



## Form B - Agency Report Form

This form to be returned to CDOP Manager at: Email:

Address:

Fax:

**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 or tick NK (Not Known) or NA (Not Applicable) or leave the item blank. It is preferable to circle or tick 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	<input type="checkbox"/>	
	Female	<input type="checkbox"/>	
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
Expected	<input type="checkbox"/>
Unexpected	<input type="checkbox"/>
Has a medical certificate of the cause of death been issued?	Yes / No / Not Known <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Was this death referred to the coroner?	Yes / No / Not Applicable / Not Known <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Was a post-mortem examination carried out?	Yes / No / Not Applicable / Not Known <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>  Date of PM if known     /     /  Place of PM if known
Has an inquest been held?	Yes / No / Not Applicable / Not Yet/ Not Known <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>  Date of Inquest if known     /     /
Registered cause of death if known (for children over 28 days)	<b>Ia</b>  <b>Ib</b>

	<p><b>Ic</b></p> <p><b>II</b></p>
Registered cause of death if known (for neonatal deaths)	<p>(a) main diseases or conditions in infant</p> <p>(b) other diseases or conditions in infant</p> <p>(c) main maternal diseases or conditions affecting infant</p> <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="text"/>
	<input type="checkbox"/>	Not known

Where was the child when the death was confirmed?	<input type="checkbox"/>	Acute Hospital	<input type="checkbox"/>	Emergency Department
			<input type="checkbox"/>	Paediatric Ward
			<input type="checkbox"/>	Neonatal Unit
			<input type="checkbox"/>	Paediatric Intensive Care Unit
			<input type="checkbox"/>	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="text"/>		
	<input type="checkbox"/>	Not known		

<b>Were any of the following events known to have occurred?</b>		
<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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Was the child fully immunised?		Yes / No / Not known <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>  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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Any medication at the time of death? If yes, please provide details below		Yes / No / Not known <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
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 or tick your responses

	Age/DoB	Gender	Relationship to child and/or family	Occupation	Living in primary household? <sup>1</sup>
Mother		F	Mother		Y / N / NK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Father		M	Father		Y / N / NK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2					Y / N / NK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3					Y / N / NK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4					Y / N / NK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Siblings (Please number and complete any information known; further siblings can be added below, please include step and half siblings)					
1					Y / N / NK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2					Y / N / NK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3					Y / N / NK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4					Y / N / NK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
6					Y / N / NK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
7					Y / N / NK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Was the child/family an asylum seeker

Yes / No / Not known

<sup>1</sup> 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.

**Further family information**

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

**Please circle or tick your responses**

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

Are mother and father related to each other (excluding marriage)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Please provide details.
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Any known domestic violence in the household? (please provide details below) Yes / No / Not known
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<p><b>Factors in the family and environment:</b> Please provide a description of any relevant factors known to you that have not been covered elsewhere. <b>Consider:</b> family structure and functioning; wider family relationships; housing; employment and income; social integration and support; community resources. Include strengths and difficulties</p>
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## 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 or tick your responses

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

<p>If no professionals involved at the time of death, what was the last known contact of a professional from your agency?</p>	<p>Professional Date of last known contact    /    / Nature of contact <input type="checkbox"/> No known contact from this agency <input type="checkbox"/> Not known</p>
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<sup>2</sup> 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.

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

**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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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Any other internal agency investigation (please specify)

Is this child death the subject of a serious case review	Y / N / NK /NA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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**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