made when a child dies and these are carried out by a twofold process by the hospital based child death review teams via a cascade process to the child's GP and other professionals, the Child Health Information System, the CDOP administrator, and, the National Child Mortality Database.

In cases of sudden and unexpected child death attending emergency department ,the SUDIC proforma defines the responsibility of nurse in charge to notify children's safeguarding specialist nurses using referral form for SUDIC team, (Appendix- Referral to SUDIC team) who will use the detailed notification form to the wider network of professionals linked to the child that has died, including CDOP administrator using a standard proforma . A copy of the notification form is sent electronically to SUDIC lead. (Appendix- Notification form)

A referral to the Coroner is required for all relevant deaths which is usually done in an unexpected death by completing an electronic form by the senior Paediatrician (See intranet for coroner referral form)

A number of decisions also need to be made by professionals in the hours immediately following the death of a child. These include:

- How best to support the family (see **key worker** below);
- Whether the death meets the criteria for a **Joint Agency Response**;
- What format the child death review meeting should take
- Whether the death meets the criteria for a health serious incident investigation.

Whenever a child dies, practitioners should work together in responding to that death in a thorough, sensitive and supportive manner. The aims of this response are to:

- Establish, as far as is possible, the cause of the child's death;
- Identify any modifiable contributory factors;
- Provide ongoing support to the family;
- Learn lessons in order to reduce the risk of future child deaths and promote the health, safety and wellbeing of other children;
- Ensure that all statutory obligations are met.

A **'key Worker'** should be identified for ongoing support throughout the time of the child death review process. A 'Key Worker' is defined as:

"a person who acts as a single point of contact for the bereaved family, who they can turn to for information on the child death review process, and who can signpost them to sources of support. This person will usually be a healthcare professional".

Core competencies for the key worker can be found at Appendix - **Child Death Review Statutory and Operational Guidance (England)**.

The key worker should provide the family with a paper copy of the leaflet: **When a Child Dies - a Guide for Parents and Carers**.

When dealing with bereaved families health professionals should have due regard to chapter 2 of the NHS England publication **National Guidance on Learning from Deaths**

Having been made aware of the child's death, the SUDIC Lead Health Professional will check that all relevant professionals have been informed of the death (as above), and ensure information is shared with the wider group e.g. the 0-19 health service, midwifery service, CCG Designated Nurse for Safeguarding Children, child's G.P. and other specialist health workers involved in the child's care.

2.2 Investigation and Information gathering

Where the death occurs outside of usual office hours the Emergency Duty Team (EDT) of Children's Social Care will be contacted by the nurse in charge of ED. The EDT is responsible for checking whether the child and family are known to services in the local authority and engaging in initial discussions with key staff and handover to the "in hours" teams. During normal working hours the responsibility lies with the nurse in charge where the child dies.

Children's Social Care should make enquiries such that relevant background information in relation to the child that has died and any siblings is obtained from all Children's Services within the Local Authority e.g. Youth Offending Team, Education (local authority maintained or academy), Youth Service and Children First Hubs. If the death does not meet the criteria for a Joint Agency Response as outlined below, information will be gathered in preparation for a child death case review meeting.

Children with recognised life limiting conditions are usually cared for by a multi-agency team led by a Paediatrician. Some of these will have a documented limitation of treatment agreement (LOTA) which will have been shared with all agencies involved. The death of these children may not be anticipated. However, many children who are at risk of rapid deterioration or sudden death do not have a formal LOTA in place even though their death may be anticipated. The SUDIC Lead Health Professional will work closely with the responsible Consultant to manage the response to the child's death.

2.3 Joint agency home/scene Visit

The purpose of the joint home visit is to provide the information that may enable identification of the cause of death and will include meeting and information gathering with parents/carers, and inspection of the place of death. The home visit is more relevant in unexpected deaths.

Decisions regarding the appropriateness of a visit to the place where the child died will be taken by the on call Paediatrician in discussion with the Senior Investigating Police Officer. This should always take place for children under 2 years who die suddenly with no medical explanation but should be considered in all cases. SUDIC Paediatrician can be contacted to discuss the appropriateness and logistics of proposed home visit.

The following principles will be considered when deciding whether a home visit will take place:

- Visits will not be taken to the scenes of crime, except at the explicit request of the Police;
- Visits will not take place to the scenes of road traffic accidents;
- A visit must add value to the process;
- Safety is paramount, and health professionals will not attend the homes of families where a child died under suspicious circumstances on their own.

When a visit is agreed, it will be undertaken by either the SUDIC Paediatrician or On call Paediatrician or other nominated health professional, usually within 72 hours after the child's death, during normal working hours. The purpose of the visit is not forensic, and it is recognised that potential evidence will have been removed from the scene by Police by the time a visit takes place. Information from this visit will be recorded by the Lead Health Professional on Form 2 the 'Record of Home Visit' (child deaths) (Appendix- Child death forms)

In all cases the police will complete an Initial Coroner's Report within 24 hours. The lead Health Professional will supply the Coroner with copies of Forms 1 and 2 (ED and Home Visit Forms), at the earliest opportunity and within a maximum of 24 hours. (Appendix- child death forms)

Joint Agency Response to Child Deaths

A **Joint Agency Response** is required if a child's death:

- Is or could be due to external causes;
- Is sudden and there is no immediately apparent cause (including sudden unexpected death in infancy/childhood);
- Occurs in custody, or where the child was detained under the Mental Health Act;
- Occurs where the initial circumstances raise any suspicions that the death may not have been natural (this could include a child death in a hospital setting;
- Occurs in the case of a stillbirth where no healthcare professional was in attendance.

The SUDIC Lead Health Professional should be consulted to ensure that there is a joint discussion and decision between lead professionals for health, police and social care about next steps as per the process set out in the Investigation of Sudden Unexpected Deaths in Childhood (West Yorkshire Consortium Procedures online). In the case of a stillbirth an obstetrician should be consulted.

If a baby dies within 24 hours of birth or shortly thereafter due to an event related to the birth whilst under medical supervision, and there is a clear medical explanation for the death, this should not require a joint agency response.

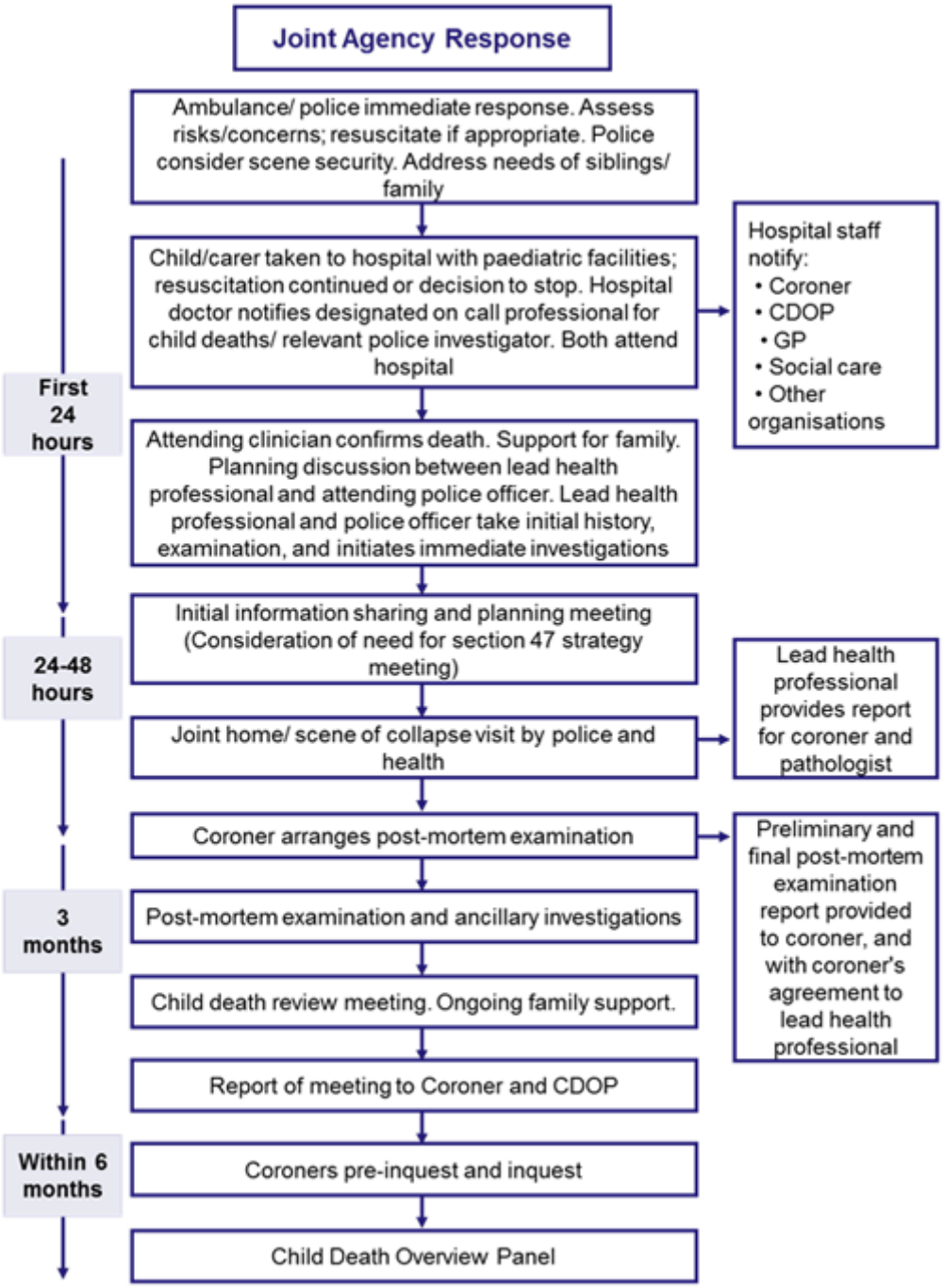
The purpose of a joint agency response to the death of a child is to:

- Understand the reasons for the child's death;
- Address the possible needs of other children in the household and of all family members;
- Identify those deaths that may be as a result of abuse or neglect and ensure an appropriate response;
- Consider any lessons to be learnt about how best to safeguard and promote the welfare of children in the future including consideration of any wider public health implications.

To support this function the joint agency response is provided by the Designated Doctor for Child Deaths or SUDIC Paediatrician (who will be an experienced consultant paediatrician) supported by a number of on call Paediatricians and Safeguarding Nurses, in conjunction with representatives from the Police and Children's Social Care.

In principle it is recognised that all information relevant to the enquiry should be shared by all agencies. The Police, however, may consider certain information *sub judice* or subject to continuing investigation and this may preclude it being released in an open forum, especially where the parents may be present. In these cases, they should ensure that the information is shared with colleagues in other agencies in an appropriate and timely manner. Any decision not to share information should be recorded by the Senior Investigating Officer (SIO) in their Police log.

The flowchart below sets out the sequence of events that should unfold in a joint agency response. Please note the sequence and timing of events may fluctuate depending on the individual circumstances presented by the child's death.



2.4 Joint Agency Response Initial Case Discussion Meeting

The SUDIC Paediatrician/Team (SUDIC admin, Key worker) will, in all cases, initiate multi-agency discussion (by telephone) within 5-7 working days, to review and update information. Planning discussions will take place between staff at an operational level in the lead agencies i.e. Health, Police (SIO) and Children's Social Care (team manager) to decide what should happen next and who will do what. The Coroner and other relevant persons or agencies, including the Fire Investigation Team if the death has been caused by fire, must also be contacted. The meeting will follow the Initial Case Discussion Meeting Agenda and will be minuted by the Health Child Death Review Team administrator.

The agreed outcome of these discussions will be recorded by the on-call Lead Health Professional on Form 3, 'Record of Interagency Discussion' (joint agency response child deaths) (Appendix- Child death forms)

This discussion will include:

- The pathologist undertaking the post-mortem;
- The Police;
- Children's Social Care;
- Consultant Paediatrician (or Consultant in Emergency Medicine) involved in the process;
- Other relevant health care professionals involved in the care of the child before death or in the period surrounding death**.**

Where the child who has died, or a child in the same household is an open case to Children's Social Care (i.e. the child is subject of a Child Protection Plan, a Child in Need Plan or and Early Help plan) the JAR Initial Case Discussion Meeting may also constitute a Strategy Meeting (see Strategy Meeting below). The chairing arrangements for this meeting will be agreed prior to the meeting. Professional judgement will need to be used when deciding the most appropriate agency to lead the Initial Case Discussion Meeting. If a child is open to Children's Social Care for support reasons e.g. Community Disability Teams providing Occupational Therapy support, then it may still be appropriate for such cases to be health led.

3 Abuse or Neglect Known or suspected to be a Factor in a Child's Death

Where there are immediate concerns that abuse or neglect has been a factor in the child's death, the case will be subject of a joint investigation involving the Police and Children's Social Care from the outset. In these circumstances Children's Social Care has the responsibility for coordinating the overall safeguarding investigation as laid out in the inter-agency procedures, and the police have responsibility for coordinating any criminal investigation. The function of the Initial Case Discussion Meeting will be incorporated into these processes which may include notifying the case to child safeguarding practice review (CSPR).

Input from Health will be sought in accordance with the MASH/MAST arrangements. The on-call Lead Health Professional should be seen as central to discussions and be invited to any meetings convened. The circumstances of these cases may meet the criteria for a Local or National Child Safeguarding Practice Review as outlined **in Working Together to Safeguard Children** chapter 4.

4 Deaths of children in specific situations

The deaths of children in certain specific situations are covered in detail in the **Child Death Review Statutory and Operational Guidance (England)**. This guidance should be referred to in the following cases:

- Deaths overseas of children normally resident in England;
- Deaths of children with learning disabilities and links to the Learning Disabilities Mortality Review (LeDeR) Programme;
- Deaths of children in adult healthcare settings e.g. adult intensive care units (ICUs);
- Deaths by suicide;
- Deaths within an Inpatient Mental Health setting;
- Deaths in custody.

5 Learning Disability Mortality Review

The LeDeR mortality review process is described on the LeDeR website (http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/).

It is expected that the child death review process will be the primary review process for children with learning disability. All deaths of children with a learning disability should be subject to structured judgement review.

When notified of the death of a child or young person aged 4-17 years who has learning disabilities, or is very likely to have learning disabilities but not yet had a formal assessment for this, the local CDR Partners should report that death to the LeDeR programme at http://www.bristol.ac.uk/sps/leder/notify-a-death/ or 0300 777 4774.

The person notifying the death to LeDeR should provide core information about the child and the relevant CDR partners. The CDR partners should then ensure that the LeDeR programme is represented at the meeting at which the death is reviewed.

As all learning disability deaths will be reviewed, we expect these reviews will highlight good practice as well as instances where care should have been improved.

The Trust will ensure that there is professional, timely, empathetic and honest communication with families of bereaved to ensure that any questions from relatives or family members are addressed in the review processes.

Postmortem
In almost all cases of an unexplained or traumatic child death the Coroner will order a postmortem examination to be carried out. The on-call Lead Health Professional should share the information collated thus far and pass copies of Forms 1,2 (ED and Home Visit Forms) and other relevant information to the Coroner. A copy of Form 1 is to remain with the body. Where a Home Office Pathologist is to conduct the postmortem, this information will be passed via the Police SIO and / or coroner's officer.

Preliminary Postmortem Results
The preliminary results of the postmortem examination (in most circumstances) should be discussed by the Pathologist and the Police SIO as soon as possible. The Coroner should be informed immediately of the initial results. This will be the responsibility of the Pathologist.

The Police should share relevant information from the postmortem with the lead professionals from Health and Children's Social Care and where appropriate arrange for a further joint agency response meeting to be convened.

The Coroner should be informed of any relevant new information coming to light as a result of these considerations. This will be the responsibility of the Police SIO.

Unusual Clinical situations
There are situations that are not clear-cut and might need consultation with the Designated Doctor for Safeguarding Children and others in the joint agency team, such as the example of an infant who is successfully resuscitated from an out-of-hospital cardiac arrest but dies subsequently or who may survive for a period of time.

In this situation, the infant might live for days or weeks before dying, for example through withdrawal of care following discussions with the family. As the initial cardiac arrest was sudden and unexpected, and the prognosis was poor, the police may secure the scene but

will not be able to do this indefinitely. Thus, such a presentation should be discussed with the Designated Doctor in order for a home visit to be undertaken, despite the infant remaining alive, as important information might be found that can assist the treating team and police. Which professionals should undertake the home visit needs to be assessed on a case by case basis following a discussion between the Lead Health Professional, Police and Children's Social Care. Further guidance in this area can be found in the section on unusual clinical situations **Sudden unexpected death in infancy and childhood Multi-agency guidelines for care and investigation (November 2016)**.

6 Child Death Review Meeting / Final Case Discussion Meeting

The child death review meeting (CDRM) is the final multi-professional meeting where all matters relating to an individual child's death are discussed by the professionals directly involved in the care of that child during life and their investigation after death. This takes place prior to the review at the CDOP.

The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved.

For example, it could take the form of:

- a final case discussion following a Joint Agency Response;
- a perinatal mortality review group meeting in the case of a baby who dies in a neonatal unit;
- a hospital-based mortality meeting following the death of a child in a paediatric intensive care unit; or similar case discussion.

The review meeting should be flexible and proportionate, and focused on local learning. It is important that all deaths are reviewed. However, in certain circumstances it may be appropriate for the review to be quite brief or for the meeting to discuss one child or several children. In every case, the Analysis Form B should be drafted at the CDRM and then sent to the relevant CDOP.

In all cases, **the aims** of the child death review meeting are:

- To review the background history, treatment, and outcomes of investigations, to determine, as far as is possible, the likely cause of death;
- To ascertain contributory and modifiable factors across domains specific to the child, the social and physical environment, and service delivery;
- To describe any learning arising from the death and, where appropriate, to identify any actions that should be taken by any of the organisations involved to improve the safety or welfare of children or the child death review process;
- To review the support provided to the family and to ensure that the family are provided with:

    - The outcomes of any investigation into their child's death.
    - A simple / relevant explanation of why their child died (accepting that sometimes this is not possible even after investigations have been undertaken) preferably in the family's first language including any learning from the review meeting.

- To ensure that CDOP and, where appropriate, the coroner are informed of the outcomes of any investigation into the child's death, and
- To review the support provided to staff involved in the care of the child.

It is usually the responsibility of the organisation where the child's death is declared to arrange the child death review meeting. Where a Joint Agency Response has occurred the designated doctor for child death (Social Care Manager where a Strategy Meeting has been held in place of an Initial Case Discussion) would be responsible for arranging this meeting.

The Child Death Review Meeting should be **chaired** by the designated doctor for child death in a joint agency response. If designated doctor for child death also had overall clinical responsibility for the child, the role of chair should be delegated to another colleague to avoid any perceived conflict of interest.

In those cases where a Strategy Meeting was held in place of a Joint Agency Response Initial Case Discussion, if it has been agreed that there are no ongoing concerns for any children in the family, the final case discussion meeting will be chaired as above. This agreement should be reached between the Lead Health Professional and the manager of the case within social care. The meeting should include the final postmortem results and up to date information from any police investigation.

The following professionals should be invited:

- Hospital or community healthcare staff involved with the child at the end of his/her life, and those known to the family prior to this event;
- Pathologist, if a hospital post-mortem examination has taken place;
- Other professional peers from relevant hospital departments and community services to ensure objective review of treatment decisions;
- Patient safety team if a serious incident investigation has taken place;
- Senior investigating police officer if there is a Joint Agency Response; and
- other practitioners for example social work, ambulance and fire services, primary care clinicians, 0-19 public health nurse, head teacher, representatives from voluntary organisations.

The meeting should take place as soon as is practically possible, ideally within three months, although serious incident investigations and the length of time it takes to receive the final post-mortem report will often cause delay. In order to best capture the views of those directly involved, it may be beneficial to start the process as soon as possible, prior to the formal CDRM. The CDRM should occur before any coroner's inquest, and before the case goes to CDOP. Further guidance in relation to the timing of the Child Death Review Meetings can be found in chapter 4 of **Child Death Review Statutory and Operational Guidance (England)**. The **CDRM** is a meeting for professionals; however, parents should be informed of the meeting by their key worker and have an opportunity to contribute information and questions through their key worker or another professional. At the conclusion of the meeting, there should be a clear description of what follow-up meetings have already occurred with the parents, and who is responsible for reporting the meeting's conclusions to the family.

The meeting should consider the following standard agenda items:

- Case presentation;
- Findings from the post-mortem examination (or from the Joint Agency Response or serious incident investigation);
- Questions raised by the family and arrangements for family follow up;
- Issues reflecting discussion;
- Lessons learnt and agreed actions;
- Conclusions regarding contributory and modifiable factors;
- Staff support.

The meeting should consider the domains contained in form C and a draft form C should be completed by SUDIC Paediatrician and provided to the Child Death Overview Panel (CDOP).

The Perinatal Mortality Review Tool
For deaths of babies in a midwifery unit, on delivery suite, and in a neonatal intensive care unit, the child death review meeting will often be known as a perinatal mortality review group meeting.

Perinatal mortality review groups should use the national PMRT, a web-based tool which supports standardised, systematic review of care in perinatal deaths.

7. The Child Death Overview Panel (CDOP)

The functions of CDOP include:

- To collect and collate information about each child death, seeking relevant information from professionals and, where appropriate, family members;
- To analyse the information obtained, including the report from the CDRM, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths;
- To make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children;
- To notify the Child Safeguarding Practice Review Panel and local Safeguarding Partners when it suspects that a child may have been abused or neglected;
- To notify the Medical Examiner (once introduced) and the doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction;
- To provide specified data to NHS Digital and then, once established, to the National Child Mortality Database;
- To produce an annual report for CDR partners on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process; and
- To contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.

CDOP should have a core representation which will include:

- Public health (chair);
- The designated doctor for child deaths; SUDIC pediatrician;
- Designated Nurse Safeguarding Children CCG
- Child Death Nurse and / or Midwife;
- Children's Social Care;
- Police;
- A health professional from community services (0-19 and Primary Care)
- Lay representation;
- Education Representative
- Safeguarding Children’s Partnership Business managers
- Child Death administrator.

Other professionals may be co-opted onto the Panel for specific individual cases or themed case reviews where they bring a particular expertise to the subject.

The CDOP review is intended to be the final, independent scrutiny of a child's death by professionals with no responsibility for the child during their life. When CDOP papers are circulated it is the responsibility of individual CDOP members to declare any conflict of interest in relation to individual cases to be reviewed.

Quoracy will require attendance of Lead Professionals from Health ,the Local Authority and public health for the area where the child normally resides. CDOP will meet with a frequency required to meet the volume of cases, and will aim to review child deaths within 6 weeks of receiving the report from the Child Death Review Meeting.

Where appropriate, CDOP administrators will liaise with counterparts from other Child Death Review areas to consider the review of non-resident children. CDOP will consider undertaking a review of a non-resident child where the majority of learning is in the Calderdale, Kirklees and Wakefield areas.

CDOP Chairs will liaise with the Designated Doctor for Child Deaths and lead nurses to identify opportunities for 'themed' meetings to collectively review child deaths from a particular cause or group of causes.

The key worker should inform the family of the CDOP meeting and its purpose. The family should be advised that they will not receive case specific feedback from this meeting.

National Child Mortality Database
The National Child Mortality Database (NCMD) is a repository of data relating to all children's deaths in England. It will enable more detailed analysis and interpretation of all data arising from the child death review process, to ensure that lessons are learned following a child's death that learning is widely shared, and that actions are taken, locally and nationally, to reduce child mortality.

The Child Death Overview Panel will submit copies of all completed forms associated with the child death review process and the analysis of information about the deaths reviewed (including but not limited to the Notification Form, the Reporting Form, Supplementary Reporting Forms and the Analysis Form) to the National Child Mortality Database.

Bereavement support

CHFT is committed to the statutory and operational guidance which stipulates all bereaved families should be given a single, named point of contact to whom they can turn for information on the child death review process, and who can signpost them to sources of support. The Key worker (Once appointed) will additionally provide local bereavement support and will signpost the bereaved to expert bereavement support.

Forget me not hospice have dedicated key worker for those families whose child has just died, suddenly and unexpectedly. Anyone can make a referral to their service with family's permission by calling 01484 411041 or completing an online referral form.

Bereaved Parents Support Organisations Network (BPSON)
Umbrella body for organisations supporting bereaved parents
www.bpson.org.uk
enquiries@bpson.org.uk

Bereaved Parent Support, Care for the Family
Peer support for bereaved parents including a telephone befriending service
www.careforthefamily.org.uk/bps

How can you help bereaved parents? BPS Handout resource
029 2081 0800

Bliss
Information and support for families of babies born premature or sick
www.bliss.org.uk
0808 801 0322
hello@bliss.org.uk

Care for the Family
Peer support for any parent whose son or daughter has died at any age, in any circumstance and at any stage in their journey of grieving.
www.cff.org.uk/bps
029 2081 0800
bps@cff.org.uk

Child Bereavement UK
Training for professionals, support for families and a directory of local support services
www.childbereavementuk.org
0800 02 888 40

Child Death Helpline
For anyone affected by the death of a child of any age from any cause.
www.childdeathhelpline.org.uk
0800 282 986 or 0808 800 6019

The Compassionate Friends
Peer support for bereaved parents and their families.
www.tcf.org.uk
0845 123 2304

The Lullaby Trust
Support for anyone affected by the sudden death of a baby or young child

Child Death Review 67
www.lullabytrust.org.uk
support@lullabytrust.org.uk
Bereavement support line: 0808 802 6868

Sands
For anyone who has been affected by the death of a baby
https://www.uk-sands.org/support
Helpline: 0808 164 3332

Survivors of Bereavement by Suicide
Support for people over 18 who have been bereaved by suicide.
https://uksobs.org/
0300 111 5065

TAMBA
Support for anyone affected by the death of a multiple
www.tamba.org.uk
0800 138 0509
support-team@tamba.org.uk

Winston's Wish
Supporting children and their families after the death of a parent or sibling.
www.winstonswish.org.uk
Tel: 08088 020 021

There are also a number of useful organisations who hold information about the many smaller, specialised and local organisations available for bereaved families. One may be able to find an organisation that focusses on a situation more specifically through one of these organisations:

The Childhood Bereavement Network
www.childhoodbereavementnetwork.org.uk

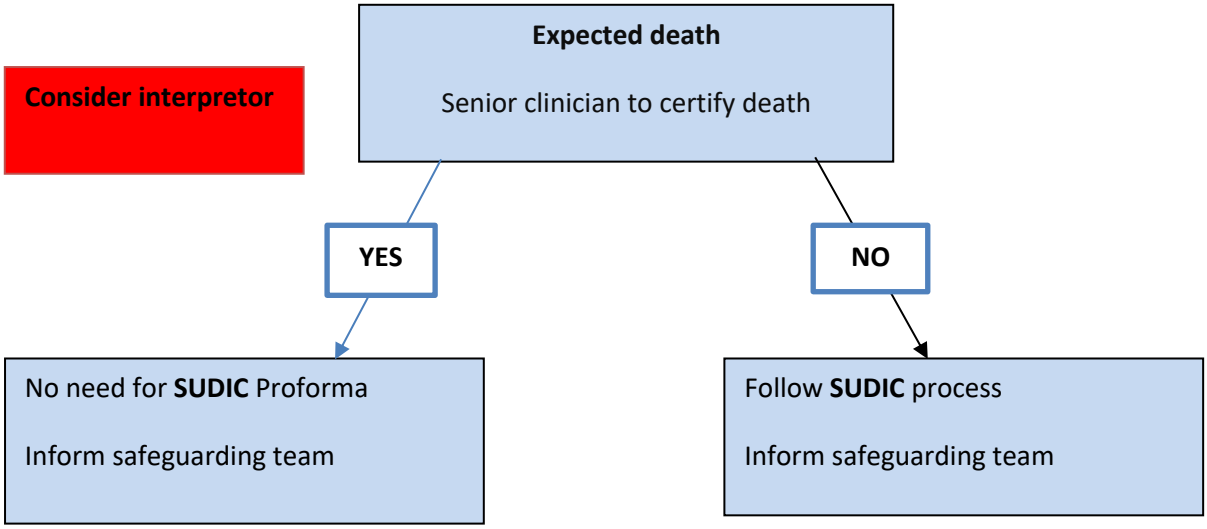
A Child of Mine
www.achildofmine.org.uk

At A Loss.org
www.ataloss.org

The Good Grief Trust
www.thegoodgrieftrust.org

Appendix 1

Guidance for the Initial Management of an Expected Death of a Child Under 18 Years



Care of family

Ask the parents/carers if they would like a family member / friend to be informed

Ask the parent/carer if they would like a religious leader to be contacted

Give the parents/ carers a copy of the Lullaby trust leaflet and provide contact details of Child death Key worker, whom they can contact for advice or to answer any future questions

Memory Box

Handprints, footprints and other mementos' may be taken if **it is clear that the death is not suspicious** in line with HM Coroner's Memorandum of Understanding.

Consent should be obtained from the family prior to any memento's being taken

Child or young person with a learning disability

The safeguarding team to refer the case to Learning Disabilities Mortality Review Programme (LeDeR)

Case record review for all child deaths

The hospital record to be reviewed by Consultant Paediatrician following Structured Judgement case note review process within 28 days

All child death to be discussed at Paediatric significant learning event and learning disseminated to medical and nursing teams

Appendix 2

Guidance for the initial management of unexpected child death under 18 years

Consider interpreter

Sudden Unexpected Death Outside Hospital

Child brought to the Emergency Department

Follow SUDIC Protocol

Initiate Resuscitation if appropriate

Nurse allocated to support parents

Senior Doctor to Certify Death

For All Children:

Check and record if the child is known to Children's Social Care. **NB -** This is not a referral

Notify CHFT Safeguarding Team

Any concerns about cause of death or potential abuse or neglect

- A formal referral must be made to Children's Social Care without delay
- Consider safety of any siblings

Senior Doctor Responsibilities:

- Inform the parents about the death and explain next steps
- Notify the Coroner – **via the on-line referral system**
- Take a detailed history from the family – **N.B.** wherever possible the interview should be conducted jointly with the attending Police Officer.
- Detailed examination of the child document physical examination findings on the relevant body map.
- Maintaining an accurate record of all specimens taken
- Document carefully.
- Ensure formal liaison with the Police in relation to the need for a joint home visit
- Gathering early information from Police, Children's Social Care, Coroner's Office and potentially others involved in the child's care such as the GP, 0-19 service.
- Collating all relevant and available information and sharing it with the Pathologist prior to the Post-Mortem.
- Notifying the CHFT Safeguarding Team - this may be the next working day if out of hours
- Offering initial follow-up to the parents including being able to see their child.
- Consultant may wish to take advice re any concern about death.
- Copy information to SUDIC Team / pathologist/ coroner / police.

The Paediatric / ED Consultant **must** liaise with the Police and Children's Social Care to determine any concerns about the death

History or examination findings suggestive of trauma / inflicted injury / neglect - STOP: Discuss with the Police who will advise re forensic examination and further action.

No suggestion of trauma / inflicted injury or neglect

Take specimens in line with HM Coroner's Memorandum of Understanding (see SUDIC Proforma for details of what is required

Paediatrician/ED Consultant

Any concerns about possible abuse or neglect – liaise directly with the Police.
Contact Coroner to inform further management
Contact Children's Social Care to ensure safety of other siblings at home

Paediatrician/ED Consultant

For all children:

Contact the coroner

Explain to parents about the potential need for postmortem and the role of the coroner

Nurse allocated to support the family

Ensure SUDIC checklist is complete.

Holding the Child

It will normally be appropriate for the family to hold and spend time with their child once death has been confirmed - this should be discussed with the Police lead investigator.
A discreet professional presence must be maintained.
Removal of IV lines and tubes from the child's body may only be done with the consent of the Coroner

Memory Box

Handprints, footprints and other mementos' may be taken if the death is not suspicious in line with HM Coroner's Memorandum of Understanding –
Consent should be obtained from the family prior to any memento's being taken

Where a Post-mortem is Required

A copy of the child's hospital notes **must** be transferred with the child to the hospital where the Post-mortem will be conducted to inform the Pathologist

Care of family

Give the parents/ carers a copy of the Lullaby trust leaflet and provide contact details of Child death Key worker, whom they can contact for advice or to answer any future questions

Appendix 3

SUDDEN UNEXPECTED DEATH IN CHILDHOOD- NEXT STEPS

Joint Visit to the Scene of the Child's Death

A decision in relation to a visit to the place where the child died should be made jointly between the Police and Paediatric / ED Consultant

Wherever possible the SUDIC Paediatrician should be in attendance along with the Police and other nominated health professionals

Where the SUDIC Paediatrician is not available, this function will be fulfilled by the On call Consultant or Consultant Paediatrician on the safeguarding clinic rota

N.B. Where a joint visit is agreed and the child died at home, the property will be secured by the Police until the visit has taken place.

The visit should therefore be conducted as soon as practicable and the child's parents offered the opportunity to be present.

The purpose of the visit is to provide information which may contribute to the identification of the cause of death

Joint Agency Response Meeting

The SUDIC paediatrician supported by the safeguarding team will facilitate an information sharing meeting (Rapid Response) with Police, Children's Social Care, GP, 0-19 service and other agency professionals involved with the family to agree any further interventions required / offer of additional support

Case Record Review for all Child Deaths

The Hospital records should be reviewed by a Consultant Paediatrician following the

Structured Judgement Review process within 28 days.

All child deaths should be discussed at the Paediatric Significant Events meetings and learning disseminated to medical and nursing teams

Appendix 4

I will attach this once the correct version has been agreed – I cannot open this link
SUDIC proforma CHFT

APPENDIX: Child death notification form
Could I please be sent a copy of this form to attach? I cannot open it

Notification of child death TEMPLATE NOV 2020.doc

Appendix 5

Information for bereaved families

The child death review: A guide for parents and carers
https://www.lullabytrust.org.uk/wp-content/uploads/lullaby-cdr-booklet.pdf

Appendix 6

Child death review: Statutory and operational guidance (England)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf

References

- Royal College of Paediatrics and Child Health (2016): Sudden unexpected death in infancy and childhood. Multi-agency guidelines for care and investigation
- HM Government (2018) Child Death Review: Statutory and Operational Guidance
- HM Government (2018) Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children
- West Yorkshire Consortium Inter Agency Safeguarding and Child Protection Procedures
- National Guidance on Learning from Deaths 2018