Southend, Essex & Thurrock
Child Death Review Partners

Southend, Essex and Thurrock Procedure for Responding to Deaths in Childhood

October 2023

Review date: October 2025

The following Procedure provides local guidance for the implementation of processes outlined in the Child Death Review Statutory and Operational Guidance, October 2018 and Chapter 5 of Working Together to Safeguard Children 2018.

This Procedure has received formal approval from the Southend, Essex and Thurrock Child Death Review Partners and from HM Senior Coroner Essex.

Within this process the term 'Essex' relates to the local authority areas of Southend, Essex and Thurrock.

This guidance should be followed by professionals in conjunction with all relevant policies, procedures and protocols from within their own agencies.

Supporting documentation for this Procedure is available on the Essex Safeguarding Children Board website: https://www.escb.co.uk/working-with-children/child-death-reviews/

Terminology and Definitions

CDOP	Child Death Overview Panel
CDR	Child Death Review
CDRM	Child Death Review Meeting
CPP	Child Protection Plan
CSPR	Child Safeguarding Practice Review
DfE	Department for Education
DoH	Department of Health
eCDOP	Online system for co-ordinating and managing Child Death Reviews
HSIB Report	Healthcare Safety Investigation Branch Report
Infant mortality	All deaths under 1 year
JAR	Joint Agency Response
LSCB	Local Safeguarding Children Board
LSCP	Local Safeguarding Children Partnership
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (Online reporting system for perinatal mortality surveillance)
MCCD	Medical Certificate of Cause of Death
Modifiable death	Where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths
NCMD	National Child Mortality Database
Neonatal mortality	Deaths up to 28 days
OOA	Out of Area
Perinatal mortality	Stillbirths and deaths under 1 week
PHE	Public Health England
PICU	Paediatric Intensive Care Unit
PMRT	Perinatal Mortality Review Tool
PSIRF	Patient Safety Incident Response Framework
RTC	Road Traffic Collision
SCDOC	Strategic Child Death Overview Committee
SET	Southend, Essex and Thurrock
Sudden Unexpected Death in Infancy (SUDI)	All unexpected deaths of infants aged 0 – 12 months at the point of presentation. Description rather than a diagnosis. Following investigation, will be divided into those with a clear diagnosis (explained SUDI) and those with no diagnosis (SIDS)
SUDC	Sudden Unexpected Death in Childhood - *the sudden and unexpected death of a child over the age of 12 months, which remains unexplained after a thorough case investigation is conducted*

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Part 1 – General Guidance

1. Application

1.1 The guidance applies to the death of any child under 18 years regardless of the cause of death.

This includes the death of any live-born baby of any gestational age where a death certificate has been issued. In the event of a stillbirth which is not attended by a healthcare professional, Child Death Review Partners will carry out a Joint Agency Response. If these enquiries determine that the baby was born alive the death will be reviewed

It does not include stillbirths where a medical professional was in attendance, late foetal loss where there are no signs of life, or terminations of pregnancy (of any gestation) carried out within the law.

Cases where there is a live birth after a planned termination of pregnancy carried out within the law are not subject to a Child Death Review.

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

2. Social Care Assessment

2.1 If **at any stage in the process** information arises that suggest concerns about surviving children in the household then a referral of the case should be made to the relevant Children's Social Care Service in accordance with Part A, Section 2 of the SET Safeguarding and Child Protection Procedures. This action should be notified to the Child Death Review (Health) team (should it not already be aware). Once Social Care services have become involved in the case a Social Care representative must become a core participant in the Joint Agency Response. Social Care assessment processes can run in parallel to the work of the Joint Agency Response and Child Death Review Panel and close liaison should be established between the two via the Social Care participant in the team / on the panel.

3. Child Safeguarding Practice Reviews

(Reference: SET Safeguarding and Child Protection Procedures, Part B, Section 15)

3.1 When a child dies or is seriously harmed* in circumstances where abuse or neglect are known or suspected (i.e. is a serious child safeguarding case), Local Safeguarding Children Partnerships/Boards are required to consider if a Child Safeguarding Practice Review (CSPR) is indicated.

**Serious harm includes (but is not limited to) serious or long-term impairment of a child's mental health or intellectual, emotional social or behavioural development, as well as impairment of physical health.*

3.2 This includes situations where a child has been killed by a parent, carer or close relative with a mental illness, known to misuse substances or to perpetrate domestic abuse. Working Together 2018 states that " Safeguarding Partners should also have regard to the following circumstances - where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings, which includes children's homes (including secure children's homes) and other settings with residential provision for children; custodial settings where a child is held, including police custody, young offenders' institutions and secure training centres; and all settings where detention of a child takes place, including under the Mental Health Act 1983 or the Mental Capacity Act 2005".

3.3 If at any stage in the review of a child's death information arises that suggests that the above circumstances apply then the CDR Team should be alerted who will then liaise with the relevant CDR Partners regarding referring the case for consideration of a CSPR to be undertaken. Child Death Overview Panels have a specific responsibility to consider whether each death falls into a category whereby a CSPR would be a requirement and, if they identify a case to refer, to consider why this has not been done previously.

4. Deaths under investigation by the Police

The investigation of a death does not necessarily need to prevent the instigation of a Joint Agency Response or discussion of a death at the Child Death Overview Panel meeting. However, any decisions made by the CDOP regarding cause of death, contributory factors etc. cannot be finalised until the conclusion of all Police investigations.

4.1 Suspicious Deaths and Criminal Proceedings

All child deaths must be reviewed in accordance with these Procedures including those that are suspicious. However, if the death is treated as suspicious the Joint Agency Response will be initiated, but the progress will be under the direction of the Joint Agency Response team officer. For these deaths the Police are the lead investigating agency. If any other evidence arises during the course of a review that indicates that a crime may have taken place the Police should be alerted immediately. The Joint Agency Response team will continue to gather the relevant information required for the Child Death Review process but will liaise with the Senior Investigating Officer to ensure there is no detrimental effect on the criminal investigation process.

4.2 Deaths subject to other Police investigations

Where deaths are subject to other Police investigation, for example those occurring as a result of road traffic collisions and rail network incidents, the Joint Agency Response team should form and establish close liaison with the investigating branch of the Police. Based on the information received the Joint Agency Response team should agree the appropriate form of their response.

5. Supply of information about child deaths by Coroners

5.1 The Coroners Rule 57a places a duty on Coroners to inform the CDR Partners, for the area in which the child died, of the fact of an inquest or post-mortem. It also gives Coroners powers to share information with the CDR Partners for the purposes of carrying out their functions.

5.2 The process of information sharing between the Coroners officers and Joint Agency Response team is outlined in detail at Appendix D

6 Inquests

6.1 The Child Death Review process does not replace the Coronial process and inquests will be held where necessary and in accordance with the law. A Child Death Review meeting can occur prior to an Inquest being held and the outcome of the CDR process (the Child Death Review Analysis form) may be provided to the Coroner to inform the Inquest. However, any decisions made by the CDOP regarding cause of death, contributory factors, etc. cannot be finalised until after the conclusion of the Inquest investigations.

6.2 The Designated Doctor for Child Deaths or members of the Joint Agency Response team may attend an inquest.

7. Supply of information about child deaths by registrars

7.1 Registrars of Births and Deaths are required by the Children and Young People Act 2008 to supply the Child Death Review Partners with information which they have about the deaths:

- Of persons aged under 18 in respect of whom they have registered the death; or
- Of persons in respect of whom the entry of death is corrected and it is believed that person was or may have been under the age of 18 at the time of death.

7.2 Registrars are required to send the information to the CDR Partners no later than seven days from the date of registration, the date of making the correction/update or the date of issuing the certificate of no liability as appropriate. This applies to deaths occurring on or after 1 April 2008.

7.3 The CDR Manager is the ‘designated person’ for receipt of these notifications.

7.4 When the CDR Manager receives information regarding registered deaths from the Registration Service they will cross reference the registration information against the death notifications received to identify any deaths which have not been subject to child death review processes. Should any deaths be identified a review process will be initiated by the CDR Manager reporting this fact to the Designated Doctor for Child Deaths.

8. Patient Safety Incident Response Framework

8.1 In addition to following the processes outlined in this document in respect of child deaths all agencies should also follow their nationally and locally agreed procedures for reporting and handling patient safety incidents.

8.2 Where notification of an incident results in a local or external review or investigation being undertaken the results of these investigations should be made available to the CDOP and will be used to inform the CDR review. The findings of the Joint Agency Response and CDR Panel cannot be finalised until these reviews are concluded.

8.3 Where the death of a young person occurs in custody, the Joint Agency Response team must co-operate with the Prisons and Probation Ombudsman. Where a child or young person has either died whilst under supervision or within three months of the expiry of supervision the Youth Justice Board for England and Wales (YJB) requires the Youth Offending Service (YOS) to report and undertake local reviews of youth offending practice. The Local Management Review undertaken by YOS in relation to the death should feed into the child death processes initiated by the CDOP.

9. Cross Border Issues

Incorporating:

- **Children dying in Essex who are not normally resident in Essex**
- **Children dying in Essex as a result of an incident or collapse occurring elsewhere**
- **Children normally resident in Essex dying elsewhere**

9.1 The statutory requirement is for this process to apply to children normally resident in Essex. However, there will be cases of children dying in Essex who are not normally resident here or who die here but as a result of an incident occurring elsewhere (for example children transferred into Essex hospitals following accidents on non-Essex roads). In both these situations the *initial response* should be undertaken by Essex.

9.2 Following the initial response and on receipt of a death notification for a child not normally resident in Essex the CDR Manager should contact their counterpart for the area where the child is normally resident. An agreement should then be reached on who should take the on-going responsibility for the

review. Liaison should occur between the relevant Designated Doctor for Child Deaths to inform this decision making.

9.3 Decisions on who should take responsibility for the review following the initial response should be made on a case by case basis. For most accidental deaths occurring due to incidents in Essex but to non-Essex resident children it would be expected that the lead in the review of the circumstances of the incident would be taken by Essex. Essex would however rely on the area where the child was normally resident to undertake a full review of the case incorporating all background and historical information held within the area in relation to that child. Essex would expect the reverse to apply for deaths of an Essex resident child occurring elsewhere due to incidents happening elsewhere.

9.4 Should a child normally resident in Essex die elsewhere in the UK it is expected that contact will be made with the Essex CDR Manager by the CDOP for the area in which the child died. Information will be obtained as to the Joint Agency Response that has already been undertaken by that area and of the circumstances of the death. A decision will be made by the CDR Manager in conjunction with the Designated Doctor for Child Deaths and the other CDOP regarding the transfer of review of the case to Essex. The CDR Manager should make the necessary arrangements to obtain the relevant records and paperwork from the other CDOP. The CDR Manager would take the same action in reverse in relation to other area resident children dying in Essex.

9.5 Decisions made on which CDOP should have responsibility for the review should have regard to the area in which any Inquest is to be held and consultation with the Coroner should therefore form part of the decision-making process.

9.6 In some circumstances reviews may be undertaken jointly by both CDOPs, in which case feeding back the results of the reviews to the parents/carers should be carefully coordinated.

9.7 Where responsibility for reviewing a case is transferred from Essex to another area, Essex would expect the other area to provide it with feedback on the outcome of the review. The reverse expectation would apply if responsibility for a case transferred from another area into Essex.

9.8 Should a child normally resident in Essex die abroad the CDR Partners will be reliant on any professionals becoming aware of this death completing the eCDOP notification. Decisions will be reached on a case by case basis by the Designated Doctor for Child Deaths as to how the reviews for these children should proceed. Relevant professionals should make efforts through the normal channels to obtain information from foreign authorities as to the circumstances of the death and feedback this into the Joint Agency Response / Child Death Review process via the Child Death Review Manager.

9.9 In the case of the death of a looked after child, the CDR Partners for the area of the local authority looking after the child should exercise lead responsibility for

conducting the child death review, involving other authorities with an interest or whose local agencies were involved, as appropriate.

10. Data Collection

10.1 Essex has adopted the eCDOP system to collect data for this process. In addition, for neonatal and post neonatal (up to 1 year of age) deaths notification should be made to MBRRACE-UK via the on-line reporting system. Notification of the death of a child resident in Essex must be made via the following link; **https://www.ecdop.co.uk/EssexSouthendThurrock/Live/Public**

10.2 It is the responsibility of each agency to establish processes by which it can collate information on *the full range* of interactions it has had with the child who has died and their family to complete the eCDOP CDR reporting form. Each agency must notify the CDR Partners of their nominated contact for receipt of requests for information from the CDR Team (Health).

10.3 It is the responsibility of the CDR Team (Health) to compile a composite dataset via eCDOP for each death based on information received from agencies and, the Joint Agency Response team.

10.4 The Child Death Review Team (Health) administrator will be responsible for updating the JAR Progress Record, and completing the draft CDR Analysis Form on the eCDOP system during the Child Death Review meeting.

10.5 Copies of datasets will be stored securely via eCDOP. The data protection and information security policies of the host agency for the CDR Manager (Princess Alexandra NHS Hospital Trust) will be applied to the management of information held.

10.6 The Child Death Overview Panel are required to provide data from all reviews to the National Child Mortality Database (NCMD). The CDR Manager will be responsible for providing this information to NCMD via the eCDOP system.

10.7 All data collected in relation to the CDR process will be published by the Child Death Review partners in an annual report and will also be made available to the Strategic Child Death Overview Committee. All published and collated information will be anonymised. Discussion at Child Death Review meetings will be undertaken with full details of the child and family. Discussion at CDOP meetings will be undertaken on the basis of anonymised data. The CDR Manager will maintain a database of unique identifiers and will be able to relate discussion to actual cases as and when required.

11. Exclusions

11.1 The Joint Agency Response process is intended to be applied when a death could be from an external cause, or when it is sudden and there is no immediate apparent cause. There are some limited circumstances in which

following the Joint Agency Response process *in its entirety* would be inappropriate. Decisions should be made on a case by case basis and where there is uncertainty the Designated Doctor for Child Deaths must be consulted.

11.2 The unexpected deaths of children with life-limiting conditions do fall within these procedures. However, whether a Joint Agency Response should be initiated must be considered on a case-by-case basis and in discussion with the professionals involved with the child. If required the advice of the Designated Doctor for Child Deaths should be sought.

NB: All deaths will be subject to a Child Death Review meeting and review by the Child Death Overview Panel even if the Joint Agency Response process has not been followed in full.

12. Media

12.1 Any enquiries made to agencies or the CDR Partners direct from the press or other media should be dealt with in accordance with the agreed CDR Partners' media protocols.

13. Care of Parents and Carers

13.1 The death of a child is an extremely traumatic time for the family involved and the actions of professionals can greatly influence their experience of the bereavement.   Appropriate single and multi-agency training should be accessed by staff working with bereaved families and who have key responsibilities in implementing this guidance.

13.2 Further information outlining the involvement of parents and carers in this process is contained within the parent information protocol in Appendix B.

Part 2 - Process

The agency / professional responsible for each stage of the process is indicated in italics.

14. Child dies / collapses in the community

NB: For children who have died at home in the context of an "End of Life Plan" or children for whom transfer to the Emergency Department would be inappropriate (for example those who have been declared dead at the scene of a major accident or fire) please refer to points 11.1 – 11.2, 14.8-14.9 and 18.14)

Professionals attending / finding a dead or moribund child

14.1 Death should not be assumed and the Ambulance Service should be called. Appropriately trained professionals should commence resuscitation prior to the arrival of the ambulance crew.

Ambulance Service, Police and other professionals attending the scene

14.2 On receipt of a call regarding a dead or moribund child the Ambulance Control Centre should contact the Essex Police Control Room on 101 to inform them of a sudden death of a child. The Police initial responders should attend the scene, assess if there are any suspicious circumstances and deal with the death in line with sudden death Police policies and procedures.

14.3 The lead responsibilities within the Police for investigating the sudden unexpected death of a child will be as follows:

- If at the outset or subsequently, there are indications that the death is suspicious, a Senior Investigating Officer
- If the death is not the result of a traffic collision, an Investigating Officer of the rank of Inspector or above
- If the death results from a road traffic collision, a Road Policing Unit Investigator

14.4 Should an ambulance crew attend an incident when a dead or moribund child is subsequently found, or a child becomes moribund during their attendance, the Essex Police Control Room should similarly be informed via the Ambulance Control centre.

14.5 On arrival at the scene resuscitation should be attempted unless clearly inappropriate (see 11.1 -11.2). Life should not be declared extinct and the child should be transported to an Emergency Department.

14.6 All professionals in attendance should record, using standard agency processes and forms. The circumstances of how the child was found and any information provided by the parents/carers or surmised from their actions, appearance or

living conditions that may be of help in explaining the circumstances of the child's death / collapse should be recorded.

14.7 In anticipation that a scene visit may be required by the Joint Agency Response team efforts should be made to preserve the scene of the death / collapse wherever this has occurred.

14.8 It is always preferable that the child is transferred to an Emergency Department prior to their death being declared. However, resuscitation should not be attempted on the child if it is clearly inappropriate according to Ambulance Service guidelines or there is a "Do Not Resuscitate" order or "End of Life Plan" in place. In these circumstances the Ambulance Service may not have been called to attend, the death can be declared at the scene by an appropriately qualified professional and the child transported direct to a mortuary / chapel of rest in place of an Emergency Department.

14.9 If declared dead at the scene the professional declaring the child's death is responsible for identifying anything about the child's death that gives cause for concern or suspicion and to share these concerns with police. In these circumstances a Joint Agency Response should be considered.

15. Transport to Emergency Department

Ambulance Service

15.1 The child should be transported to the Emergency Department along with representatives of the child's family unless they make their own arrangements to reach the hospital.

15.2 A record of the Ambulance Service's attendance and treatment provided should be recorded on standard agency forms. This will be required to complete the CDR reporting form.

16. Child declared dead

The following also applies to deaths taking place in hospital but not within an Emergency Department. NB: where the death occurs elsewhere in a hospital then as far as practical consideration should be given to preserving the scene of the death until a decision is reached on the requirement for a scene visit and the visit, if required, is carried out.

The on-call Consultant Paediatrician

16.1 On call Consultant Paediatrician should respond to the child on their arrival at the Emergency Department / when they die elsewhere in the hospital.

16.2 A detailed and careful history of events leading up to and following the child's collapse should be taken from the parents/carers and documented.

16.3 Resuscitation of the child should continue until they are declared dead.

16.4 Once the child has been declared dead the on-call Consultant Paediatrician must ensure that an appropriate professional is identified to inform the parents / carers / next of kin and to support them while they remain in the Department. Translation services should be made available as required. Consideration should be given to meeting the needs of those who may present with a physical impairment or learning difficulties.

16.5 The parents/carers must be informed during this and subsequent conversations of the following:

- The next steps in the Child Death Review process including the potential need of a home visit / visit to the scene of the death and their requirement to provide consent for this. (Parents/carers should be requested not to disturb the room / scene in which the child died until this visit is carried out).
- The future involvement of professionals including the Police, the Coroner and the CDR team (Health) who will take on the role of key worker to act as a single point of contact in relation to the child death review process.
- Details of relevant support agencies.
- Information about what will happen to their child's body including the taking of samples, post mortem, release of the body for a funeral, the ability to see, hold and take mementos from the child (hand and footprints, etc.)

16.6 Copies of the Child Death Review leaflet for parents and carers should be available in the hospital and parents should be provided with a copy (Further information available in Appendix B).

16.7 During this meeting, professionals must ensure that they take a range of contact information for the parents/carers to facilitate future engagement with them. This should include that of relatives / friends if they are not intending to return to their own home. They should also be provided with the contact information of relevant professionals who will have on-going involvement.

16.8 Parents/carers should be provided with the opportunity to ask any questions that they have at this stage and should be told who they can refer future questions to. They should also be helped in contacting other family members, friends, the hospital chaplain or other religious leaders (if required).

16.9 Any further information obtained during this conversation about the circumstances of the child's death should be recorded and provided to the on-call paediatrician.

17. Taking of samples

17.1 Where the cause of death / collapse or factors contributing to it are uncertain, investigative samples should be taken immediately on arrival and after the death is confirmed. **Full guidance is provided to hospital staff on the taking of samples in the agreed hospital trust. This is contained in the White**

Folder located in Emergency Department, NICU, Paediatric Ward and Labour Ward.

17.2 To ensure the widest range of information is available to assist with identifying the cause of death it is expected that an attempt should be made to take all samples listed within this protocol, which is included within the White Folder unless this is physically or practically impossible. Any samples not collected in the hospital setting may later be taken, where possible, by the pathologist as part of the post mortem.

17.3 Skeletal surveys: It is expected that for all children under the age of two a skeletal survey should be undertaken. This should be reported by a suitably qualified radiologist. Consideration should always be given to undertaking a skeletal survey for children over this age where there is evidence to suggest that the death is suspicious. The survey will be undertaken at the place of post mortem unless it is suspected that the child has been subject to non-accidental injury and there are other children in the household who may be at risk. In these circumstances if waiting for the post mortem will lead to unacceptable delay, (more than 24 hours), local arrangements should be made, following discussion with the Coroner.

17.4 Where the death is a Coroner's case and the Coroner considers that a skeletal survey needs to be conducted for the purposes of their investigations the costs of this will be met from the Coronial budget (but not in any other circumstances).

17.5 Consent: Samples are taken for the purpose of determining the cause of the child's death or illness – prior to the child's death consent does not need to be obtained for taking samples for this purpose. Once death has been confirmed the relevant Coroner assumes immediate responsibility for the body and all things pertaining to it. No further samples may be taken without the Coroner's consent; however agreement from the Essex Coroner has been achieved in advance for the collection of samples outlined in the previously mentioned hospital trust protocol, contained in the White Folder.

17.6 Consent to retain samples beyond the period required by the Coroner must be sought from those with parental responsibility for the child in accordance with agreed procedures. Parents/carers should have the process for the taking of samples and the situation regarding consent explained to them as part of the conversation at 16.5.

17.7 Consideration should always be given, where possible, to the taking of photographs of the child's body for the purposes of informing future discussion regarding cause and time of death. If the death is being treated as suspicious these photographs should be taken by a Police photographer. Photographs should be taken and stored and consent obtained in accordance with agreed Police procedures and the hospital trust protocol contained in the White Folder as above.

17.8 Any clothing removed from the child and any items of clothing or bedding brought in with the child should be retained by the Police and not returned to the

family without the agreement of the Coroner. The child's body should not be cleaned as this may interfere with the pathologist's investigations, however the child may be wrapped in a clean blanket. If cleaning of the body is deemed essential the Consultant Paediatrician and Police should be consulted and photographs or swabs should be taken prior to the cleaning occurring. If the parents/carers have asked to see their child's body and it has not been cleaned, this, and the reasons for it, should be explained to them.

18. Notification of death

18.1 **All** deaths of children occurring in Essex and of children normally resident in Essex but dying elsewhere must be notified to the CDR Team (Health) using the following link: https://www.ecdop.co.uk/EssexSouthendThurrock/Live/Public

18.2 **All** deaths of children occurring in Essex must be notified to the Designated Doctor for Child Deaths in addition to the CDR Team (Health).

18.3 If a MCCD can be issued the death should be notified to the Medical Examiner. All unexpected deaths or deaths where a MCCD has not been completed, should be notified to the Coroner.

18.4 Notifications should be made as soon as possible following the death in all circumstances.

All professionals

18.5 Any professional (or member of the public) who becomes aware of a death of a child which they believe has not already been appropriately notified should contact the CDR Team (Health) and provide notification. This would include if they discovered information about children normally resident in Essex who have died abroad or in other areas of the UK.

CDR Team (Health)

18.6 On receipt of a Notification of Child Death the CDR Team (Health) should cross reference details with those already held. Should the details not be held, the CDR Team (Health) should contact the Designated Doctor who should ensure that an appropriate response is initiated.

18.7 On receipt of a Notification of Child Death the CDR Team (Health) will notify the agreed agency contacts. These contacts will be requested to complete an eCDOP Reporting Form within ten working days. The CDR Team is responsible for compiling a composite version of the Child Death Reporting forms for review at the Child Death Review meeting. The CDR Team (Health) are responsible for compiling an anonymised composite version of all information for the Child Death Overview Panel meeting.

On-call Consultant Paediatrician

18.8 Following the declaration of the child's death the on-call Consultant Paediatrician must ensure that the death is notified to:

- The Designated Doctor for Child Deaths
- The Police Public Protection Investigation Unit (PPIU)
- The Coroner via Coroner's officers
- The CDR Team (Health)

If the child is being treated by a professional other than a paediatrician the same procedure still applies. **This is specifically relevant to 16 and 17 year olds.**

18.9 Contact with the Police should be made via the Essex Police control room on 101 who should be informed that a joint agency response is required (see 19.6)

18.10 During working hours contact with the Coroner can be made direct to the Coroner Office, coroner@essex.gov.uk, Tel. 03330 135000.
Outside of normal working hours contact should be made with the Coroner via the Coroner's Service Out of Hours numbers:
For Harlow, Chelmsford and Colchester area Tel. 03330 132888;
For Basildon and Southend area Tel. 03330 132889

Coroner's officers

18.11 On receipt of the notification of the death, the Coroner's office should provide written notification of the death to the CDR Team (Health) using the following link, https://www.ecdop.co.uk/EssexSouthendThurrock/Live/Public within 3 working days.

Expected Deaths in hospices or at home in the context of an "End of Life Plan"

18.12 In the case of the above deaths it would be expected that the child will be declared dead in situ and will not be resuscitated or transferred to an Emergency Department. An Ambulance is unlikely to be called and the Police will mostly not attend these deaths (unless suspicious circumstances are identified). In most cases the child will be declared dead by a GP.

General Practitioners / Professional declaring death

18.13 It is the responsibility of GPs / other professionals declaring the death of a child in these circumstances are to make a notification to the CDR Team (Health) via eCDOP; https://www.ecdop.co.uk/EssexSouthendThurrock/Live/Public

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

18.14 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 team (Health). The Police attending the incident must also ensure the Police are aware that a Joint Agency Response will be required and the Public Protection Investigation Unit (PPIU) Detective Inspector is contacted, as per their Standard Operating Procedure (Appendix F)

19. Deaths subject to a Joint Agency Response

Formation of Joint Agency Response Team (JAR)

Designated Doctor for Child Deaths

Immediate decision making

19.1 Within 1 -2 hours of the death, senior professionals attending the child at the end of his/her life should consult with each other to determine whether the death meets the criteria for a Joint Agency Response (JAR).

19.2 A JAR should be triggered if a child's death;

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

19.3 A JAR should also be triggered if such children are brought to hospital near death, are successfully resuscitated but are expected to die in the following days. In such circumstances the JAR should be considered at the point of presentation and not at the moment of death.

19.4 The Designated Doctor for Child Deaths has responsibility for ensuring a JAR team is formed in response to each death that meets the criteria and that the JAR process is carried out by them. A team must be formed as soon as possible and **within 4 hours** of the death occurring.

19.5 The Joint Agency Response team will have a standing core membership of:

- an on-call Consultant Paediatrician

- a Detective Inspector from the Public Protection Investigation Unit (PPIU)
- a CDR Team (Health) practitioner – within contracted working hours (see Standard Operating Procedure at Appendix F

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

Strategy discussion

19.6 The involvement of the Police in the team will be initiated by the Paediatrician via contact with the Essex Police Control Room. A discussion will be facilitated to decide next steps and whether a representative from children's social care is required.

19.7 It is the responsibility of the Police to check with Social Care whether there has been any previous involvement with this child or their family.

19.8 PPIU personnel will attend the hospital as agreed during this conversation. A link will be made by the PPIU representative with any other Police officers who have been involved in the initial response to the incident, for the purposes of sharing information.

19.9 The Police member of the Joint Agency Response team should also identify whether a Police Family Liaison Officer has been attached to the family.

19.10 When the Coroner is involved, the Joint Agency Response team should establish close involvement with the Coroners officer and work according to the CDR/JAR Coroner Service Protocol outlined in Appendix D.

19.11 If an inquest is required, it is likely that the Coroner's officer and Joint Agency Response team will be seeking to identify and contact a similar range of professionals.

19.12 There must be 24-hour availability from the standing membership of the Joint Agency Response team. The CDR team (Health) will be available within contracted hours, i.e. Monday to Friday 08.30 – 19.00 and Saturday and Sunday 10.00 to 14.00)

19.13 A professional should be identified as the lead for on-going liaison with the family over the process until the review of the child's death has been concluded.

19.14 Administration for the Joint Agency Response teams will be supplied mainly by the CDR Team (Health). Administrative support for the team will however only be available during normal office hours.

19.15 For further details please see Proforma to be used within hospitals in the case of any death of an infant, child or young person. This is included within the White Folder located in the White Folder located in Emergency Department, NICU, Paediatric Ward and Labour Ward and is also attached as Appendix G.

Initial Case discussion

19.16 The initial case discussion should be held between the Health, Police and (where appropriate) Social Care member of the Joint Agency Response team, the Coroner's officer and any of the other professionals identified who are deemed appropriate. This discussion must be held **within 1 - 4 hours or at the start of the next working day** following the child's death (and should not be delayed should professionals outside of the Joint Agency Response team core membership be unavailable). Case discussions may take the form of virtual meetings where it proves impractical to bring required attendees together in person. The CDR Team (Health) will have responsibility for convening future case discussion meetings.

19.17 Subsequent to this the CDR Team (Health) should identify and contact other allied professionals who have been involved with the child before and after their death. This should include:

- Ambulance Personnel
- GPs
- Nurses
- Health Visitors
- Midwives
- Mental Health Professionals
- Other physicians and surgeons
- Social Workers
- Probation Officers
- Police Officers
- Teachers
- Early years workers
- Youth Offending Team Officers
- Youth Workers
- Coroner's Officers

19.18 The members of the Joint Agency 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. Where the child is normally resident outside of Essex professionals from the home authority of the child will need to be contacted, if necessary via the CDR Manager for that area.

19.19 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 complete the dataset and any other relevant data they may know in relation to the child, their death and their family

19.20 Each professional identified as holding information on the child should be requested in addition to any verbal report to complete a Child Death Review Reporting form. On receipt of the form the professionals should consult all records held on the child by their organisation.

19.21 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 the Patient Safety Incident Response Framework, 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 Joint Agency Response team through the CDR Manager. A decision should be made on a case by case basis on when and how the Joint Agency Response and Child Death Review processes will continue while other investigations are ongoing.

19.22 Professionals should also make the necessary amendments to databases and record systems to ensure that the child is recorded as deceased. In particular health professionals must make notification to the Child Health Information Department. All steps should be taken to ensure that communications and mailings such as appointment dates are not sent out for children who have died.

19.23 On receiving the information on a child death primary health care staff should immediately begin to initiate the on-going provision of bereavement support to the family.

19.24 Responsibilities in the team for conducting future stages in the Joint Agency Response process should be agreed and documented. 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. This will almost always be the case when the child has died at home (unless this was an expected death of a terminally ill child – see 11.2) but may not be appropriate in situations such as road traffic collisions. In these circumstances information on the scene should be obtained from the investigating section of the Police, Fire and Rescue Service etc., normally by the Police Joint Agency Response team member.

19.25 NB: As in most circumstances children will not be declared dead until reaching an Emergency Department, the 'scene of the death' should be taken to mean the scene of the collapse / incident that lead to the child's death.

19.26 If it is deemed appropriate to undertake a visit to the scene of death the Joint Agency Response Team should plan the arrangements including when to undertake the visit and who will provide the lead. Consent to undertake the visit

must be obtained from the parents/carers and/or other appropriate person (e.g. house or premise owner) if the death did not occur in the family home.

19.27 If it is deemed necessary and consent is granted professionals should seek to undertake the visit **within 24 hours**. Sensitivity should be applied as to when the visit is carried out and should be arranged taking into consideration the parents' wishes. However, the only reason for not undertaking the visit within this timescale should be due to problems obtaining consent or cooperation from the parents / carers. If the visit is not undertaken within this timescale the reasons for this should be documented by the Joint Agency Response team on the draft CDR Analysis form.

19.28 The visit will be undertaken by the Police Officer and CDR Team (Health) practitioner forming the Joint Agency Response team. The Consultant Paediatrician and a Social Care representative may also be present. This visit should be undertaken together but can be undertaken separately if this cannot be arranged. A health visitor, GP or other similar professional who has had previous contact with the family may also participate in the home visit to provide support to them however it should not be delayed beyond 24 hours due to their unavailability. The Coroner's officer should not participate in the home visit however they will be provided with a summary of the information obtained from it as outlined at paragraph 19.29.

Visit to the scene of the death

See guidance at Appendix A

Following the visit to the scene of the death

Joint Agency Response Team

19.29 Information collected at the scene visit should be summarised using the form G or form H and forwarded to the CDR Manager and Coroner's officer. This will usually be completed by the Police member of the Joint Agency Response Team.

SET CDR Manager

19.30 The CDR Manager should incorporate the information provided into the dataset and into the report for the Child Death Review meeting and the Child Death Overview Panel.

Current dataset and results of scene visit to Pathologist

19.31 Where appropriate the Coroner will order that a post-mortem is undertaken on the child. It is an expectation that this will be undertaken by a paediatric pathologist. If there are concerns that the death may be suspicious the Coroner may decide that a Home Office pathologist should be used in conjunction with

the paediatric pathologist (unless a pathologist is used who is qualified in both paediatric and forensic pathology).

Police

19.32 Where a post-mortem has been instructed by the Coroner the information obtained so far on the child and their death, including the information gained from the visit to the scene should be forwarded to the pathologist responsible for conducting the post mortem as soon as possible.

Post Mortem

Pathologist

19.33 The pathologist should conduct the post-mortem informed by the information provided by the Joint Agency Response team and should undertake all relevant tests suggested by this.

Initial Post Mortem Results to Joint Agency Response Team

Coroner

19.34 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)

19.35 The Coroner will release the post mortem results to the CDR Manager/ Police

19.36 NB: Post-mortem results are highly confidential and should only be shared after consent has been granted by the Coroner and in accordance with the steps outlined in this guidance.

SET CDR Manager

19.37 On receipt of the Post Mortem report the CDR Manager will add the report to the eCDOP system so that it is available for the Designated Doctor for Child Death to view. The CDR Manager is responsible for keeping accurate records of who the information has been provided to.

Joint Agency Response Multi-Agency meeting

19.38 The purpose of this meeting is to review available information and agree on-going support for the family and professionals. This meeting should be held as soon as is practically possible. Ideally within ten days of the death.

19.39 The meeting will be convened by the Designated Doctor for Child Death. In some circumstances, i.e. fatal self-harm, Social Care may lead on these meetings. The meetings will be arranged by the CDR Team (Health). The meeting will include representation from all agencies involved in care of the child, including school, education services, early years, health, etc.

19.40 Notes of this meeting should be recorded on the Joint Agency Response progress record including an action plan and should be sent to all attendees and a copy provided to the CDR Manager and to the Coroner.

Second Case Discussion (If required)

Joint Agency Response Team

19.41 Core and (where appropriate) other members of the Joint Agency Response team may convene a second case discussion meeting when further information is required which was not available at the Joint Agency Response meeting.

19.42 The dataset including the JAR progress record should be further updated in response to this meeting.

Final Case Discussion and final Post Mortem Results

Coroner

19.49 When available and as approved by the Coroner the final results of the post mortem will be forwarded to the CDR Manager. This will be added to eCDOP for the Designate Doctor to view. If requested the results will also be sent to the parents/carers by the Coroner. The Coroner will inform the CDR Team (Health) whether the post mortem report has been provided to the parents.

Joint Agency Response Team

19.50 A final meeting of the Joint Agency Response team (the core membership and any of the wider membership considered appropriate) should be convened in response to the receipt of the final post mortem results.

19.51 The draft CDR Analysis Form will be completed at this meeting.

19.52 Case specific actions for local agencies will be identified and actioned.

19.53 Before concluding the meeting the Joint Agency Response team must agree on what information should be shared with the parents or carers of the child and how this information will be provided to them (For further information see appendix B).

This is the end of the Joint Agency Response process. The review will then proceed as from paragraph 21.

20. Deaths not subject to a Joint Agency Response

Notification and data collection

20.1 If it is decided that a Joint Agency Response is not required notification should be made as described in section 18.

Child Death Review Meeting

20.2 This will be a multi-professional meeting where all matters relating to an individual child's death are discussed. It is intended that the meeting will be attended by professionals who were directly involved in the case of the child during his or her life, and any professionals involved in the investigation into his or her death. This meeting will be chaired by the Child Death Review Team (Health).

20.3 Case specific actions for local agencies will be identified

20.4 The draft CDR Analysis form will be completed at this meeting.

21. All Deaths – Child Death Overview Panel

Information forwarded to Child Death Overview Panel

SET CDR Manager

21.1 The CDR Manager will receive all completed data collection forms, and the draft CDR Analysis form Via eCDOP. The CDR Manager will collate and anonymise all available information on each death including producing an anonymised composite Child Death Reporting form. The case will then be listed for review by the Child Death Overview Panel.

21.2 At the Child Death Overview Panel, in accordance with the agreed terms of reference, panel members will be asked to review all available information on each death and finalise the CDR Analysis form. This will include consideration of:

- any factors contributing to the death
- modifiable factors contributing to the death
- cause of death
- any learning points and issues identified
- wider learning and themes
- ongoing support needs for the family and (where relevant) involved professionals

21.3 The Child Death Overview Panel will also consider whether they have identified any information that needs to be fed back to the parents or carers.

PRACTICE GUIDANCE FOR UNDERTAKING A VISIT TO THE SCENE OF A CHILD'S COLLAPSE AND/OR DEATH AS PART OF THE JOINT AGENCY RESPONSE PROCESS

A1. Purpose

A1.1 A visit is undertaken to the place where a child has died for the purpose of:

- obtaining information to assist in identifying why and how a child has died
- providing support and information to the child's parents/carers

A2. Underlying principles

A2.1 The death of a child is an extremely traumatic event in the lives of the parents/carers. A visit to the scene of the child's death can be useful in providing the parents/carers an opportunity to talk about their child's death and in identifying information which will enable them to understand how and why their child has died and how future children can be protected from this. However, it should be recognised that parents/carers may find reliving the events leading to their child's death a distressing experience. To assist with this the following principles should be applied:

- Professionals are expected to deal with the situation demonstrating appropriate sensitivity, knowledge, skill, care and professionalism and be fully conversant with the relevant policy and procedure

- The visit should not be rushed – professionals should ensure that they have sufficient time available to undertake the visit and gather all the information required on that one occasion. Professionals should provide the parents/carers with the time they need to talk about the experience and provide all the information they want to; the pace of the visit should be led by the parents/carers

- Parents/carers should not be pressured into undertaking any part of the visit they feel uncomfortable with

- The reasons for the visit should be fully explained, the parents/carers should be reassured that they are not going to be treated as under suspicion and that the visit is not part of a police investigation. They should however be made aware of the actions professionals are obliged to take should they identify anything that appears suspicious and that these may result in further joint agency investigations.

- Questions which may imply that parents/carers should be blamed / feel guilty for their child's death should be avoided; however, it is likely that parents will feel guilty in response to questions behind which this was not the implication. Professionals should be mindful of this and seek to provide continual reassurance to the parent/carer.

- Professionals should direct parents/carers towards further sources of advice and support
- Professionals should answer any questions parents/carers have about what is happening to their child's body, when it will be available for a funeral, death registration, the role of the Coroner etc.
- The parents/carers should be fully informed about next steps in the child death review process, what they can expect in terms of information resulting from it and within what timescale.
- Professionals should be aware of the different and individual responses that those of different cultures, religions, genders etc. may have to the death of their child and be sensitive to this in undertaking the visit
- It may be appropriate to arrange for an interpreter to be available if parents/carers do not have English as a first language
- Provision should be made to ensure that visually or hearing impaired or otherwise disabled parents/carers or those with learning difficulties are enabled to understand and participate in the visit process
- Parents/carers may wish to have the support of other relatives / friends / an advocate during the visit and provision should be made for this

A3. Undertaking a scene visit

A3.1 When a child's death occurs in a private residence a visit to the scene as part of the Joint Agency Response process (where the death is not being treated as suspicious) can only be undertaken with the consent of the child's parents/carers. If during the initial case discussion professionals agree that they would like to undertake a visit the parents/carers must have the purpose and content of this visit explained to them and their consent to it must be obtained. A written explanation of the process should be provided. Parents/carers should be requested to leave the room in which the child died as undisturbed as possible until the visit has taken place and be told why this is important.

A3.2 If the death / collapse did not occur in the family home then consent to conduct the visit to the place of the death must be obtained from the parents / carers and the other appropriate person such as the house or premise owner.

A3.3 In explaining the purpose of the visit to the family it should be explained that the visit is a routine part of the investigation that takes place into every child's death, which will provide important information for the pathologist and will therefore help in the identification of the reasons for their loss.

A3.4 NB: Parental / carer refusal for a visit should not in itself be taken as an indication that the death is suspicious but should be considered by the Joint Agency Response team in the context of the other information known.

A3.5 If a child is declared dead and is not transported to hospital (for example in the case of a terminally ill child) it would not usually be expected that there would be a visit to the scene of the death. In this case it is the responsibility of the professional who declared the child's death to gather the information that would have been gathered during the visit and to provide this to the Joint Agency Response team. It is also the responsibility of this professional to identify anything about the scene which appears suspicious or could indicate that abuse and neglect may have been factors in the death and to highlight this information to the relevant authorities.

A4. Who should undertake the visit?

A4.1

- Child Death Review Team (Health) practitioner
- A Detective Inspector or delegated Officer from the Police Public Protection Investigation Unit

and, if agreed to be appropriate by the Joint Agency Response team because 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

They may be accompanied by:

- A GP, or health visitor or other health professional (ideally who has had a previous relationship with the family and where this is required by the parents/carers) who will be involved in the provision of bereavement care.*

A4.2 *The role of this GP or health visitor or other health professional is specifically to provide support to the family during the visit and to ensure that bereavement care is informed by a detailed knowledge of the situation. While important, a visit should be undertaken as soon as possible and should a professional to fulfil this role not be available this should not be a reason for delaying the visit significantly.

NB: As part of the Joint Agency Response process an agreement should be reached on which professional will take the lead in provision of on-going bereavement care for the family so as to avoid duplication of effort and confusion for the family.

A4.3 Coroner's officers normally will not participate in the visit however they should be provided with a summary of the information obtained from it (see A9.1).

A4.4 If the professionals attending have not been involved with the death prior to undertaking the visit they should liaise with those professionals who have been and ensure they are aware of all the relevant information.

A4.5 Prior to undertaking the visit the professionals present should agree who will be responsible for taking the lead. Who this is may differ on a case by case basis.

A5. Timing

A5.1 The Joint Agency Response team that forms in response to the death of a child should decide during their initial case discussion (within 1-4 hours of the death, or at the start of the next working day) whether to undertake a visit to the place where the child has initially collapsed or died.

A5.2 Whenever possible the visit should be undertaken within 24 hours of the death and always prior to the post-mortem.

A6. Forensic Investigations

A6.1 In some cases the Police may visit a scene prior to a visit as part of the joint agency response process and, in the absence of a family, to undertake their own investigations and ensure any disturbance to the scene is minimised. If this is the case and a visit as part of the Joint Agency Response process is planned, the Police officer undertaking the Joint Agency Response process visit should identify what previous investigation has been undertaken and use this to inform their own visit.

A6.2 If the death is being treated as suspicious by the Police a visit as part of the Joint Agency Response process should not be undertaken and the Police will become the lead agency in investigating the death. The Police and Criminal Evidence Act and other legal rules will apply in relation to the gathering of information and evidence. If information arises during the course of the visit that suggests the death may be suspicious then advice should be taken from the Police as to how to proceed.

A6.3 It is rarely useful to seize bedding and other similar articles as part of an investigation and this should be avoided. Where items are removed by the Police sensitivity should be demonstrated with regards to their storage and eventual return to the family.

A6.4. NB: Even in the above circumstances it may be of use for the Police to request the support of a Paediatrician with their investigation of the scene as they may be able to advise of medical explanations for circumstances which may initially appear suspicious (see separate guidance on factors arousing suspicion).

A7. Process

A7.1 The visit to the scene of the death should occur in two stages:

a) Taking a full history from the parents/carers of the events leading up to their child's death

b) Undertaking a detailed observation of the room in which the child's death / collapse occurred

A7.2 NB: Any information collected during the course of the visit that gives rise to suspicion should be shared in accordance with agreed protocols, for example by making a referral to children's social care and the Police in accordance with Part A, Sections 2 and 3 of the SET Procedures. In these circumstances the visit should cease and advice should be taken from the Police as to how to proceed.

a) Taking a full history

A7.3 The parents/carers should be asked to go through a detailed narrative account of the events leading to the death over the past 24-48 hours (or longer if appropriate). This should include:

- all the places the child and their parents/carers have been
- all the people they have come into contact with
- all activities they have undertaken
- information about when and where the child was last seen or heard alive
- information about the presentation of the child during the time period – their mood, disposition and health

A7.4 The parents/carers should be asked to indicate anything in the above that represents a change from usual practice and any exposure that the child may have had as part of the above to infection, alcohol, smoking, drugs (both prescription and elicit) or other harmful substances.

A7.5 The parents/carers should also be asked details of the family and household, e.g. members, ages, occupations, when they have been present within the relevant time period and anything that is known about medical / social backgrounds which may be relevant, e.g. history of illness, disease, substance misuse, history of violence and aggression including presence and temperament of pets / animals. This should include relevant medical and social information related to the child itself.

b) Scene Visit

(NB: the below guidance is of greatest relevance to visits made to the scene of infant deaths in the home and an additional guidance form 'Form H' has been developed to provide guidance in relation to undertaking a scene review for the death of an older child)

A7.6 Parents/carers may accompany the professionals during the scene visit.

A7.7 The parents/carers should be asked to recount and / or demonstrate:

- At the time the child was last seen alive, who was in the room, when they were there and where they were
- The position the child was in and any movement there had been from this when they were found dead/collapsed

A7.8 The following information should be recorded:

- The size of the room and its orientation (west / east facing etc.) – an ultrasound or other tape measure and a compass will be required
- The contents of the room and its position, including all furniture and in particular beds and cots in relation to radiators, heaters etc.
- Ventilation – what windows, doors or other openings are there
- Heating – what sources of heat / cooling systems are in the room, when these are switched on and off and what temperature they are set at
- Temperature – current room temperature and a temperature taken from inside a drawer for the purposes of estimating the temperature in the hours before – a thermometer will be required
- If the child was found dead having been put down to sleep, the sleep environment of the child, in particular:
  - What the environment was – for example cot, bed, pushchair, car seat
  - the type and condition of mattress or seat
  - the type, extent and condition of bedding
  - the presence of adult sized bedding, for example duvets, and pillows
  - objects present, for example toys, cushions, clothing, mobiles
  - the position and usage of any straps or restraints
  - whether other people were / are sleeping in the same bed / room
- Any defects to any of the above, for example broken cots, uneven surfaces
- Anything that appears potentially dangerous, for example overloaded shelving, badly fixed cot-mobiles, faulty lighting / electrics
- The cleanliness of the room, presence of rubbish and staining
- The amount of space available in the room and the level of 'clutter', for example the amount of space available for an adult to stand by the child's bed, the availability of clear surfaces

A7.9 The parents/carers should be asked to indicate any changes that have occurred in the room in the time between the child being found collapsed / dead and the time of the scene examination.

A7.10 Those undertaking the scene investigation should in particular seek to identify:

- Any evidence that the child has been over-wrapped or over-heated (note for example the number of layers single blankets / covers have been folded into)
- Anything that could have restricted the ventilation of the room
- Anything that could have restricted the child's breathing
- Anything that could have fallen on / smothered the child, including evidence that the child may have been over-lain
- Any other hazards in the room
- Any evidence of neglectful care

A8. Recording

A8.1 All information obtained at the scene visit should be recorded on the Form G or H. Sketch plans and other drawings should be made of the room. Audio recording equipment can be used.

A8.2 Photographs and / or video recordings can be made if it is thought that these will be useful due to the complexity of the circumstances / to enable more accurate recording of the information provided by the parents/carers.

A8.3 Parents/carers should be fully informed of the methods that will be used for recording information, the purpose of the recording and how and for how long this information will be stored.

A9. Following the visit

A9.1 The professionals undertaking the visit must ensure that the information they have collected is collated into an overview report in time for review at the second case discussion. This report should be forwarded to the CDR Manager who will ensure that it is available alongside the completed dataset for review by the Child Death Review meeting and the Child Death Overview panel. A copy of the information should also be forwarded to any Coroner's officer involved in the case by the Police member of the Joint Agency Response team.

A9.2 The Police member of the Joint Agency Response team should ensure that the information collected during the visit is collated with other information available on the death and forwarded to the pathologist **prior** to them undertaking the post mortem of the child.

A9.3 All notes (from all professionals present), photographs, video and audio recordings should be stored in medical records in accordance with agreed protocols.

A10. On-going care of the family

A10.1 By being present at the visit the CDR Team (Health) practitioner who has attended to support the family will become fully aware of what has happened and should use this knowledge to arrange appropriate bereavement care and support for the family, including other children.

A10.2 As part of the Joint Agency Response process a professional will have been identified to provide a link between the parents/carers and Child Death Review process so that they remain informed about the outcomes of this. Prior to the end of the visit the family should be made aware of the timescale in which information will be available. Professionals attending the visit should ensure that they collect a range of contact information from the parents/carers to facilitate future communications.

A10.3 If a GP, health visitor etc. was not available to take part in the visit then the professional identified to be the link professional with the family should ensure

that all relevant information is passed on to them as soon as possible following the conclusion of the visit.

A10.4 If an inquest is to be held the Coroner's officer will also have ongoing involvement with the family

Appendix B

INVOLVEMENT OF PARENTS / CARERS IN THE CHILD DEATH REVIEW PROCESS

Within this guidance the term 'parents' also refers to carers where appropriate, and the term 'family' also refers to siblings where appropriate

General guidance:

The process below outlines the responsibilities of professionals who are in direct contact with the family to judge when and how it is most appropriate to explain the process to parents. For every case all the below points should be covered.

At all stages, it should be stressed that the Child Death Review process is a normal process.

It should be explained to parents that this is process is to identify what may have contributed to their child's death and whether there are any lessons to be learnt to prevent future deaths.

Parents will be made aware that information shared with be recorded and fed into the child death review process, where relevant.

If the CDR Manager is contacted by parents requesting information about the process, statutory basis, the need for consent, access to information etc. then this will be discussed on a case by case basis with senior management.

If, however the parent wishes to provide views into the process, to receive feedback on a review or case discussion, the CDR Manager will be responsible for taking their details and passing them on to a relevant professional who will then be responsible for contacting the parent.

The SET CDR Partners will endeavour to provide any written information provided to parents in alternative formats / languages where this is required.

Do we need to obtain consent from the parents to conduct a child death review or share information for the CDR process?

Good practice is that consent should always be obtained prior to sharing information however this is a statutory process and does not require consent from the parents.

How should parents be informed of the child death review / Joint Agency Response process?

All parents will receive a leaflet in relation to the CDR process from the Child Death Review Team (Health).

Deaths not subject to a Joint Agency Review

Where the death is expected, i.e. the child has a life limiting condition, a Joint Agency Response will not be undertaken however the death of the child will still be subject to a Child Death Review meeting following information gathering.

All parents will receive written information and a leaflet in relation to the CDR process from the Child Death Review Team (Health).

The letter will be sent to those individuals clearly identified as the parents or primary carers on the notification form. Best efforts will be made to clarify to whom it is most appropriate to address this letter and whether, if the parents do not live together, the letter should be sent separately to both.

How can parents contribute to the process?

It is not expected that as part of the Child Death Review process there will be further active engagement with families.

Should parents make a specific request to provide their comments then these will be responded to on a case by case basis. These comments will then be shared with Child Death Overview Panel. Parents or parents' representatives are not able to attend panel meetings.

On-going involvement of agencies with parents should continue as part of normal bereavement care or as part of other investigations being undertaken into the death.

How should the parents be informed about the outcome of the post-mortem?

If the parents request a copy of the final post-mortem report it is the Coroner's responsibility to provide it.

Can parents see the papers from panel meetings and or forms that have been completed for the process?

Parents will not be offered the opportunity to view or receive copies of these documents. They may request copies under the Freedom of Information Act or, under the Data Protection Act, (the DPA does not apply to the deceased). All requests made would be responded to on a case by case basis. Should a request be made to a contributing agency rather than the Child Death Review Partners, the request should be dealt with by the agency following their own procedures but only after consultation with the SET Child Death Review Partners.

How and when will access be provided to the annual report?

The annual report will be made available in approximately August of each year to the CDR Partners. No information in this report will identify individual children or cases.

DESTRUCTION, RETENTION AND TRANSFER OF RECORDS POLICY

This policy covers:

- How long Child Death Review (CDR) individual case files will be stored
- How long single agencies should maintain individual case files
- How SCDOC meeting minutes will be stored
- How confidential information is sent securely by email to and from the CDR Team
- Data held by the National Child Mortality Database

In this policy the term 'CDR Individual Case File' refers to all information collected for each individual child for the child death review process. This will include: copies of Notification of Child Death, CDR Reporting form (and supplementary forms), Form G, CDR Analysis form, Post Mortems (PMs), discharge summaries and other reports made available to the CDR process.

C1. How long individual case files will be stored?

All correspondence for the CDR process will be stored on the secure eCDOP system.

C2. How long should single agencies maintain individual case files?

Single agencies should store Information in accordance with local and national policies.

C3. SCDOC meeting minutes

SCDOC meeting minutes will be held on the PAH NHS Trust secure network drive.

C4. How will confidential information be sent securely by email to and from the CDR Team (Health) and the CDR Manager?

All information will be sent securely and effectively and according to PAH NHS Trusts Email Policy.

C5. Data held by eCDOP and the National Child Mortality Database (NCMD)

Data from all Child Death Review cases will be held on the eCDOP system and submitted to the National Child Mortality Database.

eCDOP store all data on servers which are located in the United Kingdom. These servers are protected by secure passwords and firewalls. Information is transferred over an encrypted channel. eCDOP securely transfers all data gathered during the Child Death Review into the National Child Mortality Database at set intervals in the eCDOP process. Only data relevant to the National Guidance is transferred and stored in the NCMD.

Further information regarding eCDOP data storage can be obtained from QES who are the Data Processors, email info@qes-online.com

The NCMD contacts database is held on a secure server with sole use by the Bristol NCMD team. The usual PC security protocols are in place protecting this data, as is physical protection such as locked office doors and a comprehensive alarm system. No personal and confidential information is kept on paper records. All information is stored on the secured and encrypted database and secured and protected servers.
The information on the child deaths and the significant people in their lives will be kept for the duration of the programme.
Further information regarding how the NCMD programme protects personal information can be found at Privacy notice - National Child Mortality Database (ncmd.info)

Protocol for Joint Working between Child Death Review Team (Health) and Coroners Service

The Coroners and Justice Act 2009 and Coroners (Investigations) Regulations 2013

i) Place a duty on coroners to inform the CDR Partners, for the area in which the child died, of the fact of an inquest or post mortem. It also gives coroners powers to share information with CDR Partners for the purposes of carrying out their functions, which include reviewing child deaths.

ii) Rule 57A allows coroners to supply information, at an appropriate time, that will enable CDR Partners to meet their obligation to conduct child death reviews and to fulfil their statutory obligations more generally.

This process is outlined in the statutory guidance document Working Together to Safeguard Children 2018.

This procedure is an appendix of the Southend Essex and Thurrock Procedure for responding to deaths in childhood and should be followed in conjunction with this guidance.

D1. The Paediatrician or GP contacts the Coroner's Office to report the child's death. Based on the information provided by the Paediatrician or GP the Coroners officer completes the Notification of Child Death form. This should be provided to the CDR Manager at the earliest opportunity within 24 hours of the child's death.

D2. A decision will be made between the Joint Agency Response team, Paediatrician and police representative whether a Joint Agency Response will be triggered and if a home visit will be undertaken. A Joint Agency Response team member is tasked with informing the assigned Coroner's officer to provide their contact details and inform them of the intention to undertake a Joint Agency Response and home visit. The Joint Agency Response team must also inform the Coroner's officer if a home visit is not considered appropriate and provide the reasoning for this decision.

D3. During the initial case discussion the Joint Agency Response team explicitly considers whether abuse or neglect is a factor in the child's death. If considered to be a factor the Joint Agency Response team will relay this information to the Coroner's officer.

D4. If the death is being treated as suspicious the Joint Agency Response team will form but the progress of the Joint Agency Response will be under the direction of the Joint Agency Response team police officer. The Joint Agency Response team police officer will maintain communication with the Coroner's officer in relation to the progress of the Joint Agency Response.

D5. When the Scene Visit is undertaken the Form G or Form H is completed by the Joint Agency Response team. This is then provided to the Coroner's officer usually by the Police officer. This must be provided to the Coroner's officer within 24 hours of the home visit because it is provided to the pathologist.

D6. On receipt of the Form G or Form H the Coroner's officer should inform the CDR Manager that it has been received and inform the CDR Manager of when the PM is planned and where this will be undertaken.

D7. The Coroner's officer will ensure that the Form G and any other additional information provided from the Joint Agency Response team is forwarded to the pathologist before the PM.

D8. It is expected that the Coroner's officer will be in close contact with the family. It is necessary for the Joint Agency Response team to be aware of any relevant information such as cultural needs and burial arrangements, if known at this stage. The link member of the Joint Agency Response team may contact the Coroner's officer prior to the scene visit to check whether this is known.

D9. The initial PM results become available. The Coroner's officer provides the results to the CDR Manager. On receipt of the initial PM findings the Joint Agency Response team will arrange the intermediate case discussion.

D10. The Coroner's officer informs the CDR Team (Health) if the parents have requested a copy of the PM and the intention to hold an inquest.

D11. When the PM report is available this is sent immediately to the CDR Team (Health) and uploaded to eCDOP. The final case discussion is arranged. In situations where the child died in Essex but resided in another authority area, the other authority area will make requests for PM reports and information directly with the Coroner's officer.

D12. The case is listed for discussion at the Child Death Overview Panel Meeting. The CDR Analysis Form is completed.

D13. Once the date for inquest is arranged the Coroner's officer informs the CDR Manager and the CDR Team (Health).

D14. Once the Inquest is heard the Coroner's officer provides the conclusion to the CDR Manager. In most cases the case will not be referred to Child Death Overview Panel until the Inquest has concluded.

Appendix E

SET CDR Process for undertaking a Joint Agency Response

Child Dies or Collapses in the Community

Child declared deceased at scene by appropriately qualified health professional.

Police immediate response. Police consider scene security. Address needs/ safeguarding of siblings/family

Unexpected collapse of child in the community.

Ambulance/Police immediate response; assess risks/concerns; resuscitate if appropriate. Police consider scene security; address needs/ safeguarding of siblings/family

↓

Robust strategy discussion between lead health professional and attending Police Officer, CDR Team Practitioner and Social Care if appropriate.

↓

Child taken to Emergency Department

Examination of child as per usual SET CDR Protocol

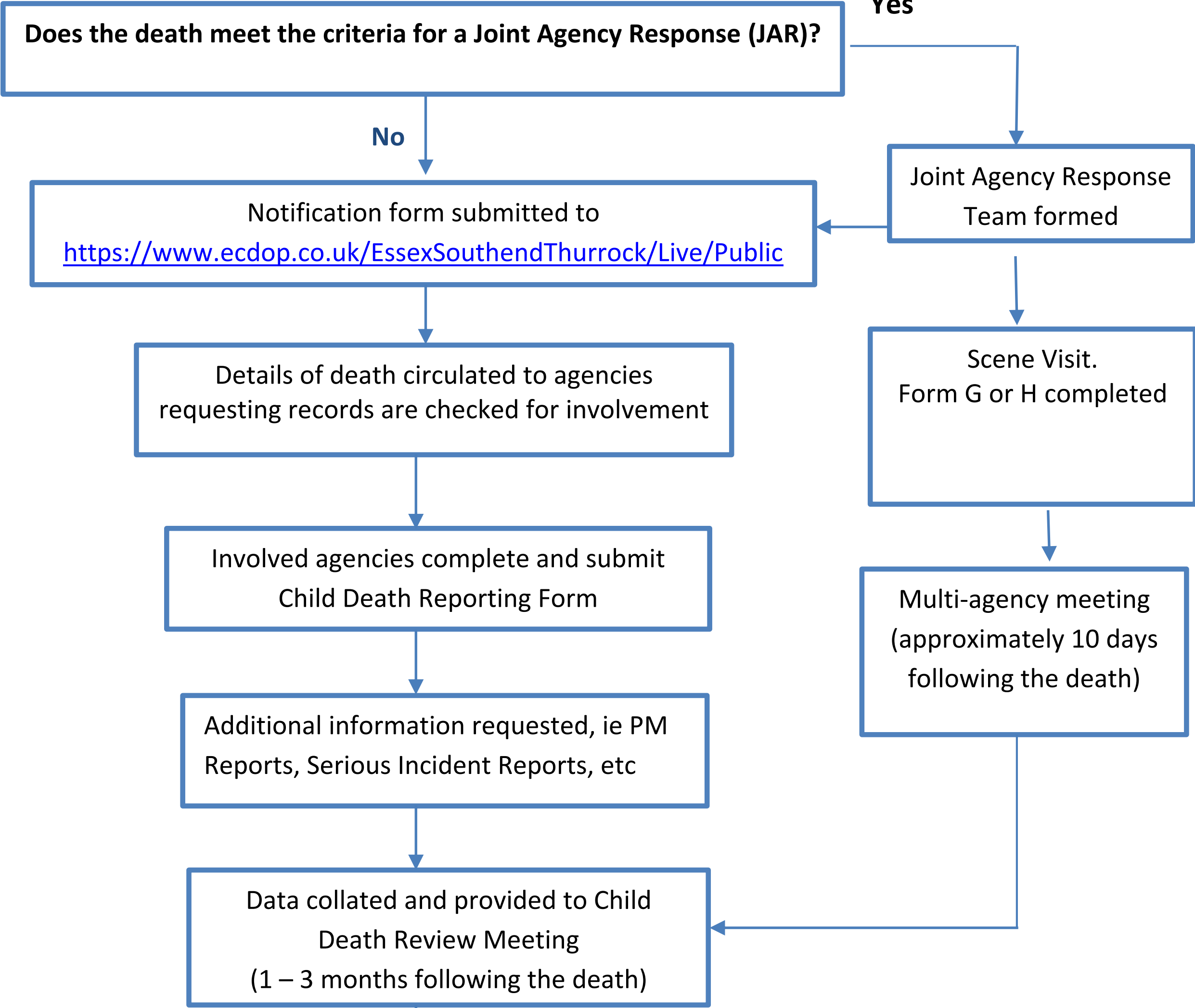
Coronavirus samples need to be taken in addition to the Kennedy samples

NB. Each hospital should risk assess any child who has died and conduct the examination and collections of samples in the most appropriate setting, whether this is in the Emergency Department or in the Mortuary

↓

Usual SET CDR process for deaths subject to a Joint Agency Response (See Appendix F)

Appendix F



[1] **Joint Agency Response** – Previously Rapid Response. To be undertaken in the case of a death due to external causes, or sudden with no apparent cause, or in custody, or suspicious circumstances, or stillbirth with no healthcare professional in attendance.

[1] **Child Death Review Meeting** – Multi-professional meeting where all matters relating to an individual child's death are discussed. Attended by professionals who were directly involved in the case of the child during his or her life, and any professionals involved in the investigation into his or her death. (source: CDR Statutory Guidance, October 2018)
This meeting will be chaired by the Child Death Review Health Response Team, except where a case has been subject to a JAR when the meeting will be chaired by a Designated Doctor or by Social Care.

[1] **Child Death Overview Panel** – Previously Local Child Death Review Panel. This is a multi-agency panel who will conduct an independent anonymous scrutiny of each child death. These meetings will be held monthly and will be chaired by a Public Health representative

[1] **Strategic Child Death Review Committee** – Previously Strategic Child Death Overview Panel.

Appendix G

Mid and South Essex
NHS Foundation Trust

East Suffolk and North Essex
NHS Foundation Trust

Family and Women's Service Health Group

Process for Initiating a Child Death Review Joint Agency Response following the unexpected death of a child.

Standard Operating Procedure (SOP) – version 5

Responsible Division	Family and Women's – Child Health
Version	5.1
Reviewer	Child Death Review Team (Health)
Date noted	04.09.2023
Noted by	Trust Policy Group
Issue Date	30.03.2023
Review date	July 2025
Target audience	All Consultant Paediatricians who are present or who have been informed of an unexpected child death across Essex, including Southend and Thurrock.

Signed…………………
Chair of Trust Policy Group

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1.0 QUICK REFERENCE GUIDE

It is the responsibility of the Designated Paediatrician (Child Death Review) or the on-call Consultant Paediatrician to know when and how to initiate a Joint Agency Response (JAR) using this Standard Operating Procedure (SOP) for reference.

This updated SOP details the immediate actions that should be taken after a child's death in line with the Child Death Review Statutory and Operational Guidance (England) published by HM Government in October 2018.

2.0 PURPOSE

It is the responsibility of the Designated Paediatrician (Child Death Review) or the on-call Consultant Paediatrician to know when and how to initiate and enable a Joint Agency Response; this document describes the SOP to be followed.

3.0 SCOPE

All Consultant Paediatricians who are present at or who have been informed of an **unexpected** child death across Essex, including Southend and Thurrock.

4.0 JOINT AGENCY RESPONSE (JAR)

A coordinated multi-agency response (Child Death Review Team Health professional, Police investigator, Duty social worker), should be triggered if a child's death:

- is or could be due to external causes;
- is sudden and there is no immediate apparent cause (including SUDI/C);
- occurs in custody, or where the child was detained under the Mental Health Act;
- where the initial circumstances raise any suspicions that the death may not have been natural; or
- in the case of a stillbirth where no healthcare professional was in attendance.

(The full process for a Joint Agency Response is set out in the SUDI/C Guidelines.)

4.1 Where there is uncertainty about whether the death of a child meets the criteria for a Joint Agency Response, the child death review team should convene a multi- agency discussion to consider the available information known at that time, reviewing it against the criteria above.

4.2 If doubt still exists following the multi-agency discussion advice from the Designated Paediatrician and the Coroner should be sought.
The Designated Paediatrician must decide on whether or not a Joint Agency

Response is required based on their professional judgement, the information available to them at the time and liaison with the Coroner.

4.3 If it is decided that the definition is met the process below must be followed in full. If it is agreed that the definition is not met the process for expected deaths must be followed.

4.4 The reasons for not proceeding with a Joint Agency Response must be documented as directed on the Notification of Child Death form (previously known as Form A)

4.5 All Child Death Notifications now need to be submitted online via the following link **https://www.ecdop.co.uk/EssexSouthendThurrock/Live/Public**

The Child Death Review Team (Health) service is available between the hours of:

08.30 – 19.00hrs Monday – Friday

10.00 – 14.00hrs Saturdays and Sundays

via 8x8: 01279 357996

5.0 DEFINITIONS

5.1 CDR – Child Death Review

5.2 CDOP – Child Death Overview Panel

5.4 CDR Team (Health) – Child Death Review Team (Health)

5.5 PAHT – Princess Alexandra Hospital Trust

5.6 SOP – Standard Operating Procedure

5.7 DGH – District General Hospital

5.8 JAR – Joint Agency Response

6.0 DUTIES

6.1 **The CDR Team (Health) Lead has responsibility for**:

- Dissemination of this SOP
- Implementing and monitoring compliance of the SOP by the Designated Dr and

Consultant Paediatrician's and other members of the CDR Team.

- Review and update of the SOP

6.2 **Designated Dr and Consultant Paediatricians have responsibility for:**

- Ensuring they meet the training standard

- Implementing the process described in the SOP

6.3 **All staff involved in the care and treatment of children have responsibility for**:

- Being aware of and supporting the implementation of the JAR process following the unexpected death of a child.

7.0 PROCESS

7.1 **Initially**

- Once the child has been declared deceased the Consultant Paediatrician will contact the Essex Police Control Room on 101; request Detective Inspector on call For Public Protection for that area.
- Contact Essex Coroner's Office at coroner@essex.gov.uk or on 03330 135000

7.2 **Essex Police / HM Coroner**

- Control room personnel / Coroner's Officer will take all required details. For this phone call the following details must be to hand:
- Name and address of the child
- Date and time of death of the child
- Contact details for the child's family
- Direct contact details for the referring Consultant Paediatrician

This document only covers the 5 District General Hospitals in Southend, Essex and Thurrock

7.3 **The on-call duty Detective Inspector will then liaise directly with the Consultant Paediatrician and the CDR Team (Health).**

The attending Consultant / Paediatrician is required to complete an online Notification

of Child Death form via the following link
https://www.ecdop.co.uk/EssexSouthendThurrock/Live/Public

7.4 The Consultant Paediatrician will take the relevant Kennedy samples / investigations from the child as directed by HM Coroner (Appendix 2)

8.0 If the child has died within a working day as detailed above

8.1 A strategy discussion with the Detective Inspector will take place at the time of the phone call.

8.2 The Detective Inspector will be responsible for contacting the CDR Team (Health) by calling: 01279 357996

8.3 From this phone call the CDR Team (Health) will either attend the relevant hospital or arrange the joint home visit with the Detective Inspector who will inform the family.

8.4 The Consultant Paediatrician will give written information to the child's parents and verbal explanation that the CDR Team (Health) will be contacting them directly within 24 hours. (Appendix 3)

8.5 If the referring Consultant is unable to attend the face to face meeting with the CDR Team (Health) he/she will nominate a named colleague to facilitate discussion.

9.0 If the child dies out of hours

9.1 All the initial procedure must be followed and the Detective Inspector will be responsible for contacting the CDR Team by calling 01279 357996 during their service provision hours.

The Child Death Review Team (Health) service is available, by calling 01279 357996, during these hours:

08.30 – 19.00hrs Monday – Friday
10.00 – 14.00hrs Saturdays and Sundays

10.0 Support for the bereaved

The CDR Team (Health) will provide the families with a single point of contact, who can provide information on the child death review process, and who can signpost them to sources of support.
Families will be able to contact a CDR Team (Health) member during normal working hours on 01279 357996

10.1 **Main Responsibilities**

- Be a reliable and readily accessible point of contact for the family after the death
- Help co-ordinate meetings between the family and professionals as required
- Ability to provide information on the child death review process and the course of
  any investigations pertaining to the child, including liaising with the coroner's officer
  and any police family liaison officer
- Represent the 'voice' of the parents at professional meetings, ensure that their questions are effectively addressed, and to provide feedback to the family afterwards
- Signpost to expert bereavement support if required

11.0 REFERENCES

Child Death Review Statutory and Operational Guidance (England)
HM Government Cabinet Office Publication date: September 2018
(This publication is available for download at www.official-documents.gov.uk)

Sudden unexpected death in infancy and childhood
Multi-agency guidelines for care and investigation 2nd edition (2016)
The Royal College of Pathologists

Working Together to Safeguard Children (2018)

Children and Social Work Act (2017).

Southend, Essex & Thurrock Procedure for responding to Deaths in Childhood (2021)

MMBRACE – UK Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Human Rights Act 1998

12.0 RELATED TRUST POLICIES

Information Governance Policy

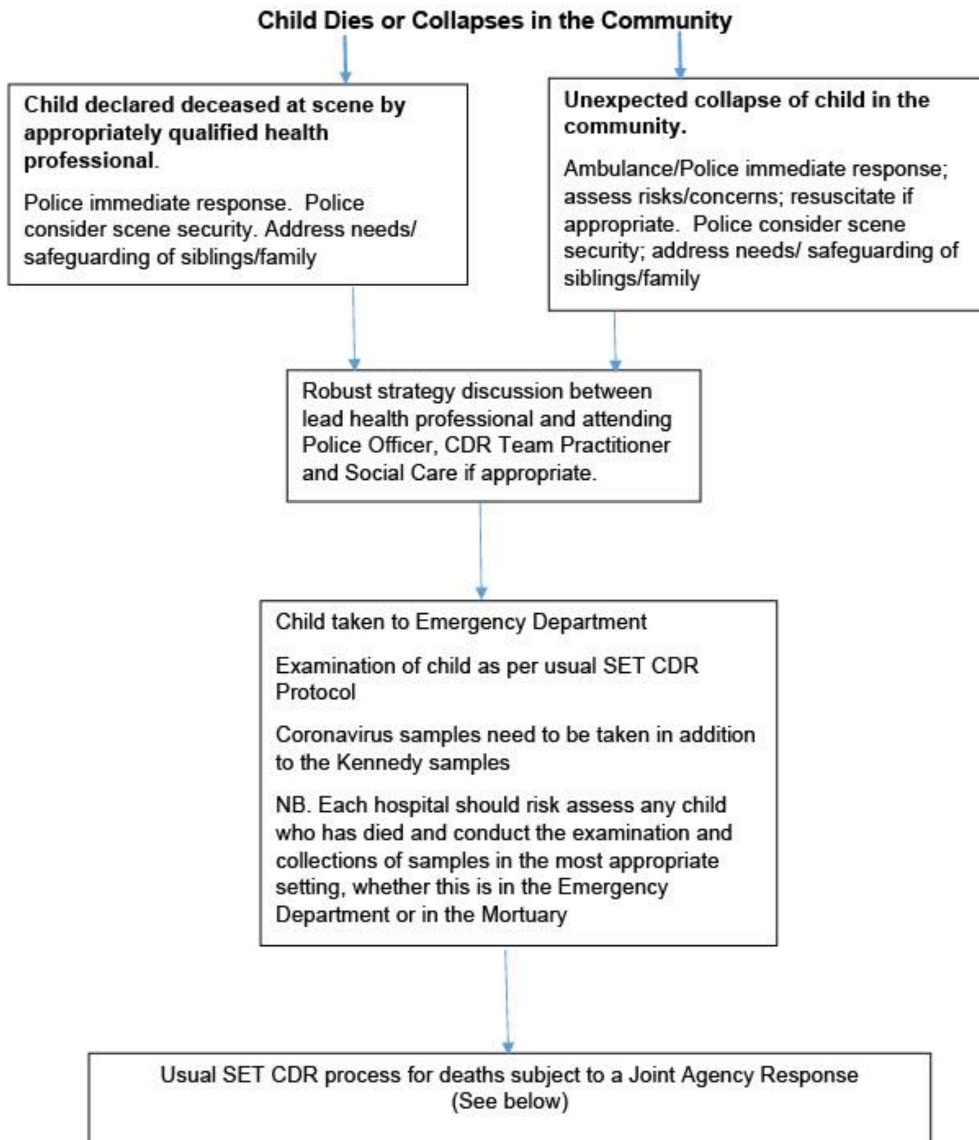
Safeguarding of Adults at Risk of Abuse Policy

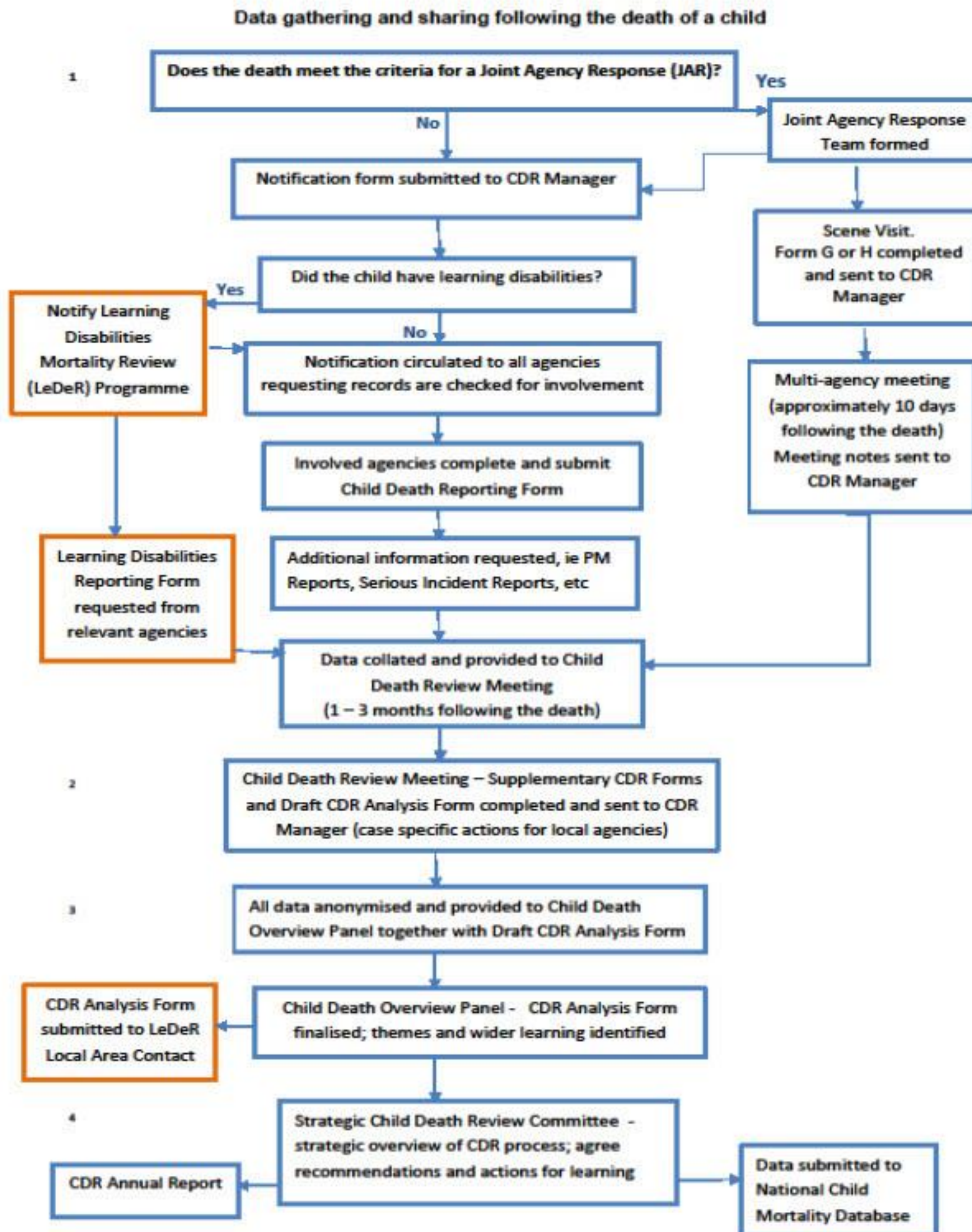
Safeguarding Children and Young People Policy

Incident Manager Policy

Procedure Risk Management Strategy

APPENDIX 1: SET CDR Process for undertaking a Joint Agency Response





2

= Orange coloured boxes indicate process to be followed in the event of a death where the child was aged 4 years or over, had (or very likely to have had) learning disabilities, and was living in England

[1] **Joint Agency Response** – Previously Rapid Response. To be undertaken in the case of a death due to external causes, or sudden with no apparent cause, or in custody, or suspicious circumstances, or stillbirth with no healthcare professional in attendance.

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[1] **Strategic Child Death Review Committee** – Previously Strategic Child Death Overview Panel

Appendix 2: GUIDANCE FOR COLLECTING SAMPLES/SPECIMENS FOLLOWING

SUDDEN UNEXPECTED DEATHS

The following table shows the various investigations that MAY be initiated during the process of resuscitation or taken after death is confirmed. The taking of these samples, and ONLY these samples, has been agreed with the Essex Coroner.

Where the cause of death / collapse or factors contributing to it are uncertain, investigative samples should be taken immediately on arrival and after death is confirmed. Full guidance is provided to hospital staff on the taking of samples in the agreed hospital trust.
To ensure the widest range of information is available to assist with identifying the cause of death it is expected that an attempt should be made to take all samples listed within this Protocol unless this is physically or practically impossible.
Blood samples should be taken from a peripheral vein (e.g. femoral vein). Cardiac puncture should be avoided as this may cause damage to intrathoracic structures and make post-mortem findings difficult to interpret.
Consideration of conducting a full skeletal survey for all children before the post-mortem examination, in accordance with the guidance in paragraph 11 on the next page.

Sample	Send to	Handling	Test
Blood cultures – Aerobic and anaerobic 1 ml	Microbiology	If insufficient blood, aerobic only	Culture and sensitivity
Blood from Guthrie card	Clinical Chemistry	Normal (fill in card; do not put into plastic bag)	Inherited metabolic diseases
Cerebrospinal Fluid (CSF) (a few drops)	Microbiology	Normal	Microscopy, culture and sensitivity
Nasopharyngeal Aspirate	Virology	Normal	Viral cultures, immuno-fluorescence and DNA amplification techniques*
Nasopharyngeal Aspirate	Microbiology	Normal	Culture and sensitivity
Swabs from any identifiable lesions	Microbiology	Normal	Culture and sensitivity
Urine (if available	Microbiology	Normal	Culture and sensitivity

* Samples must be sent to an appropriate virological laboratory

The Coroner has also provided permission for the following samples to be taken but these are not considered routine samples but can be taken if it is considered appropriate

Sample	Send to	Handling	Test
Blood (serum) 1-2 ml	Clinical Chemistry	Spin, Store serum at -20°C	Toxicology
Blood (Lithium heparin) 1-2 ml	Cytogenetics	Normal – keep unseparated	Chromosomes (if dysmorphic)

Paragraph 11:

Consideration should always be given to undertaking a skeletal survey for children especially where there is evidence to suggest that the death is suspicious. The survey will be undertaken at the place of post mortem unless it is suspected that the child has been subject to a non-accidental injury and there are other children in the household who may be at risk. In these circumstances if waiting for the post mortem will lead to unacceptable delay (more than 24 hours) arrangements should be made, following discussion with the Coroner, to undertake the survey on site.

APPENDIX 3

Parent Information Pack following the Unexpected Death of a Child

The following information pack will be given to the parents before they leave the hospital, these packs will be available in all Paediatric / Adult A&E departments, Children's Wards, ITU's and NICU's for local distribution.
The CDR Team will be responsible for the supplies of the patient information packs; if further packs are required please contact the CDR Team (Health) on 01279 357996

The pack will contain:

Contact Details for Child Death Review Team (Health)

Child Death Review Information Booklet

The white envelope containing information is in the back

of the white folders and need to be given to parents

before leaving the department.

APPENDIX 4 – VERSION CONTROL SUMMARY

Document Title: Process for initiating the Child Death Review Joint Agency Response SOP

Version Number	Purpose / Changes	Author	Date Changed
3	Updated as expires 02/18	Andrea Brewis	January 2018
4	Implementation of new Statutory and Operational Guidance October 2018	Andrea Brewis	April 2019
4a	Child Death Notification amended by ESCB on 3.7.19	Andrea Brewis	July 2019
5	Updated as expires 03/22 Updated logos Page 1 Email notification updated Page 4 and 5	Andrea Brewis	April 2022

APPENDIX 5 - CHECKLIST FOR PROCEDURAL DOCUMENTS

Document Title and Version No.	**Process for initiating the Child Death Joint Agency Response SOP V5**

	Yes/No/ Unsure	**Comments**
Title		
Is the title clear and unambiguous?	Yes	
Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
1. Rationale		
Are reasons for development of the document stated?	Yes	
2. Development Process		
Is the method described in brief?	Yes	
Are individuals involved in the development identified?	Yes	
Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
Is there evidence of consultation with stakeholders and users?	Yes	
3. Content		
Is the objective of the document clear?	Yes	
Is the target population clear and unambiguous?	Yes	
Are the intended outcomes described?	Yes	
Are the statements clear and unambiguous?	Yes	
4. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Yes	
Are key references cited?	Yes	
Are the references cited in full	Yes	
Are local/organizational supporting documents referenced	N/a	
5. Approval		
Does the document identify which committee/group will approve it?	Yes	
If appropriate, have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	

6. Dissemination and Implementation	
Is there an outline/plan to identify how this will be done?	Yes
Does the plan include the necessary training/support to ensure compliance	Yes
7. Document Control	
Does the document identify where it will be held?	Yes
Have archiving arrangements for superseded documents been addressed?	Yes
8. Process for Monitoring Compliance	
Are there measurable standards or KPIs to support monitoring compliance of the document?	Yes
Is there a plan to review or audit compliance with the document?	Yes
9. Review Date	
Is the review date identified?	Yes
Is the frequency of review identified? If so, is it acceptable?	Yes
10. Overall Responsibility for the Document	
Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the documentation?	Yes

Completed by			
Name	Andrea Brewis	Date	7.4.2022
Job Title	Child Death Review Team (Health) Lead		

Acknowledgement: Cambridgeshire and Peterborough Mental Health Partnership NHS Trust

APPENDIX 6 - EQUALITY IMPACT ASSESSMENT

<table>
<tr><td colspan="5">The organisation aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Assessment Tool is designed to help you consider the needs and assess the impact of your policy.</td></tr>
<tr><td>Name of Document:</td><td colspan="4">Process for initiating the Child Death Joint Agency Response SOP V5</td></tr>
<tr><td>Completed by:</td><td colspan="4">Andrea Brewis</td></tr>
<tr><td>Job Title:</td><td>Child Death Review Team (Health) Lead</td><td>Date:</td><td colspan="2">7.4.2022</td></tr>
</table>

		Yes/No
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**	N
	• Race	N
	• Ethnic origins (including gypsies and travellers)	N
	• Nationality	N
	• Gender (including gender reassignment)	N
	• Culture	N
	• Religion or belief	N
	• Sexual orientation	N
	• Age	N
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	N
2.	**Is there any evidence that some groups are affected differently?**	N
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**	N
4.	**Is the impact of the document/guidance likely to be negative?**	N
5.	**If so, can the impact be avoided?**	N
6.	**What alternative is there to achieving the document/guidance without the impact?**	N
7.	**Can we reduce the impact by taking different action?**	N

<table>
<tr><td colspan="2">If you have identified a potential discriminatory impact of this procedural document or the answer to any of the above is Yes, please refer it to the Head of Patient Experience, Tel 01279 444455 – Extn 2358 complaints@pah.nhs.uk , together with any suggestions as to the action required to avoid/reduce this impact. In this case, ratification of a procedural document will not take place until approved by the Head of Patient Experience.</td></tr>
<tr><td>Date of approval by Head of Patient Experience:</td><td>Evidence of approval must be available if requested</td></tr>
</table>

APPENDIX 7 - DATA PRIVACY IMPACT SCREENING TOOL

<table>
<tr><td colspan="4">Data Protection impact assessments (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet individual's expectations of privacy. The first step in the DPIA process is identifying the need for an assessment.
The following screening questions will help decide whether a DPIA is necessary. Answering 'yes' to any of these questions is an indication that a DPIA would be a useful exercise and requires senior management support, at this stage the Information Governance Manager must be involved.</td></tr>
<tr><td>Name of Document:</td><td colspan="3">Process for initiating the Child Death Joint Agency Response SOP V5</td></tr>
<tr><td>Completed by:</td><td colspan="3">Claire jakes</td></tr>
<tr><td>Job title</td><td>Lead Nurse PSQ Child health</td><td>Date</td><td>27.5.22</td></tr>
<tr><td colspan="3"></td><td>Yes or No</td></tr>
<tr><td colspan="3">1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.</td><td>No</td></tr>
<tr><td colspan="3">2. Will the process described in the document compel individuals to provide information about themselves? This is information in excess of what is required to carry out the process described within the document.</td><td>No</td></tr>
<tr><td colspan="3">3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?</td><td>No</td></tr>
<tr><td colspan="3">4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?</td><td>No</td></tr>
<tr><td colspan="3">5. Does the process involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.</td><td>No</td></tr>
<tr><td colspan="3">6. Will the process result in decisions being made or action taken against individuals in ways which can have a significant impact on them?</td><td>No</td></tr>
<tr><td colspan="3">7. Is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.</td><td>No</td></tr>
<tr><td colspan="3">8. Will the process require you to contact individuals in ways which they may find intrusive?</td><td>No</td></tr>
<tr><td colspan="4">If the answer to any of these questions is 'Yes' please contact the Information Governance Manager, Tel: 01279 444455 - Extn: 1032 tracy.goodacre@nhs.net. In this case, ratification of a procedural document will not take place until approved by the Information Governance Manager.</td></tr>
<tr><td>IG Manager approval Name:</td><td colspan="3"></td></tr>
<tr><td>Date of approval</td><td colspan="3"></td></tr>
</table>

Appendix H

Examination Proforma to be completed by the Lead Consultant in all cases of Unexpected Death of an Infant or Child

- The whole child is to be examined including the back, inside the mouth and the anogenital region.
- Measure any injuries with a tape measure from a fixed anatomical bony point. Describe in words as well as giving a pictorial representation of the images on the body maps. Include size, appearance, swelling, or discoloration. Be concise and consistent in these details. Look for signs of neglect
- Draw and describe all cutaneous injuries on diagrams.
- Discuss photography with Police

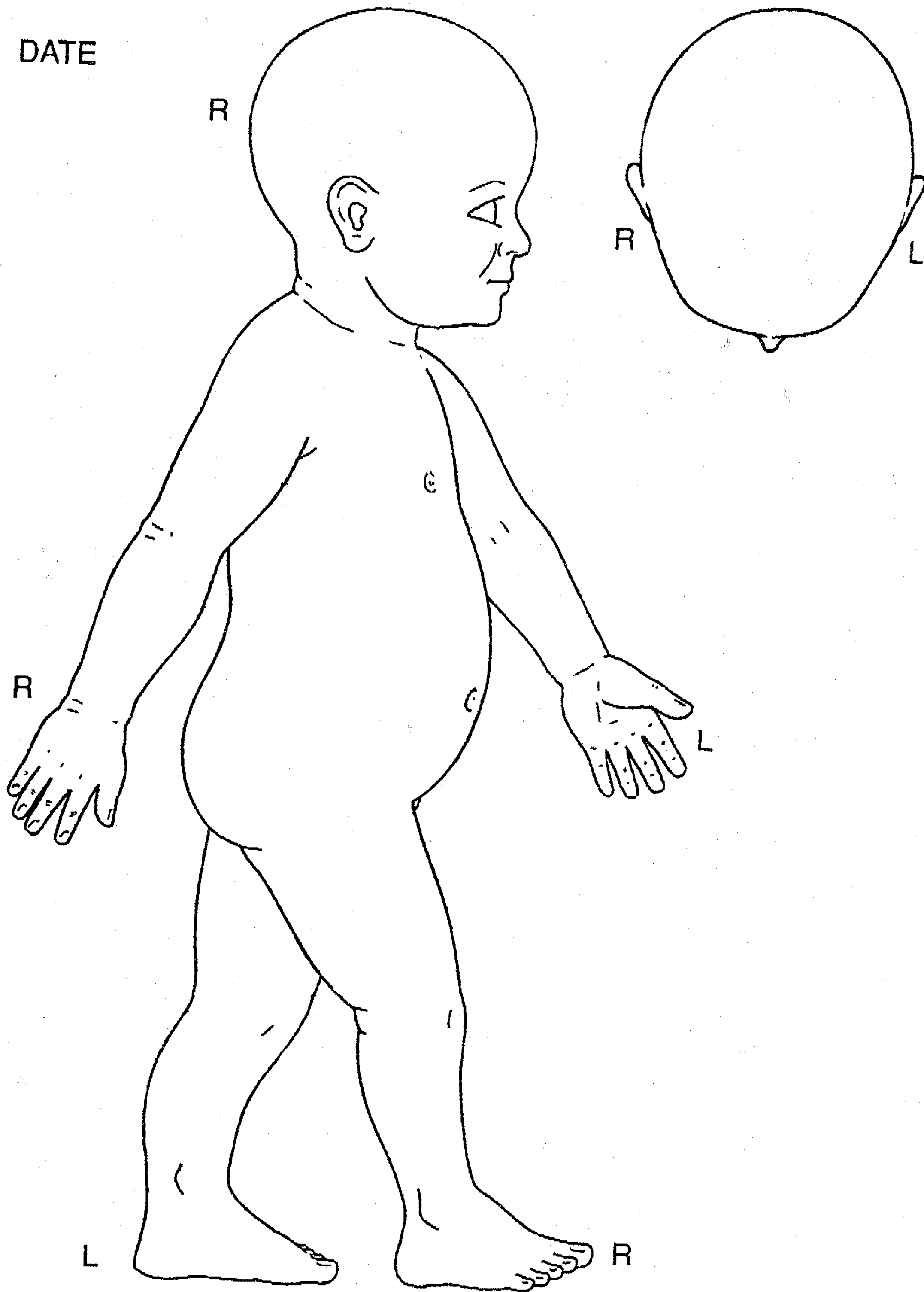
Child's Name:
Examination by:
Date:
Time:

General condition including cleanliness	
Clothes	
Hair/Nails	
Nappies/Rash	
Teeth	

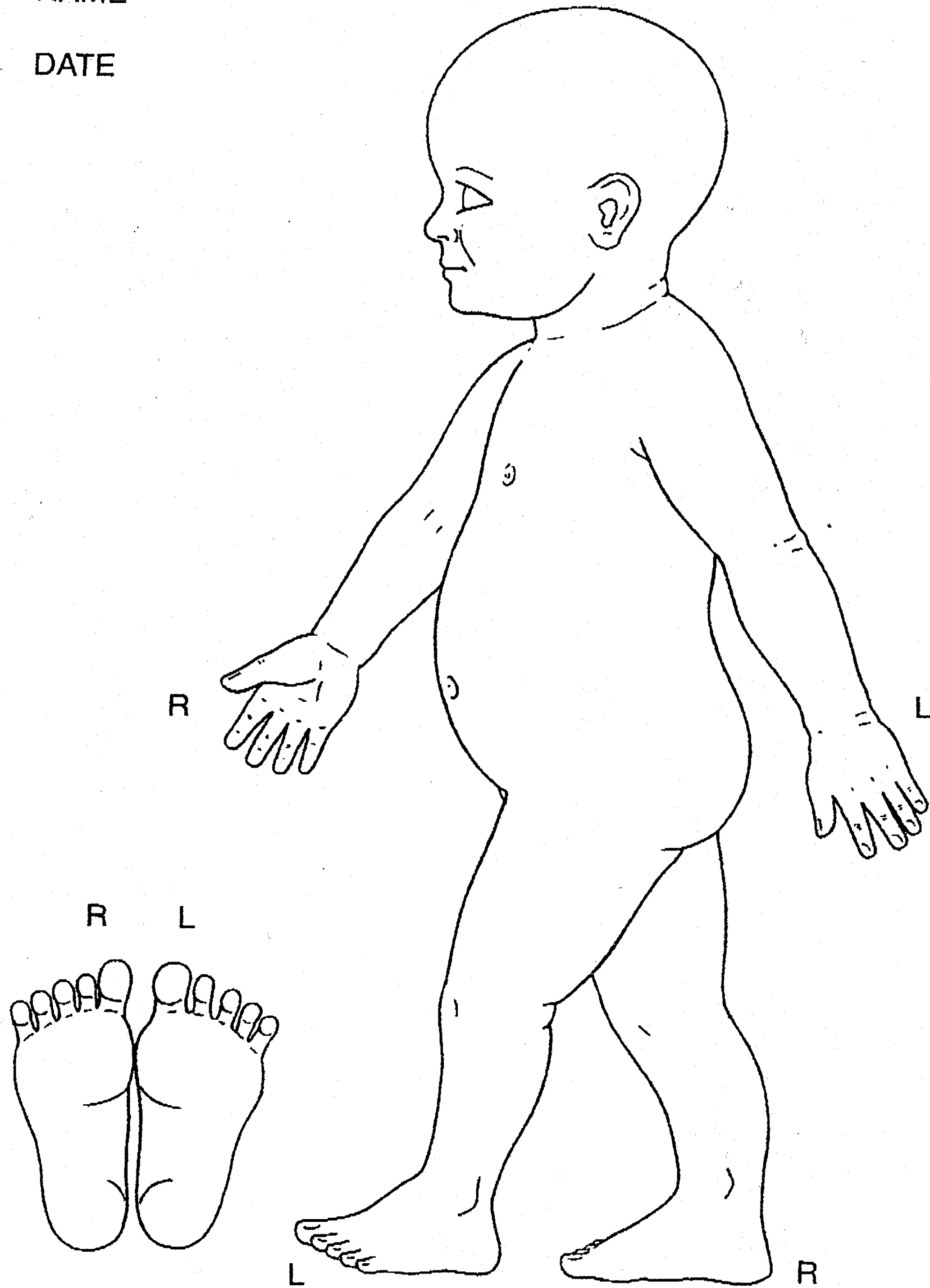
Height cm centile	Weight kg centile	OFC cm centile

Mouth including frenulae
ENT

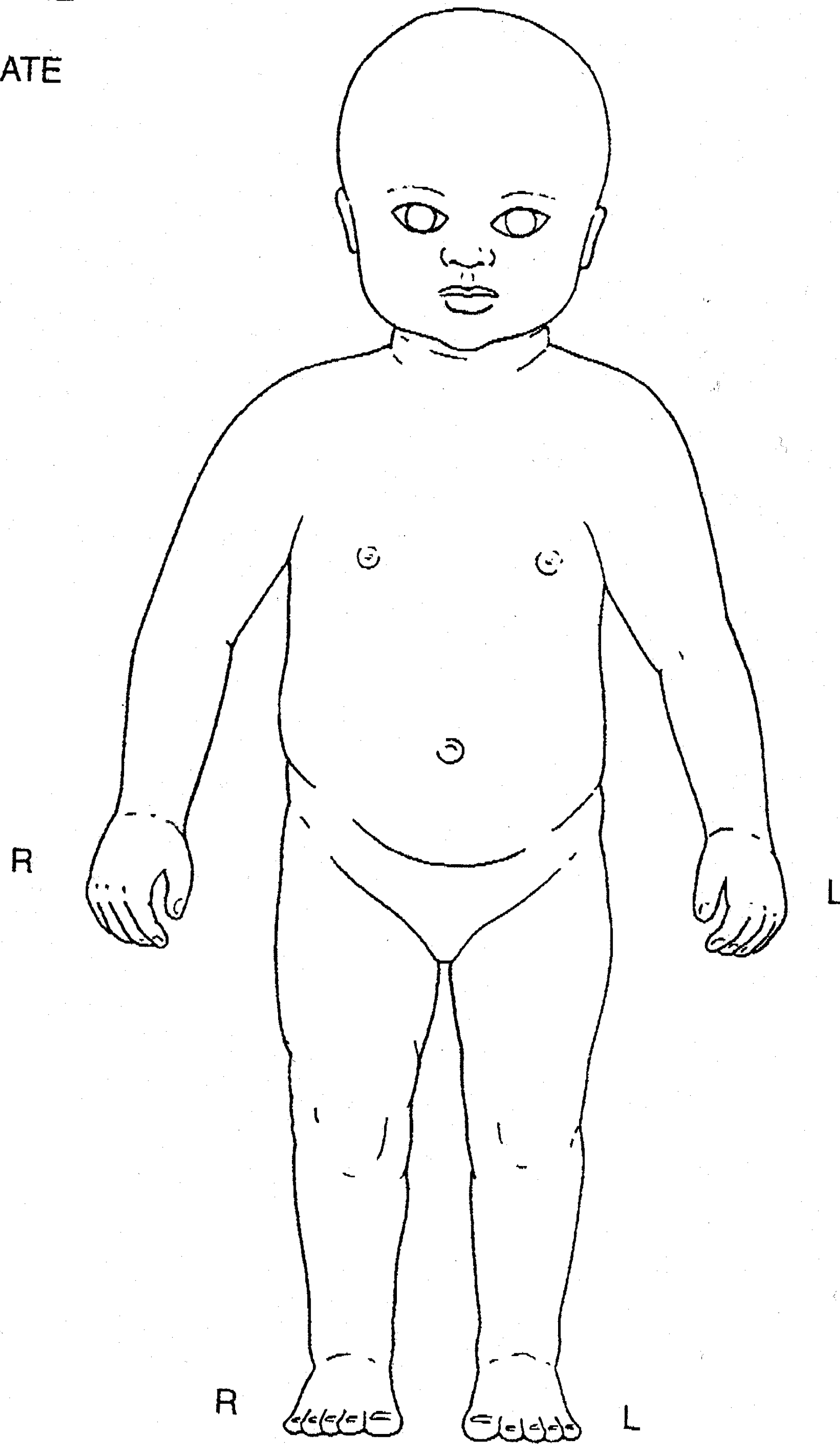
Thorax
Abdomen
Limbs



Name of examining doctor:	
Signature of examining doctor:	
Time:	
Date:	



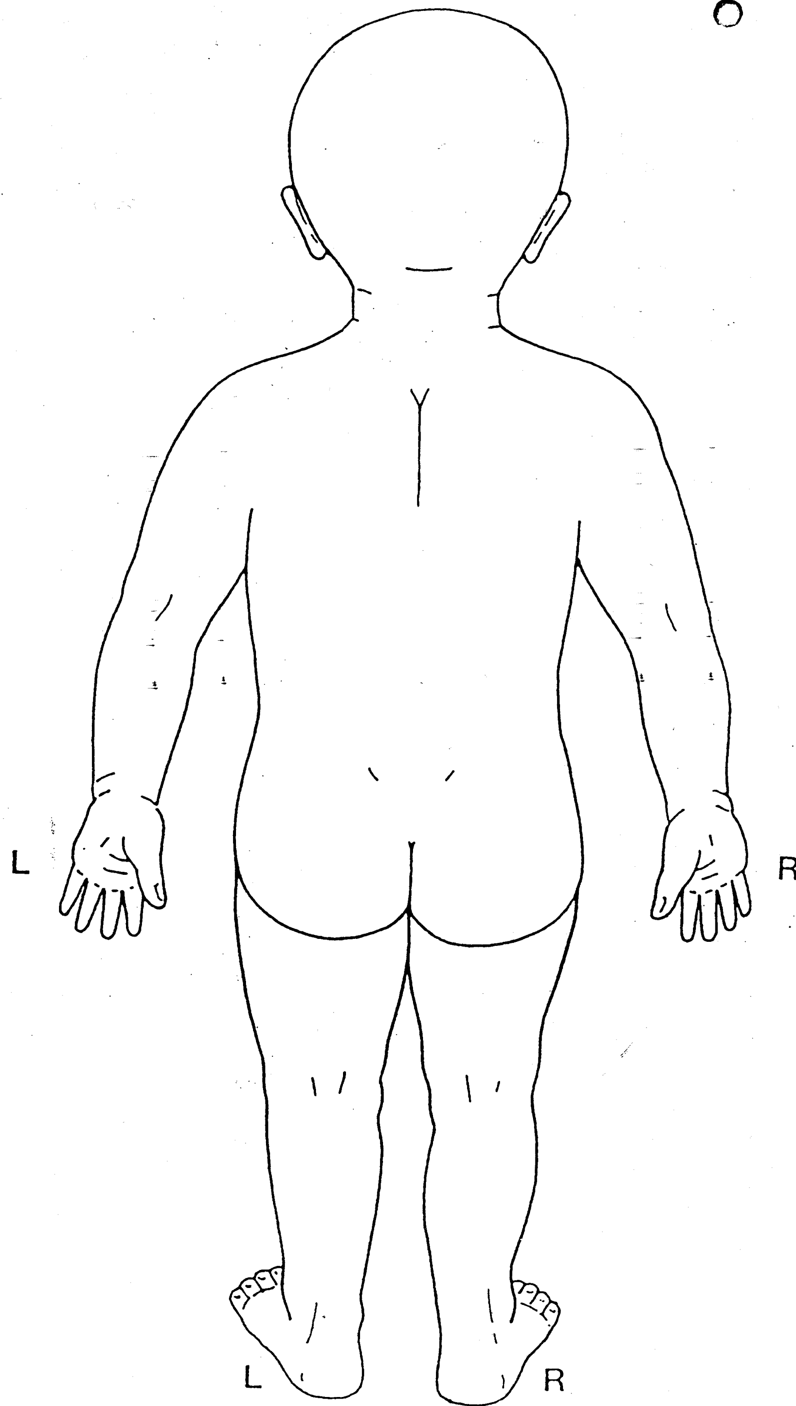
Name of examining doctor:	
Signature of examining doctor:	
Time:	
Date:	



Name of examining doctor:	
Signature of examining doctor:	
Time:	
Date:	

NAME

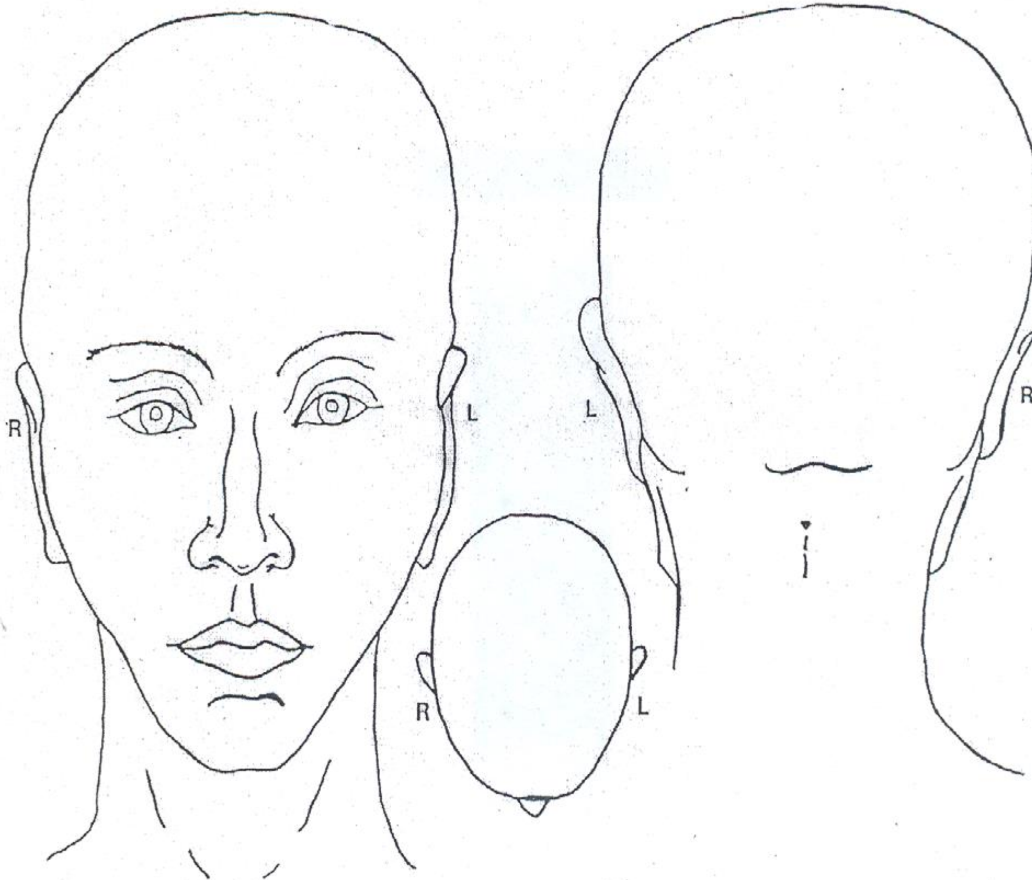
DATE



NAME OF EXAMINING DOCTOR:	
SIGNATURE OF EXAMINING DOCTOR:	
Time	
Date:	

NAME

DATE

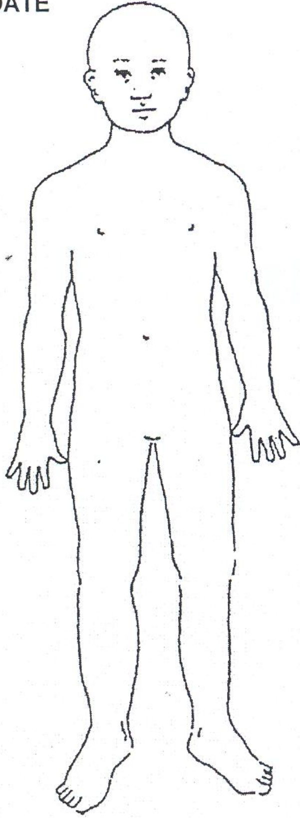


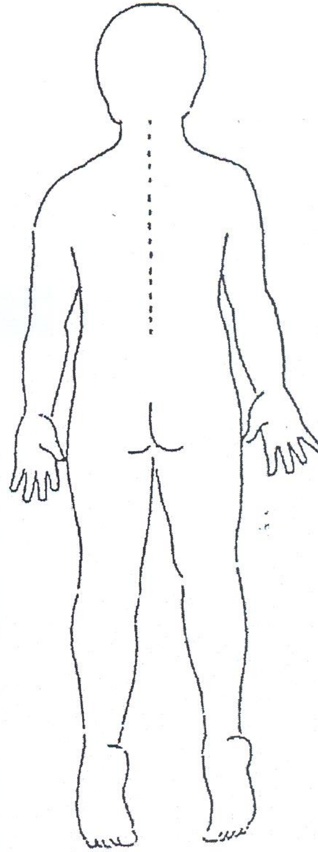
NAME OF EXAMINING DOCTOR:	
SIGNATURE OF EXAMINING DOCTOR:	
Time	
Date:	

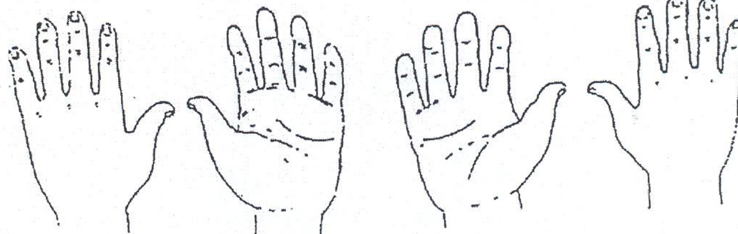
Revised: June 2009
Review: Sept 2009

NAME

DATE





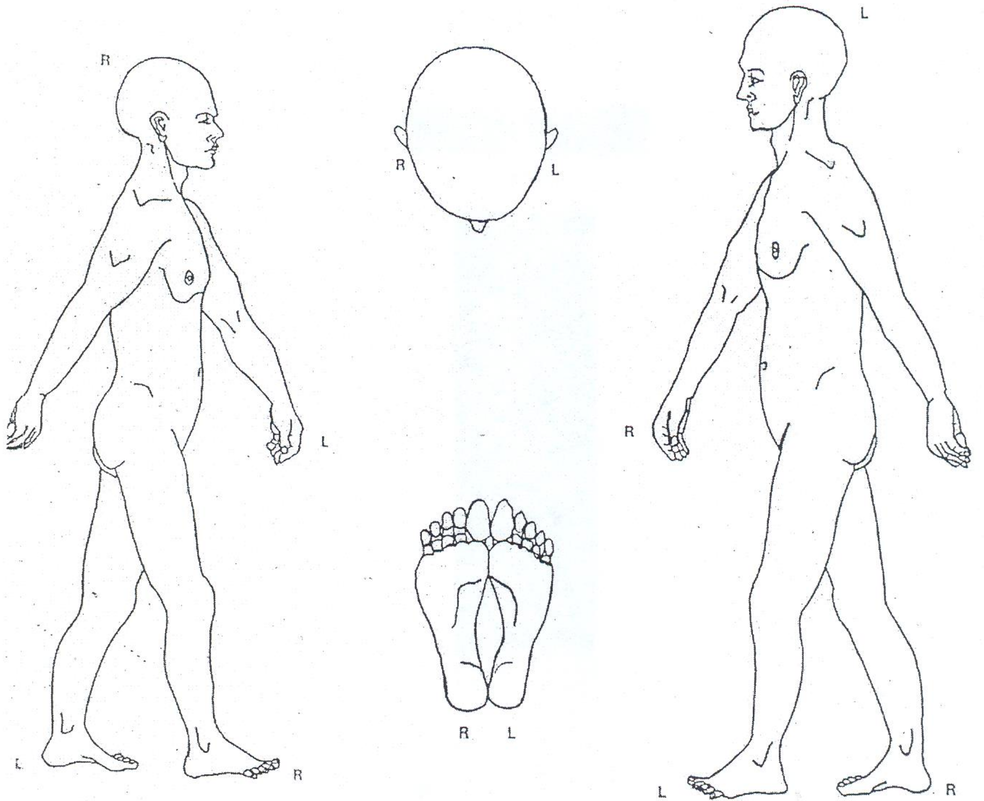


NAME OF EXAMINING DOCTOR:	
SIGNATURE OF EXAMINING DOCTOR:	
Time	
Date:	

Revised: June 2009
Review: Sept 2009

NAME

DATE



NAME OF EXAMINING DOCTOR:	
SIGNATURE OF EXAMINING DOCTOR:	
Time	
Date:	

Revised: June 2009
Review: Sept 2009

Appendix I

Role and Competencies for Designated Doctor for Child Death

Core Competencies

• Takes a lead role in ensuring robust healthcare arrangements are in place for the investigation of deaths requiring a Joint Agency Response and in providing expert advice for professionals involved in Child Death Reviews.

• Takes a strategic lead across healthcare services on all aspects of Child Death Review, working closely with all other agencies involved, including (but not limited to) Medical Examiners, Coroners, Social Care, Police, Public Health and Education staff.

• Supports provider Trusts to establish effective processes for Child Death Reviews in line with statutory guidance.

• Provides specialist advice and guidance to the Child Death Overview Panel and wider organisations and agencies on all matters relating to child mortality and Child Death Reviews.

• Takes a lead role in supporting the Child Death Overview Panel to ensure robust processes are in place across healthcare services to learn lessons identified within Child Death Reviews.

• Provides independent expert advice and guidance, aiming to continually improve the quality of Child Death Reviews to improve health outcomes for all children.

• Provides expert advice to service planners and commissioners and Child Death Review Partners, ensuring all services commissioned meet the statutory requirements as set out in Child Death Reviews: Statutory & Operational Guidance England (2018).

• Champions coordination of health economy contribution to the Child Death Review process across the local area.

• Takes a lead role in coordinating responses and health input to the child death review process, across the local area.

• Ensures that training needs analysis is undertaken, and works with commissioners and multiagency partners to plan, design, deliver, and evaluate Joint Agency Response & Child Death Review single and inter-agency training and teaching for staff involved in the CDR process across healthcare services and beyond.

• Leads/oversees/contributes to quality assurance and improvement in Child Death Reviews across healthcare services.

• Works closely and collaboratively with other members of the Child Death Review team.
• Provides, supports, and ensures contribution to appraisal and appropriate supervision for colleagues working within Child Death Review.