



Medway Safeguarding Children Board

Responding to the unexpected death of a
child

Procedure and practice guidance

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Procedures for responding to unexpected child deaths in Medway

This document is based on Chapter 7 Working together to Safeguard Children 2010 and should be used by professionals in conjunction with the relevant policies, procedures and protocols from their own agencies.

This guidance applies to the death of a child less than 18 years old, whether from natural, unnatural, known or unknown causes, at home, in hospital or in the community.

General Guidance

1. Definition of unexpected death

- 1.1 An unexpected death is defined as the death of an infant or child which:
- was not anticipated as a significant possibility for example 24 hours before the death; or
 - where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.¹

(The second part of this definition is especially relevant when there is a significant time delay between the collapse of the child and their eventual death).

- 1.2 Unexpected deaths include those of children with existing medical conditions or disabilities (including those that are life limiting or life threatening) whose death *at the time that it occurred* was not expected as a natural consequence of that condition.
- 1.3 An interagency rapid response will be undertaken in each case of an unexpected death.
- 1.4 There are two designated doctors for child death, dealing with neonatal and paediatric deaths separately, who should be consulted where professionals are uncertain about whether a death is unexpected. If there is any doubt as to whether the death is expected or unexpected, the processes for an unexpected child death (notification to CDR Coordinator and initiation of the rapid response process) should be followed until the available evidence enables a different decision to be made.² The designated doctor should then make a decision on whether or not a rapid response is required based on their professional judgement and the information available to them at the time.

¹ Working Together 7.21

² Working Together 7.22

- 1.5 Deaths of children that do not fall within the definition of an unexpected death – either where this is clear from the outset or where this is the judgement call of the Designated Paediatrician for Unexpected Child Deaths following referral to them – must be notified by the professional declaring the death direct to the CDR Coordinator.
- 1.6 On receipt of a notification of an expected death the CDR Coordinator will forward a copy of the notification form to agreed agency contacts. These contacts will be requested to provide any additional and relevant information held by the agency on the child and their death within a set timescale. The CDR Coordinator is responsible for compiling a composite version of the notification and any other information received for review at the child death overview panel.

2. Social Care Assessment and Serious Case Review

- 2.1 If at any stage in the process information arises that suggests concerns about surviving children in the household discussions should take place with Medway's Children's Social Care³ who may decide that it is appropriate to undertake an initial or core assessment or instigate child protection enquiries as detailed in chapter 5 of Working Together.
- 2.2 This process can run alongside the rapid response and child death review process but should be notified to the rapid response team and the CDR Coordinator as the outcomes may inform the review process. If social care (or the Out of hours service) become involved in the case they must be a core participant in the rapid response to the death.
- 2.3 If the information suggests that there might be grounds for a serious case review (SCR) as detailed in Chapter 8 of Working Together the relevant processes should be initiated. The designated doctors will take responsibility to notify the Medway Foundation Trust safety manager as appropriate.
- 2.4 In the circumstances of an SCR the usual child death review process will cease and the SCR process will commence. The CDOP panel will be informed of any decision to undertake an SCR and kept up to date on progress. The panel will not be able to conclude the child death reviewing process until after the SCR Executive summary has been published. However the CDOP panel will need to be satisfied that the lessons that have been highlighted in the SCR are being learned from and being acted upon in a timely manner. The MSCB Quality Assurance and Case Review Subgroup will do this through the monitoring of the SCR action plans.

³ Working Together 7.55

3. Suspicious Deaths and Criminal Proceedings

- 3.1 If any evidence arises during the course of a review that indicates that a crime may have taken place the Police should be alerted as soon as possible. In the event that a death is identified as suspicious and a criminal investigation is launched the Senior Investigating Officer and the Crown Prosecution Service must be consulted as to what is appropriate for the professionals involved in reviewing a child's death to be doing, and what actions to take in order not to prejudice any criminal proceedings⁴.
- 3.2 For these deaths the Police are the lead-investigating agency, however Medway Children's Social Care will be the lead agency for s.47 investigation if there are other children remaining in the household or who visit regularly.

4. Inquests

- 4.1 The child death review process does not replace the Coronial process and inquests will still be held where necessary. The results of the child death review should inform any inquest that occurs. Interim and final reports on the death will be collated by the designated doctors for the MSCB.

5. Death of a child not normally resident in Medway

- 5.1 On receipt of a death notification for a child not normally resident in Medway the MSCB CDR Coordinator will contact their counterpart for the area where the child is normally resident and an agreement should be reached on the on-going responsibility for the review of the case.
- 5.2 Where a child is known to or has had contact with agencies in more than one LSCB area the LSCB for the area where the child was normally resident should take lead responsibility for conducting the child death review.
- 5.3 For deaths resulting from long term illnesses and occurring during a temporary stay in the Medway area it is expected that the child's home Board will lead the review

6. Death of a child usually resident in Medway occurring elsewhere

- 6.1 An area's CDR Coordinator/Administrator will contact Medway's CDR Coordinator if a child normally resident in Medway dies in their area. This notification will then be sent to those involved with the child, or if this is unknown to the designated doctors for child deaths, other leads in Health, Medway Children's Social Care and the Police. In these

⁴ Working Together 7.51

situations Medway will lead on gathering necessary information but rely on the informing LSCB for cooperation in contacting their local services for additional information.

- 6.2 For unexpected deaths due to accidents or incidents happening elsewhere it is expected that the Board for the area where the incident causing the death occurred will take the lead.
- 6.3 In some circumstances reviews can be undertaken in parallel by two (or more) Boards. In such a case any feed back of the results of the reviews to the parents should be carefully coordinated.

7. Data Collection

- 7.1 A Notification of Child Death form (form A) must be completed for every death. This form is based on a national template and is held (and stored securely) by the MSCB CDR Coordinator and owned by the MSCB.
- 7.2 It is the operational responsibility of the CDR Coordinator to compile a composite form A on each death. The designated doctor is strategically responsible for overseeing the rapid response to each death including the completion of the form A and B. The Coordinator will refer problems experienced in completing the form, not resolved through their own, enquiries to the designated doctor.
- 7.3 On receipt of a verbal notification of an expected death the CDR Coordinator will await the form A to be completed and forward copies to agreed agency contacts, however this will not prevent the Coordinator making verbal notifications as required.
- 7.4 If additional information is required from agencies, that can not be gathered using Form A, they will be asked to complete the Form B with any other relevant information. Once received this information will be compiled into a composite Form B by the CDR coordinator and will be forwarded to the child death overview panel for review.
- 7.3 Copies of completed forms will be stored securely on the Medway Council internal server, which, the CDR Coordinator/MSCB Development Officer, MSCB Manager and the MSCB administrator have access to. Information from the datasets will also be transferred to a child death database, owned by the MSCB and managed by the MSCB CDR coordinator. The data protection and information security policies of the host agency for the Administrator will be applied to the management of information held.

8. Media

- 8.1 The initial/rapid response team should agree a media strategy on a case-by-case basis.
- 8.2 Any enquiries made to individual agencies concerning the rapid response and the child death review process in individual case should refer journalists to their agencies' press office.
- 8.3 Medway Council's press office manages the MSCB's relationship with the media. If there are any media enquiries regarding the functions of CDOP to the MSCB they will inform the press office who will deal with the enquiry. Contact details for the press office can be found on <http://www.medway.gov.uk/councilanddemocracy/communications/mediacentre.aspx>

9. Care of Parents and Carers

- 9.1 The death of a child is an extremely traumatic time for the family and the action of professionals can greatly influence their experience of the bereavement. In applying this process professionals should treat families with sensitivity, discretion and respect at all times, and professionals should approach their enquiries with an open mind⁵. Care should also be taken to ensure families receive appropriate bereavement support.
- 9.2 Appropriate single and multi-agency training should be accessed by staff dealing regularly with the child death review process, bereaved families and who have key responsibilities in implementing support for the family.
- 9.3 Staff that deal regularly with child death and supporting families and parents should have access to support arrangements within their agency e.g. supervision. They should also be debriefed after each death.

Responding to an unexpected death and notification processes

10. Immediate response to a death in the community

- 10.1 The ambulance crew will usually be the first at the scene. They should not assume death but should start resuscitation and take the child to the nearest A&E department.

⁵ Working Together 7.5

- 10.2 If the child has clearly been dead for some time it may be inappropriate to start resuscitation and the ambulance crew should consider this carefully.
- 10.3 If the body can be removed from the scene the child should be taken to the nearest A&E department. The child should be transported to A&E along with representatives of the child's family unless the family make their own arrangements to reach the hospital.
- 10.4 There may be some situations where it is inappropriate for a children to be transferred to the hospital; including where a child has obviously been dead for some time when found and it has been agreed with the police that the child remain in situ until the scene has been examined. Also where the circumstances of the death e.g. when the death is suspicious or there are obvious signs of neglect/assault mean the body must remain at the scene for forensic examination; or there is significant trauma to the body as a result of fire or other major incident.
- 10.5 On receipt of a call regarding an unexpected child death the Ambulance Control Centre should contact the Police to inform them (this will also allow the rapid response procedure to be initiated). The Police should attend and secure the scene to preserve it in case of forensic capture. The Senior Investigating Officer will visit at a later time, usually within hours, as their first action will be to visit wherever the deceased is and to link with the family and health.
- 10.6 The ambulance crew (or other professionals) should provide history and information about the scene to A&E staff and police. All efforts should be made to preserve the scene of the death.
- 10.7 The lead responsibilities within the Police for the investigation into the death of a child will be undertaken by:
 - A Senior Investigating Officer (SIO) from the Major Crime Department; If at the outset or subsequently there are indications that the death of a child raises suspicion of homicide.
 - A SIO from the Serious Collision Investigation Unit (SCIU); If the death results from a Road Traffic Collision.
 - Out of hours; In all other cases a SIO of Detective Inspector rank who will subsequently handover the investigation to the Public Protection Unit (PPU) Detective Inspector, if they are not already in attendance.

11. Immediate response in the A&E department

- 11.1 A&E staff and the senior paediatric doctor will assess the child and make the decision to stop resuscitation.

- 11.2 An experienced A&E nurse should be assigned to support the family/carers until they have left the hospital.
- 11.3 A&E staff should inform police, when not already notified by the Ambulance service, and children's social care/out of hours to determine relevant information on the child and family.
- 11.4 A senior paediatric doctor should examine the child, in the presence of the police, and document a detailed history of events leading up to and following the child's collapse (see paediatric guideline).
- 11.5 Engaging with the family by hospital staff should not be delayed to wait for other agencies e.g. the police, the family can be kept informed of what is happening and why; as appropriate.
- 11.6 A team including senior paediatric doctor, nurse, the senior investigating officer or the coroner's officer must provide the following information to the parents before they leave the hospital.
- Information about the death and known medical facts
 - Involvement, and future involvement, of the coroner and possibility of a post-mortem/taking of samples
 - Involvement of social care, police and possibility of a home visit/scene visit.
 - Parents should be requested not to disturb the room in which the child died until a home visit is carried out
 - Details of relevant support agencies, local and national
 - Information about what will happen to their child's body including taking samples, post mortem, release of the body for funeral, arrangements to re-visit and take mementos from their child (hand and footprints etc)
 - Details of relevant support agencies, local and national
 - The next steps in the child death review process (MSCB Leaflet "The Child Death Overview Panel Information for parents")
 - Contact information for relevant professionals who will have on-going involvement with the investigation of their child's death
- 11.7 During this meeting the team **must** take a range of contact information for the parents including that of relatives/friends if they are not intending to return to their own home. They should also be provided with contact information for relevant professionals who will have on-going involvement with the investigation of their child's death.
- 11.8 The senior paediatric doctor must discuss the death with the coroner as soon as possible after the event. Samples can be taken before this discussion (see below).

12. Immediate post-mortem investigations

- 12.1 The Kent coroner has given permission to Consultants within the hospital for samples to be taken from children under one year whose death is unexpected, without the need for prior discussion with the coroner.
- 12.2 The consultant paediatrician should decide which samples are taken and consider whether a skeletal survey is necessary. If the death is being treated as suspicious, a police photographer should take photographs.
- 12.3 Items of clothing/bedding/personal mementos should not be removed by the family prior to consultation with the police and coroner.
- 12.4 The assigned A& E nurse should seek clearance from the police before dressing/cleaning the body to ensure that any potential forensic information is not compromised.

13. Notification of death, Multi agency liaison

See flowchart at appendix II

Notification of Unexpected Deaths occurring in hospitals

- 13.1 All (expected and unexpected) deaths of children (up to 18 years of age) occurring in Medway and of children normally resident in Medway but dying elsewhere must be notified to MSCB.
- 13.2 Following the declaration of the child's unexpected death the on call consultant paediatrician must ensure that the death is notified to:
 - The Police, immediately in order for the appropriate response
 - The Designated Paediatrician for Unexpected Child Deaths
 - The Coroner via Coroner's Officers(these notifications may come via the Safeguarding Children Administration team at Medway Hospital)
- 13.3 The Police will not be previously aware of an unexpected child death if the death has occurred within the hospital while the child was an in-patient there, not following their transfer from home into an A&E department.
- 13.4 It is the responsibility of all attending professionals to provide notification and detail of an unexpected death as soon as possible after the event using the following methods;
 - Verbal notification (as soon as possible)

At Medway Maritime Hospital – contact the Safeguarding Children Administration team 01634 830000 ext 6722. (CDR coordinator 01634 336340). This should be followed by written notification as below within 24hrs.

- Written notification

The MSCB child death notification form A can be downloaded from the front page of the MSCB website www.mscb.org.uk

13.5 The Designated Doctor must ensure that the notification form (Form a) is completed appropriately and sent to the safeguarding team at the hospital who will inform the CDR coordinator of the MSCB.

13.6 Once notified of an unexpected death the Safeguarding Children Administrator (MMH) will;

1. Inform the CDR coordinator of the death, the Police, Children's Social Care and Medway Community Healthcare; and any other relevant agencies by phone to facilitate information sharing,
2. arrange a meeting of representatives from the following professions who will constitute the rapid response team:
 - The designated doctor for child deaths, paediatric/neonatal
 - The identified paediatrician (it should also be established if they are available for discussion prior to the meeting)
 - Consultant paediatrician or senior paediatric doctor attending the death/on call at time of death. Or the registrar when that is not possible.
 - Police officer/ Representative from CAIU
 - Representative from Children's Social Care (as necessary)
 - Safeguarding nurse Children representative

13.7 The rapid response team must meet within 24 hrs of the death, for an initial case discussion, and after a home visit has been conducted by the police. An earlier meeting may be necessary in the light of information from social care or police regarding the safety of other children in the affected family. The rapid response will be chaired by the operational safeguarding lead for children's social care, or a senior practitioner/team manager from the area team, when there are concerns re the circumstances of the child's death or for the safety of any other children in the family which mean a s.47 investigation should be instigated; otherwise it will be chaired by either of the designated doctors for children death, neonatal/paediatrics. The named Midwife for Child Protection or the Designated Nurse for Safeguarding Children may assist the chair.

13.8 The purpose of the rapid response meeting is;

- To plan further investigation and enquiries to support/inform any coroner/criminal/child protection investigation,
 - to delineate the circumstances around the death with information provided by health, police, children's social care and partner agencies.
 - to ensure safeguarding procedures have been instigated, where necessary, for other children in the family
 - to ensure support is provided for the family, including follow-up by the professionals involved and if needed a paediatrician
 - to include any follow up via the paediatrician regarding sharing and discussion of post mortem results and medical investigations
- 13.9 Minutes of the Rapid Response should be sent to the relevant Designated Doctor for Child Death (neonatal or paediatric) acting as chair and the paediatrician in attendance to check for accuracy; and then disseminated by the Safeguarding Children administrator at MMH.
- 13.10 The relevant Designated Doctor will be kept updated on all information pertaining to the death in order to bring the case to a conclusion at the final case discussion via their personal secure email accounts.
- 13.11 Registrars for Births, Deaths and Marriages receive notifications of all deaths occurring in Medway. This information is shared with the CDR Coordinator. Once received, the CDR Coordinator will cross reference the registration information against the death notifications received by the MSCB to identify any deaths which have not been subject to MSCB child death review processes. Should any deaths be identified a review process will be initiated by the CDR Coordinator reporting this fact to the Designated Paediatrician for Unexpected Child Deaths. If the death was unexpected a Rapid Response meeting must be convened.
- 13.12 Any professional who becomes aware of a death of a child that, they believe has not for whatever reason already been appropriately notified, should contact the MSCB CDR Coordinator and provide a notification. This would include if the professional has discovered information about children normally resident in Medway who have died abroad or in other areas of the country – for example those receiving medical care in specialist centres, those in out of county respite, hospice or foster care placements or those on holiday.

Notification of Unexpected Deaths not occurring in hospital

- 13.13 The Designated Doctor should contact the Coroner or Coroner's Officers directly to establish appropriate course of action and whether police attendance is necessary.
- 13.14 The Designated Doctor should call a rapid response where the death was unexpected as a consequence of the child's life limiting illness.

- 13.15 Where a General Practitioner is declaring the death of a child outside of the hospital, it is their responsibility to make a notification of the death to the appropriate Coroner, the Designated Paediatrician for Unexpected Child Deaths and the MSCB CDR coordinator.
- 13.16 The coroner's officer, in Medway a Police officer, will attend the scene for all unexpected child deaths. The Designated Paediatrician for Unexpected Child Deaths will initiate the rapid response process as appropriate including ensuring that an appropriate health representative is available to participate, and that the police are alerted to the start of the rapid response process.
- 13.17 If the child's death was expected, but the G.P. identifies anything about the place where the child died or the manner of the child's death that appears suspicious, it is the responsibility of the GP to record information about the scene of death and notify the police and coroner immediately so a scene of death visit can be made.

**Unexpected deaths occurring at scene as the result of fires,
transport collisions or other major incidents**

- 13.18 If there is significant trauma to a child's body they will not in all cases be transported to hospital and may be declared dead at the scene. There will however be a Police presence at the incident. It is therefore the responsibility of the Police (if present the Forensic Medical Examiner) to make the notification to the CDR coordinator, the Designated Paediatrician for Unexpected Child Deaths and the Coroner.
- 13.19 The Designated Paediatrician for Unexpected Child Deaths will initiate the rapid response process as appropriate including ensuring that an appropriate representatives from specific relevant services are available to participate in this.

14. The Rapid Response Team (continued from 13.7/8/9)

- 14.1 The Designated Paediatrician for Unexpected Child Deaths has responsibility for ensuring a rapid response team is formed in response to each unexpected death and that the rapid response process is carried out by them. This may be delegated to the on call paediatrician or consultant or registrar attending the child death; with administrative support from the safeguarding team at Medway Maritime Hospital.
- 14.2 The Rapid Response team will have a standing core membership of:
- An on call consultant paediatrician
 - A police officer

and if there has been prior involvement of social care or abuse or neglect are suspected to be a factor in the death:

- A representative of social care (may be the out of hours service)
- 14.3 The required involvement of social care will be identified and initiated by the operational safeguarding lead at Medway Council or the out of hours team.
 - 14.4 If the Coroner is involved in the case the Coroner's Officer and the rapid response team should establish close involvement and the Coroner's Officer should remain fully informed about the team's work.
 - 14.5 The Police member of the rapid response team should also identify whether a Police Family Liaison Officer (FLO) has been attached to the family; the SIO will decide whether a FLO is deployed or not. If this is the case the Police rapid response team member will be responsible for maintaining close liaison with them and ensuring exchange of relevant information.
 - 14.6 There must be 24 hour availability from the standing membership of the rapid response team. Members of the team must agree who will have responsibility for convening future case discussion meetings and where these will take place.
 - 14.7 The MSCB Child Death Review Coordinator will support the rapid response to each death and will be responsible for undertaking the administrative work involved in compiling a composite Form B. (This role will be available during normal office hours only).
 - 14.8 Once the membership of the team has been identified there should be immediate sharing of information already obtained on the child's death, the child's family and relevant history between the team members. The Police member of the team should ensure that a full check of all relevant police databases is undertaken and the results of this fed into the team. The social care member should arrange a similar check of social care databases. The paediatrician should ensure that all records held by the child in the hospital are made available.
 - 14.9 Subsequent to this the team should identify and make contact with other professionals who have been involved with the child before and after their death. This should include:
 - GPs
 - Nurses
 - Health Visitors
 - Midwives

- Mental Health Professionals
- Other physicians and surgeons
- Social Workers
- Probation Officers
- Police Officers
- Schools
- Early years workers
- Youth Offending Team Officers

14.10 The members of the rapid response team should agree amongst themselves responsibility for identifying and notifying involved professionals and obtaining information from them. Due to the timescales involved in the process it is essential that the involvement of professionals should be identified as soon as possible.

14.11 The purpose of this contact is to:

- Inform the professional of the death of the child and about the requirements of the child death review process.
- Obtain from the professional information required to inform rapid response and any other relevant data they may know in relation to the child, their death and their family
- To agree the method and frequency of future liaison and exchange relevant contact information, including that of the CDR Coordinator
- Ensure any future appointments for the child is cancelled and all professionals that may make contact are aware and sensitive to the family's bereavement

14.12 Information can be provided verbally to team members however each professional identified as holding information on the child should be requested in addition to any verbal report to complete a copy of the form b, a written report, and supply this to the MSCB CDR Coordinator. The professionals should consult all records held on the child by their organisation. Information from hospital, police and social care records should be obtained prior to a post mortem being undertaken, information from other agencies may not need to be obtained with such urgency depending on the individual circumstances of the death.

14.13 The disclosure of information about a deceased child is to enable the MSCB and its partner agencies to fulfil statutory requirements related to child deaths and therefore should be disclosed as requested.

14.14 If an inquest is required, it is likely that the Coroner's Officer will also be contacting the above professionals to obtain information on the child. If this is the case consideration should be given to arranging

for this information to be shared with the rapid response team or vice versa to avoid duplicating requests.

- 14.15 The identified professionals should be invited to meetings of the rapid response team in person/by phone as considered appropriate – consideration should in particular be given to inviting them to attend the second case discussion meeting.
- 14.16 The coroner's officer is the lead professional for on-going liaison with the family over the process until the review of the child's death has been concluded. In most cases the professional fulfilling these responsibilities will be the Police/Coroner's officer rapid response team member. This liaison will be in addition to any bereavement support that may be provided by other professionals such as health visitors, GPs or those working for bereavement support organisations. (On receiving the information on a child death primary health care staff should immediately begin to initiate the provision of bereavement support to the family).
- 14.17 Once they are aware of a death, in addition to this multi-agency protocol, professionals should follow their own internal procedures related to childhood deaths as appropriate. This includes following serious incident protocols, informing relevant inspectorates and government departments and making appropriate notifications to the Health and Safety Executive and other organisations. Where appropriate the outcome of this activity should be fed into the rapid response team through the lead professional from that agency.
- 14.18 Responsibilities in the team for conducting future stages in the rapid response process should be agreed and documented by the chair of the meeting. The discussion should include deciding whether it is appropriate (based on the information already known) to undertake a visit to the place where the child has died and who should undertake this. This will almost always be the case when the child has died at home (unless this was a planned death of a terminally ill child) but may not be appropriate in situations such as road traffic collisions.

15. Post Mortem

- 15.1 If the s/he deems it necessary, and in almost all cases of an unexpected death, 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). The designated doctor/paediatrician should collate information provided by those involved in the child's death and share it with the pathologist prior to the post mortem.

Initial Post Mortem Results to Rapid Response Team

- 15.2 On completion of the post mortem the initial results will be provided by the pathologist to the Coroner (results of histology, toxicology etc will not be available at this stage).
- 15.3 The Coroner has agreed for the release of the post mortem results to the Child Death Review Coordinator. The CDR Coordinator will share these with the chair of the rapid response team.

Final Post Mortem Results

- 15.4 When available and as approved by the Coroner the final results of the post mortem will be forwarded to the CDR Coordinator. This should then be forwarded to the rapid response team via the chair in the same manner as in 15.3.
- 15.5 The Coroner's officer should meet with the parents and with the permission of the Coroner provide them with the results of the post mortem and answer any questions they have in relation to this.

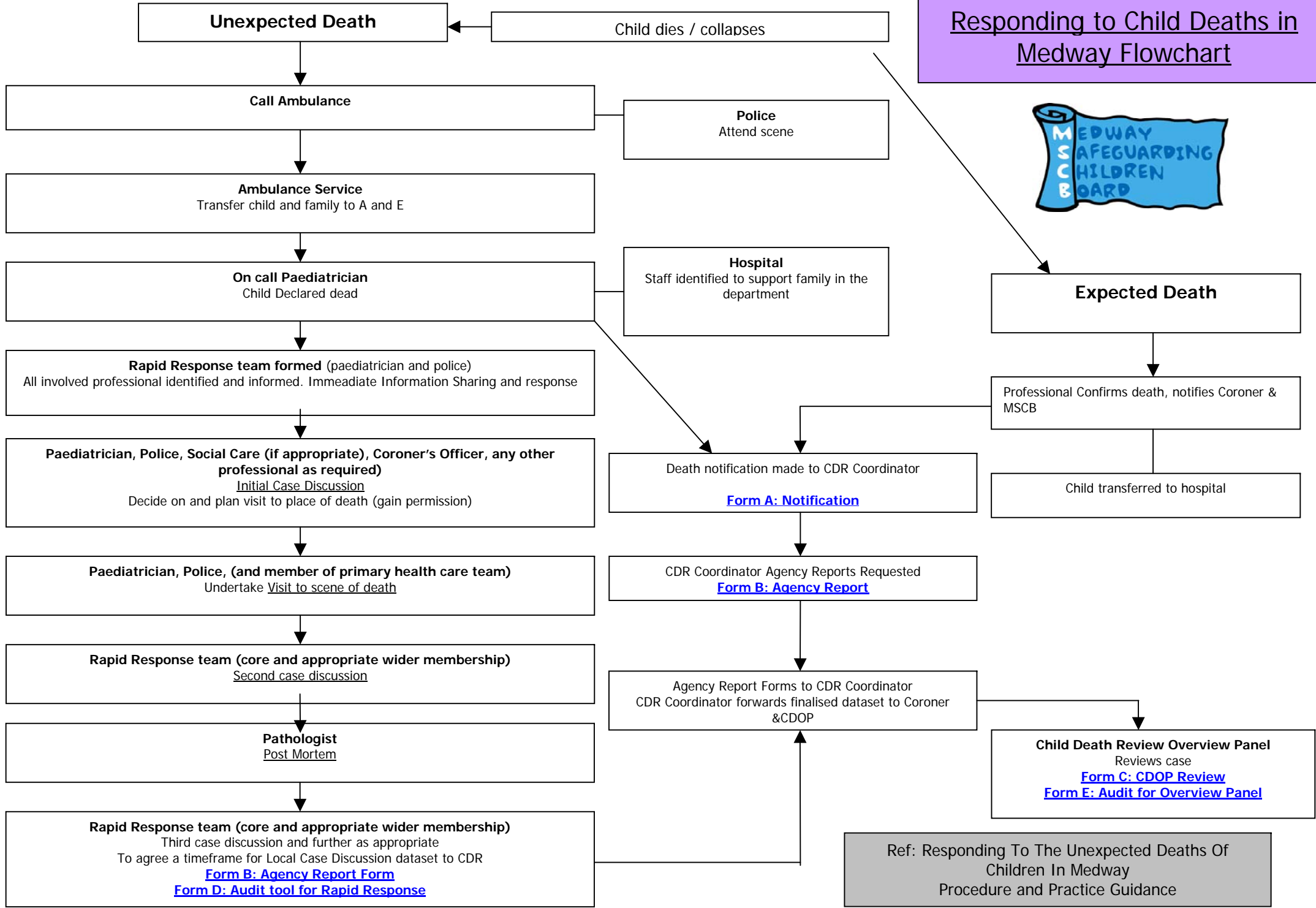
Second Case Discussion/Meeting

- 15.6 Core and (where appropriate) other members of the rapid response should convene a second case discussion/meeting to discuss the initial/further post mortem results, the outcome of the home visit and the current version of the form b.
- 15.7 This case discussion is to consider any other factors that may have contributed to the death that were not identified at the first rapid response, and any subsequent plans for future care of the family.
- 15.8 Previously completed form bs should be available for the final discussion and should be further updated to reflect the results of the discussion and any further information that has become available and resubmitted to the CDR coordinator as appropriate. The CDR coordinator will collate the form bs and circulate this collated form b to the members of the rapid response team for agreement before it is presented at CDOP.

16. Report for CDOP

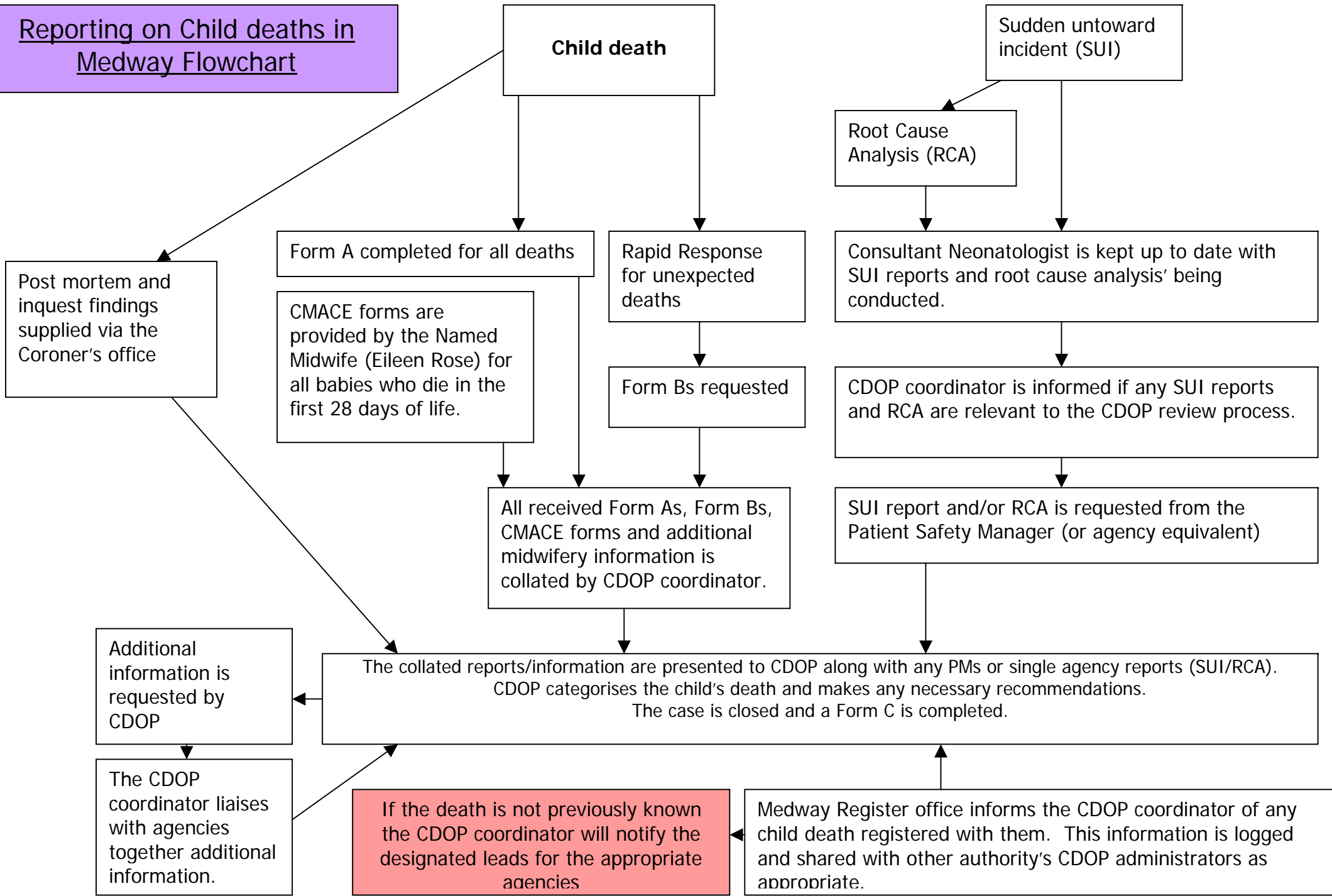
- 16.1 The CDR Coordinator will receive all completed form As and Bs, CMACE forms or equivalent, SUI and RCA reports and should ensure that these are stored and logged appropriately. The Coordinator will compile all available information on each death into a summary report and forward to the local child death review panel who will undertake the multi-agency review of the case at their next meeting.

Responding to Child Deaths in Medway Flowchart



Ref: Responding To The Unexpected Deaths Of Children In Medway
Procedure and Practice Guidance

Reporting on Child deaths in Medway Flowchart



DCSF National Data Collection Forms

Notes for users.

There are three key stages of documentation to support the child death overview processes:

1. Form A: Initial Notification Form.
2. Form B: Agency Report / Case Record – a case summary to be compiled in a local case review or by the Child Death Review (CDR) Coordinator from contributions from individual agencies. This acts as the “input data set” for the Child Death Overview Panel (CDOP).
3. Form C: Analysis Proforma, output from the Child Death Overview Panel.

The security of any system for transferring the information on these forms must be clarified and agreed with the Caldicott guardian.

1. **Form A: Initial notification form.** The prompt initial notification of all deaths will be an important part of the process of child death review, whether or not the particular case warrants a “Rapid Response” investigation process. We anticipate that most notifications will be by telephone, and the completion of the notification form will be the responsibility of a member of staff in the local notification office. There is the further option for the notification form to be completed by the notifier and sent by secure fax or email to the CDR Coordinator.
The security of any system for transferring the information on these forms must be clarified and agreed with the Caldicott guardian.

Professionals (or occasionally members of the public) who become aware of a child death will be encouraged to contact the office and give whatever information they may have – preferably including the full name, age and address of the child who has died, but people should not be discouraged from informing the notification office of a death because they do not have full information. It is better to receive multiple partial notifications rather than to miss collecting information on a child death.

On receipt of an initial notification of a possible child death the staff in the notification office should promptly attempt to confirm this information by contacting the relevant local agencies who may have been involved. It is important at this stage to obtain as much information as possible – including information on all members of the household, and identifying all key professionals – particularly the child’s General Practitioner and paediatrician if one has been involved. Each relevant agency should be contacted, and given information on the identity of the child, and all members of the household, together with any other

relevant contacts or family members. This will allow those agencies that may have information on past history, family or household members to check existing records, particularly any information on prior child protection concerns. Great care will be required to ensure accuracy of identification - to avoid duplication and mistaken identities – of the child who has died and of other household members. The use of the child's NHS number as a unique identifier (together with name, address and date of birth) will help minimise the risk of mistaken identity or duplication of notifications.

Having ensured that all relevant agencies are aware of the child's death, and the relevant agencies are providing appropriate support and care to the family, the next stage of the process will be to ensure that all relevant agencies are involved in preparation for any local case review meeting to investigate and review the circumstances of the case, any contributory factors and the ongoing support needs of the family, and to contribute to the Child Death Overview Panel's review.

- 2. Form B: The Agency Report Form / Case Record.** This form is sent to agency representatives to enable all relevant information on the case to be collected and collated to form a case summary. This may be compiled in a local case review or by the CDR Coordinator from contributions from individual agencies. This acts as the "input data set" for the Child Death Overview Panel.

In order to ensure completeness and accuracy of the information collected and reviewed at the local case review meeting – or to inform the discussions between the relevant key local professionals in those cases in which no local case review meeting takes place, all representative from each key agency should complete as much as they are able of form B, drawing on a review of the agency records and discussions with individual practitioners. Some aspects of the form are specific to individual agencies (e.g. health), but all agencies should be able to prepare summaries of relevant information available to them.

There are 6 sections to the form:

A Identifying and Reporting Details

This section will normally be completed by the CDR Coordinator from the notification form (Form A) prior to sending out to agency representatives. This identifying information can be separated from the rest of the form in order to anonymise the case prior to distribution to the CDOP members.

B Summary of Case and Circumstances leading to the death

Information is included on the nature and circumstances of the death. For some specific categories of death (e.g. road traffic accidents, apparent suicides, SUDI) further specific information will be gathered as part of the core data set. Additional forms will be distributed as appropriate. As well as the core data items, narrative information on the circumstances leading to the death is included to inform the understanding of the case

- C The Child**
- D Parenting Capacity**
- E Family and Environment**
- F Service Provision**

Each of these sections contains specific data items as well as space for narrative accounts of the relevant factors relating to the child's death.

In addition to the narrative and questionnaire components, the form should include a brief summary of the relevant positive and negative findings from the post mortem examination (form B-11), (where one has been conducted) as well as a full copy of the final postmortem report and (for deaths of children in hospital or under the care of a secondary/tertiary care team) a copy of the final discharge / death summary.

Once all agency reports are received, the CDR Coordinator should collate the information onto one form, either through a local case discussion, or in discussion with the individual agency representatives. This collated Form B then forms the case summary and input to the Child Death Overview Panel, and can at that point be anonymised. Where there are any discrepancies or disagreements between agencies as to any of the factual information, this should be noted and where possible, consensus reached.

Recent changes to the coroners' rules will facilitate the sharing of information (particularly police reports and postmortem reports) at this meeting for those deaths subject to coroners' investigations and/or Inquests. For all such deaths, the coroner or coroner's officer should be invited to attend the local case review meeting (as recommended in Chapter 7 of "Working Together"). The information made available, the discussions, and the outcome of the local case review meeting in such cases will provide potentially valuable information to inform the conduct of the inquest, which in most cases we anticipate will take place after the local case review meeting but before the Child Death Overview Panel meeting that review the death. The summary report from the local case review meeting should, in all cases in which the coroner remains involved be copied to the coroner to help inform the Inquest.

3. **Form C: Analysis Proforma**

The first page provides for identifying details of the case. These details can be removed and replaced by a unique identifier if the Panel is discussing cases anonymously, and in any event should be removed after the Panel meeting in order to ensure that any outputs from the panel are anonymised.

A summary of the case should be completed, along with any identified or agreed cause of death.

The panel should then consider any relevant factors identified from form B in each of the following domains, considering the degree to which any factors may have contributed to the death.

Factors intrinsic to the child

Factors in the parenting capacity

Factors in the family and environment

Factors in relation to service provision

The third section of the form is a categorisation of the child's death using a scheme developed for the CDOP process. This classification is hierarchical: where more than one category could reasonably be applied, the highest up the list should be marked. This will form part of the national core data set and enable analysis of information in relation to different types of death.

The Panel needs to make a decision on the degree to which each death is considered preventable. It is important to recognise that this categorisation is to inform any efforts to reduce childhood deaths, it does not in itself carry any implication of blame on any individual party, but simply acknowledges where factors are identified which, had they been different, may have resulted in the death being prevented.

The final section of the form allows the Panel to identify any lessons to be learnt, recommendations to be made or actions to be taken in response to the review of the death. It is anticipated that in most cases, any individual action in relation to specific case management will have been identified and addressed through the local case discussion or other related processes; the focus of these actions and recommendations are on lessons to be learnt at a population level. The overview panel will have the advantage of being able to review each individual child death in the context of other deaths of children in their area, and to be able to identify any potentially contributory recurrent themes, circumstances, or possible limitations in service provision by one or more agencies. The main public output from the Overview Panel will thus be in summary form - drawing on the information from individual cases and from the overall pattern of events, contributory factors and service provision in their local area.

This will allow the overview Panel the opportunity to develop local recommendations to help reduce childhood deaths, for inclusion in annual reports, and where appropriate, specific ad hoc recommendations (e.g. dealing with particular road or environmental factors). This information, together with both the factual and opinion-based outcomes of the Overview panel reviews will be aggregated in the regional and national reports on the child Death Review process, which will in turn be able to produce more generalisable sets of recommendations aimed at reducing child deaths.