

**Bedford Borough Safeguarding Children Board &
Central Bedfordshire Safeguarding children Board**
Working together to safeguard children

Luton
Safeguarding
Children
Board



Bedfordshire and Luton Child Death Overview Panel Processes and Procedures

**Updated:
November 2010**

**Review:
November 2011**

CONTENTS

1. Statutory basis of Child Death arrangements	3
2. Child death overview arrangements	3
3. Data set collection	4
4. Child death overview panel meetings	5
5. Reporting arrangements	6
6. Administrative arrangements	6
7. Unexpected child death response arrangements	7
8. Framework for the response to sudden or unexpected deaths	8
9. Relationship to other procedures	8
10. Working principles	9
11. General guidance	9
12. Factors that may arouse concern	10
13. Ambulance responsibilities	12
14. GP/health visitor/community nursing staff responsibilities	13
15. Responsible paediatrician/lead paediatrician/other health care staff responsibilities	14
16. Rapid response/information sharing meeting	19
17. Lead Paediatrician on going responsibilities	23
18. Police responsibilities	24
19. Coroner and pathologist involvement	25
20. Final case discussion	26
21. Appendix 1	27
• Data collection Form A	
• Data collection Form B	
Appendix 2	
• Samples to be taken when a child dies unexpectedly	44
Appendix 3	
Child Death Review leaflet	46

INTRODUCTION

1. STATUTORY BASIS OF CHILD DEATH OVERVIEW ARRANGEMENTS

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.

1.2 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 lead to the death. This definition is adopted throughout this procedure.

1.3 Statutory guidance on the fulfilment of this requirement is contained in Chapter 7 of *Working Together to Safeguard Children (2010)* and these procedures are consistent with that guidance.

1.4 Within Bedfordshire 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 on a bi monthly basis.

2. CHILD DEATH OVERVIEW ARRANGEMENTS

Notification of deaths

2.1 The CDOP Manager will be notified of the death of any child, aged less than 18 years, normally resident in Bedfordshire or Luton or the death of any other child in, or consequent to an unexpected event in, Bedfordshire 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 to whom any death of a child in Bedfordshire or Luton, or of a child normally resident in the county, is reported
- 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 head of the PCT Child Health Records Department on receipt of notification that a child has died from the Registrar of Births and Deaths

2.2 The CDOP Manager will also accept details of a relevant child death occurring outside of Bedfordshire or Luton from another LSCB or representative of a LSCB partner agency.

Notification of a child death to the CDOP Manager should be made or confirmed in writing, by Secure Fax or by email, within 48 hours of becoming aware of the death and include the information specified in **Appendix 1**.

These procedures along with the notification form for notifying a child death to the CDOP is available for downloading on both Bedfordshire & Luton LSCBs' websites www.bedfordshirelscb.org.uk or www.lutonsafeguarding.gov.uk

2.3 On receipt of notification that a child has died the CDOP Manager will check the child death database for previous notification of the death. If not previously notified, a record on the database will be made of deaths within the remit of the Panel. Where details supplied suggest that the death is outside of the remit of the Panel, are incomplete or there is variance between any duplicate notifications of the same death the CDOP Manager will make any necessary enquiries to ensure that relevant, accurate and complete details are held.

2.4 If a child whose death is notified to the CDOP is normally resident outside of Bedfordshire or Luton the CDOP Manager will provide immediate notification of that death to the CDOP Manager/Administrator of the local LSCB either in writing/secure fax or secure email.

3. DATA SET COLLECTION (Appendix 1- data collection Forms A & B)

3.1 The CDOP Manager will arrange for the Data collection Form A to be completed, this form can be downloaded from the websites above. In most cases this will be the health professional with overall responsibility for the care of the child at the time of their death but occasionally it might be the Police where a crime has been committed.

3.2 For unexpected child deaths occurring in Bedfordshire or Luton, or consequent to an event in the county, completion of the form is part of the CDOP unexpected child death response procedure and only verification with the Lead Paediatrician that the response arrangements have been initiated is required.

3.3 For some children, particularly those normally resident or who have died consequent to an incident outside of Bedfordshire or Luton, another CDOP will also be collecting information on the death. In these cases the CDOP Manager should liaise with the CDOP Administrator/Manager for the other CDOP regarding collection of the data set to avoid duplication of requests to professionals. A reciprocal arrangement for the sharing of information obtained following such liaison should be agreed.

3.4 In normal circumstances, where the death is not sudden or unexpected, the professional requested to provide the data set information should do so **within 14 days** of the death. If all information is not available within that time frame, the missing data should be flagged on the Core Data Collection form and arrangements made for this to be provided to the CDOP Manager when available.

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

3.6 On receipt of a completed Core Data Collection form the CDOP Manager will add the information provided to the record of the death on the CDOP database.

4. CHILD DEATH OVERVIEW PANEL MEETINGS

4.1 The Panel will meet bi monthly. 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.

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

In agreement with the Lead Paediatrician and where there is a complete data set of information on a child's death, the CDOP Manager will, at least 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 e-mail or posted using recorded delivery.

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

4.4 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.

4.5 The panel will also consider:

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

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

5. REPORTING ARRANGEMENTS

5.1 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.

5.2 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.

5.3 An annual report from the Panel will be provided to both 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.

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

6. ADMINISTRATIVE ARRANGEMENTS

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

6.2 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.

7. UNEXPECTED CHID DEATH RESPONSE ARRANGEMENTS

Introduction

7.1 The following procedures detail 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.

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

7.2 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).

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

7.3 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.

7.4 These procedures are primarily applicable to deaths occurring in Bedfordshire or Luton but will also be applied to deaths occurring elsewhere consequent to a sudden unexpected event in Bedfordshire or Luton. It will, however, normally be most appropriate for the CDOP child death arrangements where the death occurred to provide the initial response.

7.5 Similarly, it will normally be appropriate for the initial response to a death occurring in Bedfordshire or Luton consequent to a sudden unexpected event 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.

7.6 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.

8. FRAMEWORK FOR THE RESPONSE TO A SUDDEN OR UNEXPECTED CHILD DEATH

8.1 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.

8.2 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.

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.

8.3 The key events described in these procedures are:

Transfer of the child to an Accident and Emergency Department unless the child is found dead for quite some time (e.g. days) so that need for resuscitation is clearly out of question. In latter case transfer the child's body to the mortuary.

- Initial response and early investigation
- Early inter-agency information sharing and planning
- Hospital procedures
- Lead Consultant Paediatrician/ Police home visit
- Liaison with HM Coroner and Post Mortem examination arrangements
- Multi-agency review and planning arrangements

9. RELATIONSHIP TO OTHER PROCEDURES

9.1 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
- Criminal investigations
- Serious Case Reviews
- Child Protection (Section 47) investigations
- Health and Safety Executive Investigations
- Health Service Serious Untoward 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 (see above in procedures)
- Prison Service investigations
- Independent Police Complaints Commission investigations

9.2 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.

10. WORKING PRINCIPLES

10.1 The following principles should be adhered to by professionals from all agencies:

- Ensuring that bereaved families are treated with sensitivity and respect, offered appropriate support and kept fully informed
- Adopting an open minded, proportionate and professional approach to the circumstances

- Effectively working together and sharing information within a multi-agency response
- Ensuring that evidence is preserved and that the death is thoroughly investigated
- Providing a prompt response and ensuring that the investigation is completed expeditiously

11. GENERAL GUIDANCE

11.1 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.

It is the right of every child to have their death properly investigated. Families also desperately 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.

11.2 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.

11.3 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.

11.4 Unless there are clear and compelling reasons to the contrary, it is inherent in these procedures that all children who die suddenly or unexpectedly in the community are transferred to a hospital Accident and Emergency Department unless they are discovered dead for hours or days, in which case they can be taken to a hospital mortuary and attended by Paediatrician On Call there. This is regardless of whether the chances of successful resuscitation are thought to be negligible, and specifically so that the response to the death may be effectively managed in accordance with these procedures.

11.5 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.

11.6 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.

11.7 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.

11.8 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.

12. FACTORS THAT MAY AROUSE CONCERN

12.1 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.

12.2 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 cot 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

13. AMBULANCE STAFF RESPONSIBILITIES

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

13.1 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 possible.

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

The 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.

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

13.3 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 present a clear and compelling reason for the body to remain at the scene for forensic examination.

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

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

13.6 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.

13.7 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.

13.8 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.

13.9 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.

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

13.11 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.

13.12 A representative of the Ambulance Service will always be invited to the rapid response/information sharing meeting and will be a member of the CDOP panel

14. GENERAL PRACTITIONERS / HEALTH VISITORS / COMMUNITY NURSING STAFF RESPONSIBILITIES

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

14.1 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.

14.2 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.

14.3 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.

14.4 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.

14.5 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.

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

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

15. RESPONSIBLE PAEDIATRICIAN / LEAD PAEDIATRICIAN/ OTHER HEALTHCARE STAFF RESPONSIBILITIES

15.1 This section deals with the roles of health professionals. 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 '**Lead Paediatrician**' with wider remit, who would be a Community Paediatrician will take over and will

remain connected with the process.

Introduction

15.2 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.

15.3 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

15.4 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 who 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.

15.5 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

Initial Response

15.6 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.

15.7 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.

15.8 The child should immediately be assessed and unless it is clear that the baby 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.

15.9 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 until this is taken over by the Lead Paediatrician.

15.10 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. A Child Abuse Investigating Unit Supervisor will attend in response and will liaise with the Responsible Paediatrician.

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

15.12 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.

15.13 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.

15.14 The Responsible Paediatrician will contact the Lead Paediatrician and agree an appropriate point for that doctor to assume responsibility for management of the case. The Police Investigating Officer will be informed of this transition.

History taking from the child's family

15.15 Initial history would be taken by the Responsible Paediatrician at the time of presentation at the hospital. Subsequently, the Lead Paediatrician should take history in a way to fill in the gaps. 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.

15.16 The history will be taken in conjunction with the police

15.17 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.

15.18 Appendix 3 is provided as a guide to areas which should be covered in the history taking. It cannot be regarded as comprehensive, as additional specific questions may arise as a consequence of information provided by the family. Some parts of the checklist are applicable to all children who have died. Others will be relevant only for children under the age of 2 and older children where there is no readily identifiable external cause of death or the child had a chronic medical condition or disability.

15.19 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.

15.20 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. 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.

Examination of the child's body

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

15.22 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.

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

15.24 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.

15.25 Full growth measurements (length, weight and head circumference) should be taken and plotted on centile charts. The child's general appearance,

cleanliness and descriptions of any blood or secretions around nose or on clothes should also be noted.

15.26 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.

15.27 Any 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.

Obtaining samples

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

15.29 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 2**

15.30 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.

15.31 The radiology must be a full skeletal survey not a 'babygram'. 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.

Care of the child's family

15.32 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.

15.33 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.

15.34 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.

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.

15.35 The family should be informed that the death must be notified to HM Coroner and that formal identification of the child's body to the Police and a post mortem examination will be required. It should be sensitively explained to the family what this involves and that tissue samples will be taken for examination under the microscope. They should be told where this will be done and that if it is to be at a specialist centre, that the child will normally be returned to the hospital afterwards. They will usually be able to spend time with their baby after the post mortem examination.

15.36 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.

15.37 The Care of Next Infant (CONI) scheme operates to support families with children born following a cot death. The programme offers a flexible approach with supportive measures including weekly health visitor home visits, apnoea monitors, weighing scales/charts and symptom diaries. If there are other young children in the family and especially if the dead child is from a multiple birth, urgent institution of the CONI scheme should be considered.

15.38 If the child is a twin the other twin should be assessed immediately and admitted for a period of observation and investigation. It must be emphasised to the family that the admission of the surviving twin is because of the possibility of a natural medical condition. If the family decline the offer of admission, this should prompt an urgent reconsideration of the family's needs and the health needs of the surviving twin.

15.39 The family should be given a copy of the Foundation for the Study of Infant Deaths (FSID) booklet "When a baby dies suddenly and unexpectedly", the Department of Health leaflet "Guide to the post-mortem examination: brief notes for parents and families who have lost a baby in pregnancy or early infancy", and the FSID helpline number. An offer should be made to inform the (FSID) who provide counselling for affected families and professionals. Any health staff involved in an unexpected child death can also contact the FSID.

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

15.41 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.

15.42 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.

15.43 In Luton there is a Lead Nurse for Child Death reviews. She will work with the Lead paediatrician for child deaths in Luton to support the bereaved families, undertake home visits as required and ensure families are aware of the child death review process.

15.44 The DCSF leaflet entitled 'The Child Death Review' will be given to bereaved families by a professional known to the family when deemed most appropriate. <http://www.dcsf.gov.uk/everychildmatters/download/?id=8282>

16. RAPID RESPONSE/ INFORMATION SHARING MEETING

16.1 The Lead Paediatrician, Responsible Paediatrician and the Police Investigating Officer will liaise as early as feasible to ensure following arrangements are made. Any other professional/agencies who knew the child or family will also be invited to attend. This should also include where possible the ambulance crew transferring the child to the hospital

In the mean time any medical issue can be clarified with the Responsible Paediatrician by the Police or by other professionals if needed.

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

- Share all currently available information on the death
- Plan the urgent review of all records held at the hospital
- Agree responsibility for notifying other agencies and professionals of the death and obtaining relevant information from their records
- Plan initial actions to be undertaken jointly by health and Police professionals including:
- Maintain the chain of evidence
 - Obtaining a full history from the family
 - 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
- Agree arrangements for liaison with the pathologist
- Identify and coordinate any other actions required by the agencies own policies and protocols
- Agree the point at which responsibility for multi-agency management of

the case will be handed over to the Lead paediatrician, unless the case is being dealt as a suspicious death.

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

16.4 If any safeguarding concerns arise from the circumstances of the death the appropriate Social Care professional should be requested to attend the hospital and a formal Strategy Meeting should be held under LSCBs Safeguarding Procedures

16.5 If there are indications that the death is suspicious and an immediate forensic post mortem examination is 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.

16.6 At the conclusion of their actions at the hospital the Responsible and 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.

Agency notification and information gathering

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

16.8 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:

- Designated and Named Health Professionals for Safeguarding Children are informed (who will notify, obtain information from and facilitate liaison with the GP, Health Visitor and School Nurse)
- 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)

16.9 Where the child is normally resident outside of Bedfordshire or Luton the corresponding professionals in the home area should be notified and asked to check their records in addition to the Bedfordshire and Luton professionals.

16.10 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 Lead Paediatrician and may be requested by the Police.

16.11 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.

Home Visit

16.12 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 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 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.

16.13 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.

16.14 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.

16.15 If it is not possible for the Lead Paediatrician to undertake the visit at this stage, the Police or the Responsible Paediatrician will fully brief the Lead Paediatrician as soon as possible afterward who will then arrange to visit when feasible.

16.16 If a joint visit is impossible within this time frame, separate visits should occur. If separate visits are arranged, then the Lead Paediatrician and the Police Investigating Officer should confer soon afterwards to share their findings and discuss their interpretation.

16.17 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.

16.18 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

16.19 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.

16.20 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.

16.21 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.

16.22 The preliminary home visit should essentially just involve the Lead Paediatrician (in some instances nominated senior nurse) and Child Abuse Investigating Supervisor. They will consider if it would be appropriate at that time to invite the Coroner's Officer to either the preliminary visit, or at a subsequent home visit. If the Coroner's Officer attends he/she should explain direct to the parents the post mortem procedure, how they will be informed of the preliminary results, and answer any questions they may have.

16.23 Time will also be needed for the paediatrician to help the parents deal with the very powerful emotions that are commonly brought out by this discussion.

17. LEAD PAEDIATRICIAN RESPONSIBILITIES

17.1 The Lead Paediatrician for Child Deaths will be notified by 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.

17.2 The Lead Paediatrician will thereafter have responsibility for ensuring a coordinated health service response to the death is in accordance with these procedures and should agree with the Responsible Paediatrician the point at which he/she will take over that role the operational management of the response. In most circumstances this will be when the initial response at the hospital is completed.

17.3 The 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 lead Paediatrician will liaise with the Police

Investigating Officer to coordinate a subsequent response which complies with these procedures as closely as possible.

17.4 The 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. If the Lead Paediatrician does not undertake the visit he/she should ensure that they are fully briefed by the health professional concerned as soon as possible afterwards.

17.5 The 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 Lead Paediatrician should, in conjunction with the Police Investigating Officer, arrange for these to be completed. .

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

17.7 The Lead (or Responsible) Paediatrician should provide the Pathologist with all medical records relating to the child and details of any x-rays and tests carried out. The original x-ray films, test results and any unexamined samples should also be provided to the Pathologist. These should be transferred in such a way that their evidential integrity is maintained.

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

17.9 The 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.

17.10 Inadequate briefing may result in failure to carry out the tests that might lead to the identification of a cause of death.

17.11 The Lead or Responsible Paediatrician may attend the post mortem examination. Where this does not occur there must be adequate discussion between the Lead & Responsible Paediatrician and the Pathologist both before and after the post mortem examination.

17.12 The interim findings of the post mortem examination should be provided in

writing by the pathologist to HM Coroner, the Police Investigating Officer and the Lead Paediatrician immediately after the post mortem examination is completed.

17.13 The final report on the post mortem examination should be similarly provided to HM Coroner, the Police Investigating Officer and the Lead Paediatrician.

18. POLICE RESPONSIBILITIES

18.1 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.

18.2 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

18.3 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).

18.4 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.

18.5 If there are indications that the death is suspicious and an immediate forensic post mortem examination is 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. This may also affect the manner in which the history is obtained and the briefing of the Pathologist by the Responsible Paediatrician.

19. CORONER & PATHOLOGIST INVOLVEMENT

19.1 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

19.2 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

19.3 The Police Investigating Officer should 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

20. FINAL CASE DISCUSSION

20.1 A multi-agency Final Case Discussion will be convened by the Lead Paediatrician as soon as possible after the final post mortem result is available (the timing will vary according to circumstances, from immediately after the initial post mortem results to three to four months after the death)

Whenever possible, the meeting should be held at the family GP's surgery.

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

20.2 The meeting should be chaired by the 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.

20.3 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

Equally consideration should be given as to whether there are any unaddressed child protection risks to 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

20.4 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 lead paediatrician involved in the investigation of the child's death and he/she will have the responsibility for initiating this meeting. A member of the primary health care team should usually attend this meeting.

20.5 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.

20.6 An agreed record of the case discussion meeting and all reports should be sent to the Coroner to take into consideration in the conduct of the inquest and in the cause of death notified to Registrar of Births and Deaths. The record of the case discussions and the core data set should be made available to the Child Death Overview Panel

Appendix 1

Form A - Notification of Child Death

Notification to be reported to CDOP Manager at: Bedfordshire-cdopmanager@nhs.net

Tel: 01234 292955

Elstow Medical Centre

Abbeyfields

Elstow

Beds MK42 9GP

Fax: 01234 292956

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?	<input type="checkbox"/>	Expected	<input type="checkbox"/> 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**

Agency Report Form B

This form to be returned to CDOP Manager at: Bedfordshire-cdopmanager @nhs.net

Address: Elstow Medical Centre

Abbeyfields, Elstow

Beds MK42 9GP

Fax: 01234 292956

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 7 of Working Together. 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?	<input type="checkbox"/> Planned palliative care <input type="checkbox"/> Withholding, withdrawal or limitation of life-sustaining treatment <input type="checkbox"/> Brainstem death <input type="checkbox"/> Failed Cardiopulmonary resuscitation <input type="checkbox"/> Witnessed event <input type="checkbox"/> Found dead <input type="checkbox"/> Not known
Has a medical certificate of the cause of death been issued?	Yes / No / Not Known <i>Please circle as appropriate</i>
Was this death referred to the coroner?	Yes / No / Not Applicable / Not Known <i>Please circle as appropriate</i>
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

	<p>(d) other maternal diseases or conditions affecting infant</p> <p>(e) other relevant conditions</p>
--	--

All – please complete

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

Where was the child when the death was confirmed?	<input type="checkbox"/>	Acute Hospital	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Emergency Department Paediatric Ward Neonatal Unit Paediatric Intensive Care Unit Adult Intensive Care Unit
---	--------------------------	----------------	--	---

			<input type="checkbox"/>	Other
	<input type="checkbox"/>	Home of normal residence		
	<input type="checkbox"/>	Other private residence		
	<input type="checkbox"/>	Foster Home		
	<input type="checkbox"/>	Residential Care		
	<input type="checkbox"/>	Public place		
	<input type="checkbox"/>	School		
	<input type="checkbox"/>	Hospice		
	<input type="checkbox"/>	Mental health inpatient unit		
	<input type="checkbox"/>	Abroad		
	<input type="checkbox"/>	Other (specify)		
	<input type="checkbox"/>	Not known		

Were any of the following events known to have occurred?		
<input type="checkbox"/>	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.
<input type="checkbox"/>	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
<input type="checkbox"/>	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
<input type="checkbox"/>	Road traffic accident/collision	Complete B5
<input type="checkbox"/>	Drowning	Complete B6
<input type="checkbox"/>	Fire/burns	Complete B7
<input type="checkbox"/>	Poisoning	Complete B8
<input type="checkbox"/>	Other non-intentional injury/accidents/trauma	Complete B9
<input type="checkbox"/>	Substance misuse	Complete B10
<input type="checkbox"/>	Apparent homicide	Complete B11
<input type="checkbox"/>	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? If yes, please provide details below		Yes / No / Not known	
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	<input type="checkbox"/>	Not yet in education	
	<input type="checkbox"/>	Nursery	
	<input type="checkbox"/>	School	
	<input type="checkbox"/>	College	
	<input type="checkbox"/>	Not in education	
	<input type="checkbox"/>	Left education	<input type="checkbox"/> Employed
			<input type="checkbox"/> Unemployed
If employed, please provide occupation			
Ethnic group	<input type="checkbox"/>	White	<input type="checkbox"/> English/Welsh/Scottish/Northern Irish/British <input type="checkbox"/> Irish <input type="checkbox"/> Gypsy or Irish Traveller <input type="checkbox"/> Any other White background (please specify)
	<input type="checkbox"/>	Mixed/multiple ethnic groups	<input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian <input type="checkbox"/> Any other mixed/multiple ethnic

			background (please specify)
	<input type="checkbox"/>	Asian or Asian British	<input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Chinese <input type="checkbox"/> Any other Asian background (please specify)
	<input type="checkbox"/>	Black/ African/ Caribbean/ Black British	<input type="checkbox"/> African <input type="checkbox"/> Caribbean <input type="checkbox"/> Any other Black/African/Caribbean background (please specify)
	<input type="checkbox"/>	Other ethnic group	<input type="checkbox"/> Arab <input type="checkbox"/> Any other ethnic group (please specify)
	<input type="checkbox"/>	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

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.

Any known domestic violence in the household? (please provide details below)
 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?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	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)	<input type="checkbox"/> <input type="checkbox"/>	Mother Father
	<input type="checkbox"/>	Other adults (please list and give adults relationships to the child)
	<input type="checkbox"/>	Child/young person (please list and give age and relationships to the child)
	<input type="checkbox"/> <input type="checkbox"/>	Health care staff Others (please list below)

Was the child subject to a child protection plan?	<input type="checkbox"/> At the time of death <input type="checkbox"/> Previously <input type="checkbox"/> Not at all
---	---

Category of most recent child protection plan:	<input type="checkbox"/> Physical abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Emotional abuse <input type="checkbox"/> Sexual abuse <input type="checkbox"/> Not known
Was the child subject to any statutory orders?	<input type="checkbox"/> At the time of death <input type="checkbox"/> Previously <input type="checkbox"/> Not at all
Category of most recent statutory order:	<input type="checkbox"/> Police Powers of Protection <input type="checkbox"/> Emergency Protection Order <input type="checkbox"/> Interim Care Order <input type="checkbox"/> Care Order <input type="checkbox"/> Supervision Order <input type="checkbox"/> Residence Order <input type="checkbox"/> Section 20 (Children Act 1989) <input type="checkbox"/> Antisocial behaviour order <input type="checkbox"/> Other court order, please specify:
Had the child been assessed as a child in need under section 17 of the Children Act 1989?	<input type="checkbox"/> At the time of death <input type="checkbox"/> Previously <input type="checkbox"/> Not at all
Were any siblings subject to a child protection plan?	<input type="checkbox"/> At the time of death <input type="checkbox"/> Previously <input type="checkbox"/> Not at all
Were any siblings subject to any statutory orders?	<input type="checkbox"/> At the time of death <input type="checkbox"/> Previously <input type="checkbox"/> 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 <input type="checkbox"/> No known contact from this agency <input type="checkbox"/> 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		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.

		arrangements for FORENSIC processing of the sample. PACE (Police Criminal Evidence Act)		
Guthrie card	Biochemistry	Standard operating procedures	Carnitine profile	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.

