Gloucestershire Child Death Overview Panel

Gloucestershire Child Death Review Published Arrangements (Protocol) 2024

Incorporating the Acute Life Threatening Event (ALTE) Process

A Joint Agency Protocol for Gloucestershire

Produced by CDOP on behalf of
Gloucestershire Safeguarding Children Partnership (GSCP)

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Document Details

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Acknowledgement

This protocol is based on a version produced by Dorset Safeguarding Children Board in 2007 and the version produced for Gloucestershire September 2008.

Amendments made to this document version

Date	Section	Page/s
January 21	Whole document due to rebranding to GSCP	
April 21	Whole document – annual review	
June 21	Update of Skeletal Survey, Movement of Body and ME pages	
August 22	Whole document review	
October 23	Whole document review	
September 24	Whole document review	

This protocol:

- Relates to the county of Gloucestershire, covered by the Gloucestershire Safeguarding Children Partnership (GSCP) and as such is to be adhered to by all agencies.
- Should be applied to all deaths from infancy (20+0 weeks gestation) where the baby has gasped (but excludes live born terminations) to all children and young people less than 18 years of age.
- Can be applied in other circumstances e.g. in dealing with a child who has suffered an Acute Life Threatening Event (ALTE).

Abbreviations

ALTE	Acute Life Threatening Event
CAIT	Child Abuse Investigation Team
CSC	Children's Social Care
CDOP	Child Death Overview Panel
CDR	Child Death Review
CDRC	Child Death Review Coordinator
CDRT	Child Death Review Team
DD	Designated Doctor for Child Death ED Emergency Department
EDT	Emergency Duty Team (Social Care)
FCR	Final Case Review
GP	General Practitioner
GRH	Gloucestershire Royal Hospital
GHT	Gloucestershire Hospital Trust
GSCP	Gloucestershire Safeguarding Children Partnership
GSEP	Gloucestershire Safeguarding in Education Partnership
ICB	Integrated Care Board
ICD	Initial Case Discussion
LNCD	Lead Nurse for Child Death
MASH	Multi Agency Safeguarding Hub
PPU	Public Protection Unit
ROLE	Record of Life Extinct
SIO	Senior Investigating Officer
SUDI	Sudden Unexpected Death in Infancy
SUDIC	Sudden Unexpected Death in Childhood
SOCO	Scenes of Crime Officers
SWASFT	South West Ambulance Service Foundation Trust

Child Death Review Process

Introduction

Each death of a child is a tragedy for his or her family (including any siblings), and subsequent enquiries/investigations should keep an appropriate balance between forensic and medical requirements and the family's need for support. A minority of unexpected deaths are the consequence of abuse or neglect or are found to have abuse or neglect as an associated factor. In all cases, enquiries should seek to understand the reasons for the child's death, address the possible needs of other children in the household, the needs of all family members, and other children well known to the child. It should also consider any lessons to be learnt about how best to safeguard and promote children's welfare in the future.

This is a mandatory process (*Working Together to Safeguard Children, 2023*) and has provided the opportunity to establish a standardised approach to the management of a child's death and to identify further support to the family.

General Principles

- The Child Death Review Process provides a systematic multi agency reviewof all deaths in childhood up to 18 years of age (excludes live born terminations).
- The aim of the review is to:-
    a) establish the cause of death in conjunction with the coroner.
    b) identify contributing factors,
    c) support the family.

Deaths can be classified as Unexpected, Expected and Neonatal

All deaths in childhood are anonymized and reviewed at the multi-agency Child Death Overview Panel (CDOP). This enables any child death trends to be identified and learning to be disseminated.

Category of Death

Unexpected child deaths are defined as the death of a child that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death. This includes children and young people with disabilities or life limiting illnesses, children and young people who die in road traffic accidents, by drowning etc. and children who are admitted to a hospital ward and subsequently die unexpectedly in hospital.

Expected child deaths are defined as a child with a life limiting condition (Advanced Care Plan usually in place) or in a hospital/hospice and are anticipated to die.

Neonatal deaths are defined as babies born that die within 28 days of birth of any cause or for the purposes of this process a baby who dies that has not left hospital since birth (excluding live born terminations).

Statutory Role of the Child Death Review Process

If at any point in the investigation or review of the child's death there are safeguarding concerns about surviving children living in the household, Children's Social Care should take the lead. The Police will be the lead agency for any criminal investigation. The CDRT will maintain a close link with the GSCP.

eCDOP Forms

Three standard forms should be used in the child death review process:

Notification Form complete electronically via eCDOP for initial notification of a death to CDR partners;
https://www.ecdop.co.uk/Gloucestershire/Live/Login
For guidance on completing this form click here

Reporting Form complete electronically via eCDOP for gathering information from agencies or professionals who have information relevant to the case. Email will be sent to relevant professionals via Holistix eCDOP (check your Junk Inbox). Reporting forms should be completed by the relevant responsible professional and shared with the relevant CDOP.
For guidance on completing this form click here

Analysis Form initially drafted via eCDOP at the CDRM and finalised at CDOP for evaluating information and identifying lessons to be learned. The Analysis is the final output of the Child Death Review Process.

These forms should **not be copied or stored in the child's record**, but will be retained electronically as part of the Child Death Review Process.

Guides for completing these forms can be found on the Child Death Review pages for Gloucestershire Click here

For Notification or Reporting Form queries please use the contact details below –

Child Death Review Coordinator cdop@gloucestershire.gov.uk

Notification of a Child Death to Trusts and Agencies

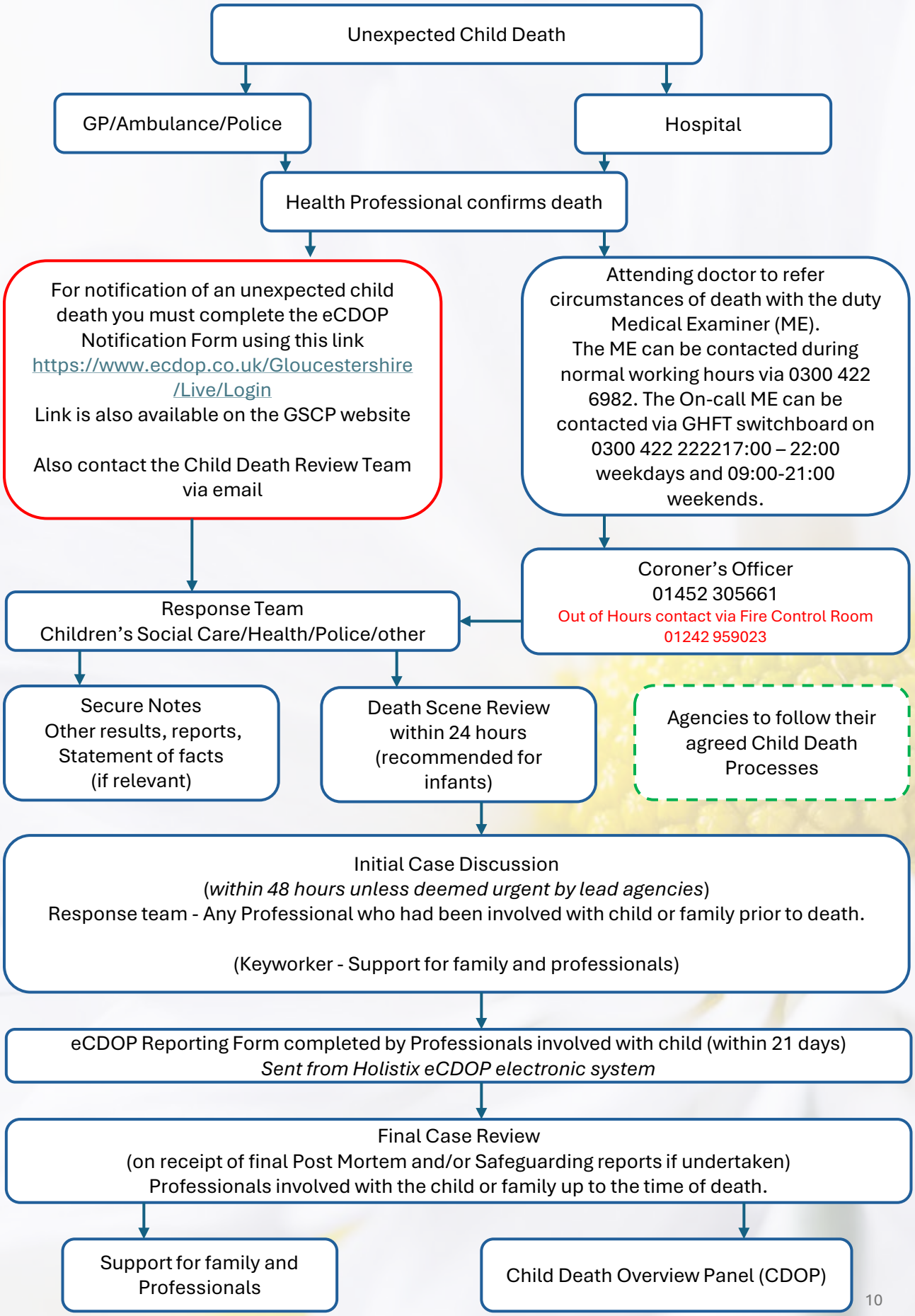
Once notification of a child death has been made through eCDOP to the Child Death Reviews Coordinator, Trusts and Agencies will be informed through the eCDOP notification process. Individual Trust and Agencies will then share this information through their own internal cascade as per their own child death review policy.

Case Specific Notifications to Professionals Involved with the Child

A CDOP, on behalf or CDR partners, may request any professional or organisation to provide relevant information to it, or to any other person or body, for the purposes of enabling or assisting the performance of the child death review partner's functions. Professionals and organisations must comply with such requests. Child Death Review Statutory and Operational Guidance (England) 2018

Every child death review requires involvement of all professionals, agency's and departments that have been involved with the child during their life and subsequently at the time of their death. These professionals will be contacted by the Child Death Review Coordinator via email and/or the eCDOP reporting system. They are legally required to complete the reporting form or appropriately respond with information requested for the purposes of the child death review.

Unexpected Flow Chart



General Guidance for Sudden Unexpected Deaths in Childhood – an Overview

Multi Agency Involvement, Discussion and Assessment

All cases of sudden unexpected child death (including the sudden demise of a child with a life limiting or life threatening conditions) needs to be notified to

1. Coroner's Officer 01452 305661 during working hours or via Fire Control Room if out of hours 01242 959023.

2. Child Death Review Coordinator (CDRC) via cdop@gloucestershire.gov.uk . The CDRC will alert the Designated Doctor and the Lead Nurse for Child Death so that further investigation and management of the cases will follow a multi agency approach, as set out in this protocol.

Immediate Joint Agency Response.

Although most unexpected deaths in childhood are due to natural causes, it is essential that at the time of the sudden unexpected death relevant information is shared between statutory agencies (Police/Children's Social Care/Health professionals involved with the child) and Coroner's Officer. This will assist in assessing the level of any suspicions in relation to the death and in deciding upon any further safeguarding concerns for any siblings. It also directs further investigation. If suspicion or safeguarding concerns are raised, Police and/or Children's Social Care become the lead agency. For the majority of cases, Health continue as the lead agency ensuring a balance is kept between medical and forensic requirements and the need to support the family members grieving for their child.

The parents of the child will be informed, at the earliest opportunity, of the nature of the Child Death Review Process and the need for multi agency information gathering and sharing by the agencies involved with the child and family. Leaflets explaining the child death process will be provided to the family.

If no safeguarding concerns are raised, those professionals who have been involved with the child either during life or at the time of their unexpected death will come together to enquire into and evaluate the child's death at an Initial Case Discussion. This usually occurs on the next working day. The aim of the meeting is to gather and discuss information in relation to the child's life and events leading to their demise.

The following professionals will be invited to the Initial Case Discussion meeting and will be requested to send information to the meeting:

- Paediatrician on-call (where possible) or senior representative
- Emergency Department/Ward Representative
- Ambulance Staff
- Police
- Children's Social Care
- Any other key professional identified for family or siblings e.g. GP, Public Health Nurse, SALT, Physiotherapy, Midwife etc.
- Education representation
- Coroner's Officer

Where there are issues relating to other children in the family, or there has been previous relevant Children's Social Care involvement or, where there are suspicions requiring Child Protection (*Section 47*) enquiries, Children's Social Care will need to be more directly involved. Such concerns may be apparent at the outset, or may come to light at any stage during the investigation.

Where Children's Social Care have had no previous involvement with the child or family and are not needed to be involved in the investigation, they should still be notified of the outcome for future file reference.

Initial Case Discussion

All professionals who have been involved with the child in life or at the time of the death will be invited to attend an ***Initial Case Discussion*** in addition to representatives from Children's Social Care, Police, Health and the Child Death Review Team. This will usually occur within 48 hours unless lead agency's deem the matter urgent and the meeting will be held the next working day. At each meeting all participants will be logged as attending by the CDRC on the Attendance/Confidentiality Declaration. The Chair will read out the Confidentiality Declaration at the start of the meeting and ask all professionals to agree their understanding of this. This meeting will be chaired by the Lead Nurse for Child Death or Designated Doctor for Child Death in exceptional circumstances.

The purpose of this meeting is to

- share information,
- identify the Key Worker who will facilitate support for the family
- determine the need for a home visit if this has not already taken place (this visit should take place for infants who die unexpectedly).
- Identify the health professional who will feed back to parents results of investigation or Post Mortem (if not the key worker)

Where a home visit is to take place, a decision should also be made about how soon (preferably within 24 hours) and who should attend. It is likely to be a Senior Investigating Officer from the Police and a healthcare professional experienced in responding to unexpected deaths. They may make this visit together or separately and then confer to discuss any additional information which may raise concerns about the possibility of abuse or neglect having contributed to the child's death.

Contact details of professionals who attended the Initial Case Discussion meeting will be shared with those professional identified as being involved with the child. An internal report of the meeting will be produced and stored on the child's CDOP file. If a report is required for further review this can be requested via cdop@gloucestershire.gov.uk . Once signed off by the Chair of the meeting and the Designated Doctor the report will be shared with that professional for the purposes of that review only. Any reports produced will only be retained by the CDRT on eCDOP for future access if necessary. The Key Worker will be responsible for keeping the family informed of the outcome of the meeting and any updates.

Following the preliminary results of the Post Mortem examination (usually 5 – 7 days after the death) the Child Death Review Coordinator will, under instruction from the Designated Doctor, disseminate provisional results to the relevant professionals involved in the review and if deemed necessary the LNCD may convene a multi agency case discussion to review any further information that has come to light.

On receipt of the final Post Mortem examination the Coroner will have already shared the results with the family. The Key Worker or appropriately trained health professional should be available to discuss the findings with the parents at the earliest opportunity if requested, except in those cases where abuse is suspected or the Police are conducting a criminal investigation. In these situations the Paediatrician must discuss with Children's Social Care, Police, Coroner's Office and the Pathologist what information should be shared and when.

Strategy Discussions

Where suspicious factors around the death have been identified and there are other children, there must be a formal child protection strategy discussion in relation to the other children led by Children's Social Care. This is separate to the Child Death Review Process. The purpose of the strategy discussion is to identify if there are concerns about the circumstances of the death, and the safety of the other children. The strategy discussion should include a Senior Police Officer from the Public Protection Unit Team (PPU), the Police Supervisor, a Paediatrician and LNCDR/CDRC; and a Social Worker from the relevant Children and Family Social Care Referral and Assessment Team or Emergency Duty Team (EDT). If the other children are at school or early years settings then a representative from Education/Early Years should attend and, if possible, it should also include a Public Health Nurse/GP. The prompt timing of the strategy meeting is essential and if key professionals are not able to attend, all relevant information should be sought from them by the Social Worker and brought to the strategy meeting.

The purpose of the meeting is to –

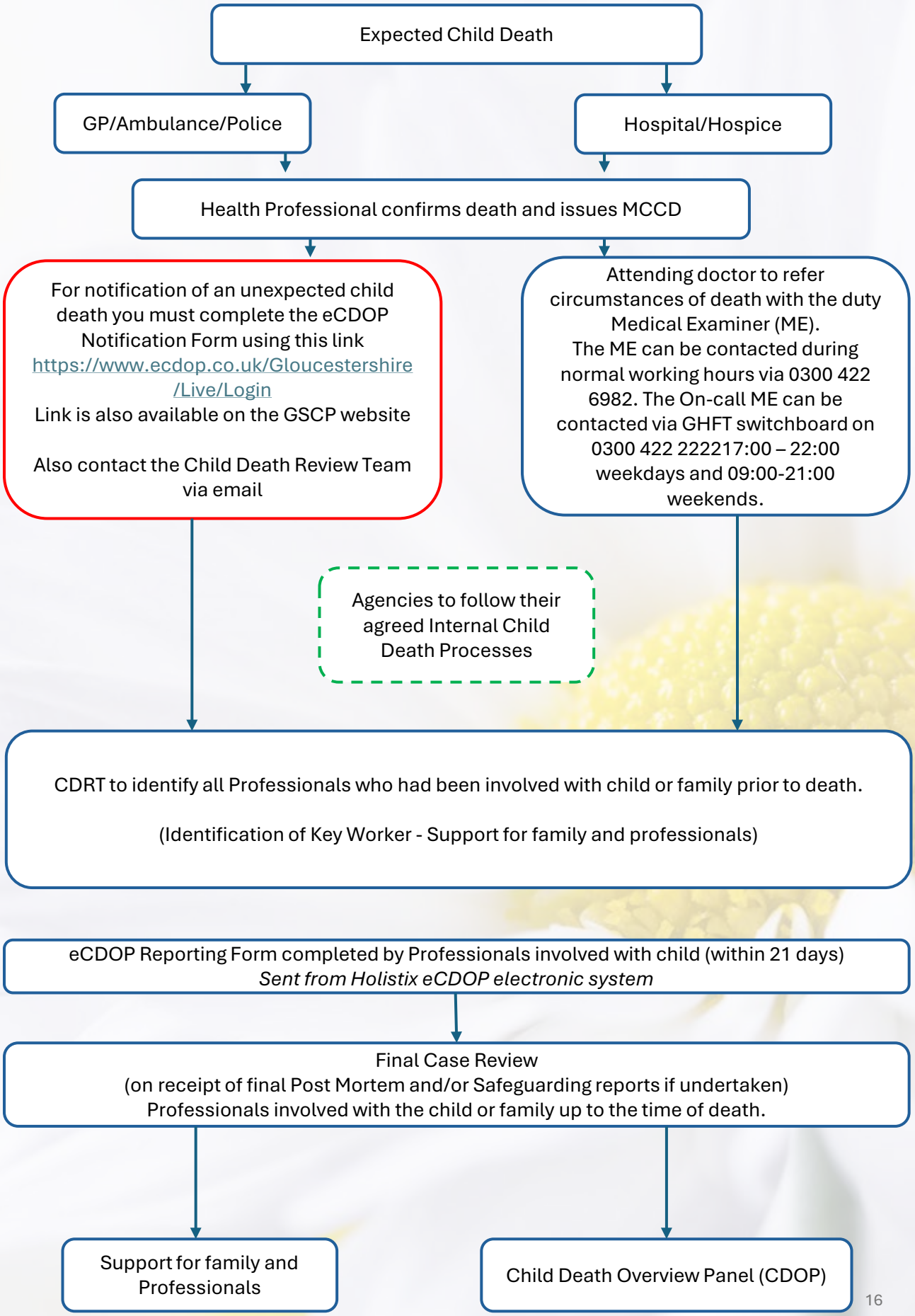
- Share available information.
- Decide whether a *section 47* enquiry under *The Children Act 1989* should be initiated and undertaken.
- To decide whether there is a need for medical assessment of siblings, and if so who will carry out what actions, by when, and for what purpose.
- Determine what information from the strategy discussion will be shared with the family, without jeopardising the Police investigation or causing significant harm.
- Agree the conduct and timing of any criminal investigation.
- To decide whether a Joint Interview will take place, to agree who should be interviewed by whom, for what purpose and when.

If necessary, further multi agency discussions should be held with the same representatives to review the situation and plan accordingly.

Consideration should be given to the well-being and any potential risks to the care of other children in the family. This may require a medical examination, and enquiries under Section 47 of The Children Act 1989, the children to be temporarily cared for by members of the family network or in extreme circumstances, the children to be looked after in foster care. Wherever possible however, children should remain with their family, recognising that this is a particularly traumatic time for all family members.

Where there is the need for a core assessment led by Children's Social Care, this should be carefully planned through the multi agency meeting to ensure co-ordination with any Police investigation and ongoing Paediatric involvement.

Expected Flow Chart



General Guidance for Expected Deaths in Childhood – an Overview

For children who have been determined to have a shortened life expectancy it is good practice to complete an Advanced Care Plan (ACP) which should be shared with the Designated Doctor for Child Deaths via cdop@gloucestershire.gov.uk and SWAST swasnt.Clinical-Alerts@nhs.net .

Notification of the death of the child should occur in the same way as for unexpected deaths and the professionals involved with the child will be expected to complete the eCDOP Reporting Forms https://www.ecdop.co.uk/gloucestershire/Live/Login .

A Final Case review will be convened as per unexpected deaths and the case will be anonymized and reviewed at CDOP Panel.

Neonatal Flow Chart

THIS DOES NOT APPLY TO LIVE BORN TERMINATIONS OR GESTATIONS BELOW 20+0 WEEKS

Neonatal Child Death

Health Professional certifies death

Attending doctor to refer circumstances of death with the duty Medical Examiner (ME). The ME can be contacted during normal working hours via 0300 422 6982. The On-call ME can be contacted via GHFT switchboard on 0300 422 222217:00 – 22:00 weekdays and 09:00-21:00 weekends.

Doctor agrees cause of death with ME and issues MCCD.

If no obvious cause of death identified Coroner must be notified after discussion with ME

For notification of an unexpected child death you must complete the eCDOP Notification Form using this link https://www.ecdop.co.uk/Gloucestershire/Live/Login
Link is also available on the GSCP website

Also contact the Child Death Review Team via email

Agencies to follow their agreed Internal Child Death Processes

CDRT to identify all Professionals who had been involved with child or family prior to death.

(Identification of Key Worker - Support for family and professionals)

eCDOP Reporting Form completed by Professionals involved with child (within 21 days)
Sent from Holistix eCDOP electronic system

Final Case Review
(on receipt of final Post Mortem and/or Safeguarding reports if undertaken)
Professionals involved with the child or family up to the time of death.

Support for family and Professionals

Child Death Overview Panel (CDOP)

General Guidance for Neonatal Deaths (including infants who have not left the hospital) – an overview

Notification of the death of the child should be made by the professionals involved with the child by completing the eCDOP Notification Forms https://www.ecdop.co.uk/gloucestershire/Live/Login .

The Final Case Reviews for neonatal cases will be undertaken as part of the local Neonatal Review Meeting held where/when possible within the Hospital Trust. In cases where the baby died in Bristol Hospitals, the local assimilated information will be forwarded for the relevant Bristol reviews. Once all reports have been received by Gloucestershire CDRT, cases will then be anonymized and reviewed at CDOP panel.

Key Worker Role

Key Worker Role

The Child Death Review Statutory and Operational Guidance states –

Support for the family (Chapter 6). Supporting and engaging the family who have lost a child is of prime importance throughout the whole child death review process. Recognising the complexity of the process, and the different emotional responses that bereavement can bring, families should be given a single, named point of contact, i.e. the "key worker", for information on the processes following their child's death, and who can signpost them to sources of support

Parents should be informed by their key worker that the review at CDOP will happen, and the purpose of the meeting should be explained.

Keyworkers in Gloucestershire are experienced members of the Child Death Review Team.

These allocated keyworkers understand child bereavement, understand the Child Death Review Process, are contactable via email or phone and are able to signpost to local and national support organisations (for the whole family).

The keyworker has a vital role to play in supporting parents after a child death and are able to ensure that parents, if they so wish, are involved in the Child Death Review.

<u>Key Responsibilities</u>

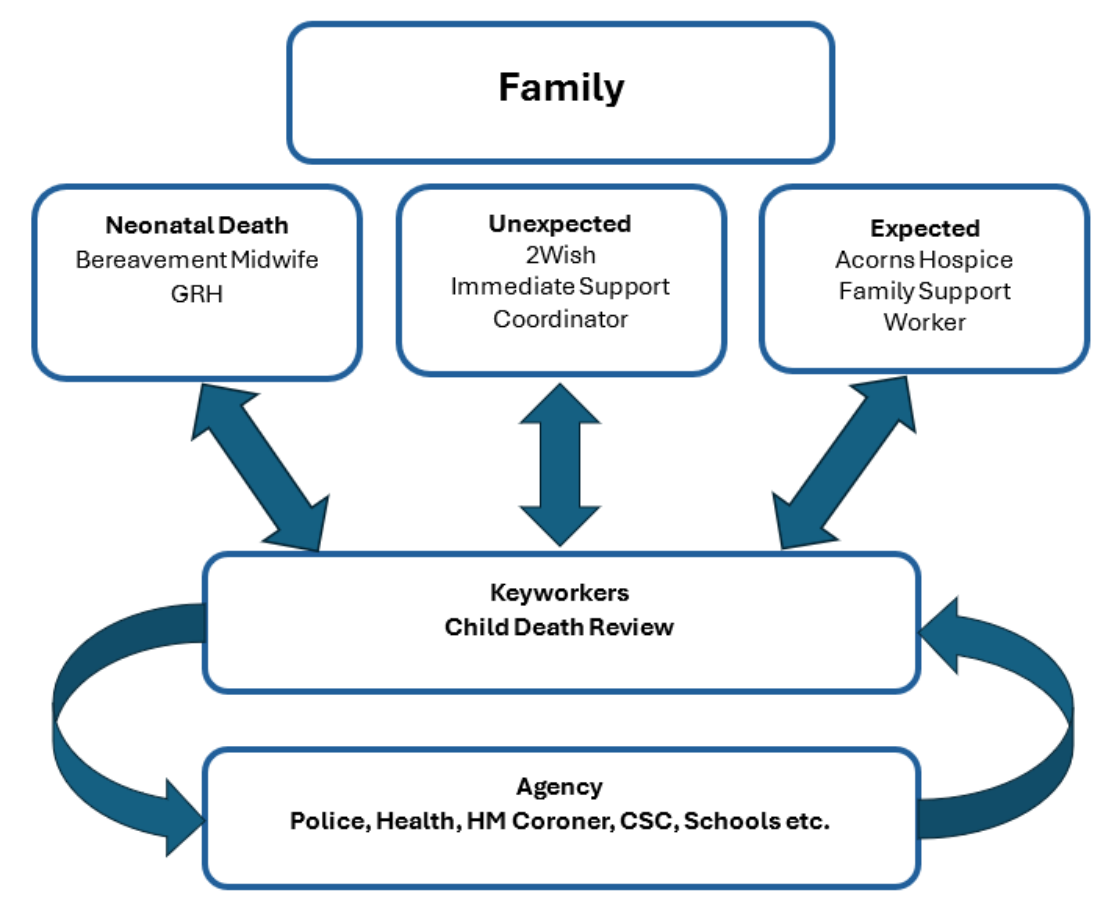
- Make and maintain contact and support for bereaved parents within the recommended timeframes and until the CDR process is complete.
- Use the parents preferred method of contact where possible and if parents wish to maintain contact.
- Provide bereaved parents with all relevant information and assist their understanding of the CDR process and how they can be involved. This can be achieved using template letters and regular contact via their preferred method.
- Facilitate bereaved parents to think about and voice any questions, concerns or other feedback. A feedback form can help with this.
- Represent bereaved parents at the CDR meeting, bringing their questions, concerns or feedback for those present to discuss.
- Inform bereaved parents if there are any delays to the process and, using their preferred method of contact, let them know that the meeting has taken place.
- Ensure that any response to their questions, concerns or other feedback is relayed to parents in a timely manner after the final meeting.

Key Worker Role

- Offer opportunity for bereaved parents to meet to discuss the outcome of the meeting (with whichever professional they prefer if possible)
- Arrange follow-up meetings for the parents with the lead clinician if needed to discuss any medical issues.
- Throughout the process, provide signposting to further bereavement support

The Keyworker will not provide counselling to any family member but will signpost to Partner agencies (GP) and locally recognised charities and organisations as listed in the Information for Parents, Families and Carers Leaflet (CDOP).

Keyworkers will work alongside Bereavement Midwife GRH (Neonatal), Acorns Hospice (Expected) and 2wish (Unexpected) to ensure that families are supported and advised appropriately, are aware of the child death review process along with partner agency processes and will aim to get feedback for the purposes of the child death review.



Final Case Review (FCR)

Prior to the Final Case Review the Key Worker will be requested to obtain family feedback as to the provision of services to the child during their life and any issues which may have arisen since death.

The Designated Doctor for unexpected deaths or nominated representative will convene and chair a Final Case Review meeting following receipt of the final results of the Post Mortem examination if one was carried out. The meeting should include professionals who knew the child and family and those involved in investigating the death. The purpose of this meeting is to share information to identify the cause of death and/or those factors that may have contributed to the death, and then to plan future care for the family. Potential learning points may also be identified. The meeting may also inform any Inquest being held. By joining these meeting all professionals agree to the terms of the Confidentiality Agreement which will be read by the Chair at the start of the meeting.

- A Summary of the Final Case Review meeting can be produced on request.
- Meeting notes will be retained by the Child Death Review Team.
- The Key Worker will contact the family and share the outcome from this meeting (if the family wishes).
- The Coroner will be informed of the outcome of the Final Case Review (if required).

Where a child normally resident in another area dies within Gloucestershire, that death shall be notified to the CDOP in the child's area of residence. Similarly, when a child normally resident in Gloucestershire dies outside of our County, the Gloucestershire CDOP should be notified. For children not resident in Gloucestershire but have died in our County, Gloucestershire CDRT will assist the resident CDOP by holding an Initial Case Discussion to gather local information and forward all details to the CDOP of residence. In both cases an agreement should be made as to which CDOP (normally that of the child's residence) will review the child's death and how they will report to the other.

Outcomes of Final Case Reviews

Following the Final Case Review of a Child Death or the review of the case at the Child Death Overview Panel (CDOP), issues which may have contributed to the death of the child or areas of good practice may be identified. These will be classed as - Learning Points, Issues Identified and Recommendations

Learning Points & Issues Identified

During the Child Death Review, recommendations, learning or issues might be identified which may highlight good practice or modifiable factors for improvement or service development.

CDOP is keen to share examples of good practice with Partners to encourage more widespread endorsement.

Modifiable factors

Modifiable factors highlighted for service improvement or development will become part of the work program for the GSCP Business Unit to ensure appropriate implementation. Where any learning points or issues identified are raised these will be forwarded to the Clinical Governance Departments of all Health Trusts and Agencies for action, if relevant. The CDR process will require evidence that actions have been completed to be overseen by the CDOP. An Annual Report of the learning points and issues identified will be shared with the CDOP and all Agencies and Health Trusts as per routes of communication below.

Recommendations

All recommendations will be reviewed at the CDOP and if approved will be accountable through the Gloucestershire Safeguarding Children Partnership. These will be implemented in the same manner as recommendations from Safeguarding Children Practice Reviews. The recommendations will be forwarded to the relevant Chief Executive of the Agency or Health Trusts with copies to the relevant Designated Leads. The Agency or Health Trusts will be expected to provide evidence of implementation to the CDOP Panel of what action has been taken to address the recommendations. The CDOP will then report to GSCP with regular updates.

Child Death Overview Panel (CDOP)

An overview through a comprehensive and multidisciplinary review of all child deaths in Gloucestershire will be undertaken by the Gloucestershire Child Death Overview Panel. This is, based on anonymised information gained from those involved in the care of the child and other sources as appropriate. The panel aims to better understand how and why children in Gloucestershire die and use our findings to take action to prevent other deaths and improve the health and safety of our children.

The CDOP will meet the functions set out in Chapter 5 of Working Together to Safeguard Children 2018 in relation to the deaths of any children normally resident in Gloucestershire. Namely collecting and analysing information about each death with a view to identifying –

(i) any case giving rise to the need for a Learning Review
(ii) any matters of concern affecting the safety and welfare of children in Gloucestershire
(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in Gloucestershire

CDOP Terms of Reference

Terms of Reference Child Death Overview Panel
The subgroup is accountable to the Gloucestershire Integrated Care Board and Gloucestershire County Council's Children's Services. It supports the Gloucestershire Safeguarding Children Partnership Executive to fulfil its statutory responsibility to review all deaths in childhood and to monitor and evaluate the effectiveness of local arrangements to safeguard and protect children.

1. Purpose

Through a comprehensive and multidisciplinary review of child deaths, the Child Death Overview Panel (CDOP) aims to better understand how and why children in Gloucestershire die and use local findings to take action to prevent other similar deaths and improve the health and safety of Gloucestershire children.

In carrying out activities to pursue this purpose, the CDOP will meet the functions set out in Appendix 4 of the Child Death Review Statutory and Operational Guidance 2018 and chapter 6 of Working Together to Safeguard Children 2023 in relation to the deaths of any children normally resident in Gloucestershire. Namely collecting and analysing information about each death with a view to identifying –

(i) any case giving rise to the need for a Rapid Review/LSCPR
(ii) any matters of concern affecting the safety and welfare of children in Gloucestershire
(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in Gloucestershire

2. Objectives

- To ensure, in consultation with the local Coroner, that local procedures and protocols are developed, implemented and monitored, in line with the guidance in Working Together on enquiring into unexpected deaths.
- To ensure the accurate identification of and uniform, consistent reporting of the cause and manner of every child death.

- To collect and collate an agreed minimum data set of information on all child deaths in Gloucestershire and, where relevant, to seek additional information from professionals and family members.
- To evaluate data on the deaths of all children normally resident in Gloucestershire, thereby identifying lessons to be learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children.
- To evaluate specific cases in depth, where necessary to learn lessons or identify issues of concern.
- To identify significant risk factors and trends in individual child deaths and in the overall patterns of deaths in Gloucestershire, including relevant environmental, social, health and cultural aspects of each death, and any systemic or structural factors affecting children's well-being to ensure a thorough consideration of how such deaths might be prevented in the future.
- To identify any Public Health issues and consider, with the Director of Public Health and other provider services how best to address these and their implications for both the provision of services and for training.
- To identify and advocate for needed changes in legislation, policy and practices to promote child health and safety and to prevent child deaths.
- To increase public awareness and advocacy for the issues that affects the health and safety of children.
- Where concerns of a criminal or child protection nature are identified, to ensure that the Police and Coroner are aware and to inform them of any specific new information that may influence their inquiries; to notify the GSCP of those concerns and advise on the need for further enquiries under section 47 of the Children Act, or of the need for a Rapid Review/LCSPR.
- To improve agency responses to child deaths through monitoring the appropriateness of the response of professionals to each unexpected death of a child, reviewing the reports produced by the rapid response team and providing the professionals concerned with feedback on their work.
- To provide relevant information to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family.
- To monitor the support and assessment services offered to families of children who have died.
- To monitor and advise the Statutory Child Death Partners on the resources and training required locally to ensure an effective inter-agency response to child deaths.

To co-operate with any regional and national initiatives – e.g. the Confidential Enquiry into Maternal and Child Health (CEMACH). Collation of data with other neighbouring CDOPs across the region – in order to identify lessons on the prevention of child deaths.

3. Scope

The CDOP will gather and assess data on the deaths of all children from infancy where the baby has shown signs of life (but excludes live born terminations and babies who are stillborn) to all children and young people less than 18 years of age who are normally resident in Gloucestershire. This will include neonatal deaths, expected and unexpected deaths in infants and in older children. Where a child normally resident in another area dies within Gloucestershire, that death shall be notified to the CDOP in the child's area of residence. Similarly, when a child normally resident in Gloucestershire dies outside Gloucestershire the Gloucestershire CDOP should be notified. In both cases an agreement should be made as to which CDOP (normally that of the child's area of residence) will review the child's death and how they will report to the other.

Team Membership

The Child Death Overview Panel will have a permanent core membership drawn from the following key organisations:

- Consultant in Public Health
- Designated Consultant Paediatrician
- Designated Safeguarding Nurse
- Coroner's Office
- Midwifery
- Lay representative
- Children's Social Care
- Police Child Protection Unit
- Bereavement Professional
- University Academic
- Administration Support
- Not mentioned health providers – GHT/GHC/SWAST/Primary care

CDOP core members will nominate a suitable deputy who will attend meetings in the absence of core members.

Other members may be co-opted to contribute to the discussion of certain types of death when they occur:
Emergency Department medical and nursing staff
Primary Care
Other paediatric input
Obstetric staff
Other Police representatives including accident investigators
Fire Services
Education
Paediatric Pathologist
Child and Adolescent Mental Health Services (CAMHS)
Adult Mental Health Services
Voluntary agencies
Registrar of Births, Deaths, Marriages
Community Safety
Others as required

The Chair has the discretion to defer the meeting if the appropriate representatives or deputies, with relevant skill mix are not available for a meeting or there are insufficient numbers for the meeting to be held effectively.

4. Confidentiality and Information Sharing

Some information discussed at the CDOP meetings will not be anonymised prior to the meeting, it is therefore essential that all members adhere to strict guidelines on confidentiality and information sharing. Information is being shared in the public interest for the purposes set out in Working Together and is bound by legislation on data protection.

CDOP members will all be required to sign a confidentiality agreement before participating in the CDOP. Any ad-hoc or co-opted members and observers will also be required to sign/verbally agree the confidentiality agreement. At each meeting of the CDOP all participants will be required to acknowledge and sign the attendance sheet, confirming that they have understood the confidentiality agreement. If virtual meetings are held members will be asked to confirm their agreement at the beginning of the meeting.

Any reports, minutes and recommendations arising from the CDOP will be fully anonymised and steps taken to ensure that no personal information can be identified.

5. Accountability and Reporting arrangements

The CDOP will be accountable to the ICB and GCC Statutory Child Death Partners under Child Death Review Statutory and Operational Guidance (England) 2018.

The Child Death Overview Panel is responsible for ensuring the child death review team is held to account for the thorough review of all child deaths. CDOP will develop and approve its workplan and ensure that an annual report is produced in keeping with the Child death Review Statutory and Operational Guidance (England) 2018 for the GSCP.

The CDOP takes responsibility for disseminating the lessons to be learnt to all relevant organisations and acts on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.

The CDOP will supply data regularly on every child death as required by the Department for Education and Skills to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of these deaths.

The CDOP will also provide data to the National Child Mortality Database (NCMD) on a regular basis via eCDOP.

6. Frequency of Meetings

The CDOP will in general meet at 2 monthly intervals but may hold extra meetings if matters are identified by the Chair of the panel or Chair of the Executive which require an earlier response.

7. Administration

Meetings will be supported by the Child Death Review Coordinator and documents and minutes will be circulated 7 days prior to the next meeting.

The Chair of the CDOP will ensure co-ordination with other working groups and will facilitate an annual review of these terms of reference and other associated documentation, amending as necessary.

Next review date for this document September 2025

Standards for CDOP Chair

The chair of a Child Death Overview Panel (CDOP) plays a crucial leadership role in facilitating the panel's activities, ensuring effective collaboration among members, and overseeing the review process of child deaths. To be effective, a chair should possess several key qualities and characteristics:

1. Leadership Skills: A good chair demonstrates strong leadership qualities, including the ability to inspire and motivate panel members, set clear goals, and provide direction for the CDOP's activities.

2. Effective Communication: The chair must be an excellent communicator, capable of facilitating productive discussions, summarizing findings, and conveying recommendations clearly to panel members and relevant stakeholders.

3. Expertise in Child Welfare: Ideally, the chair should have expertise in child welfare, child protection, or a related field. This knowledge enables them to guide discussions and decisions effectively.

4. Neutrality and Impartiality: The chair must remain neutral and impartial throughout the review process, ensuring that the panel's activities are not influenced by personal or organisation biases or external pressures.

5. Organizational Skills: A good chair possesses strong organizational skills to manage the CDOP's activities, including scheduling meetings, setting agendas, and keeping track of progress and deadlines.

6. Conflict Resolution: The chair should be skilled in conflict resolution and capable of mediating disputes or disagreements that may arise among panel members. Maintaining a harmonious and productive working environment is essential.

7. Respect for Confidentiality: The chair must uphold strict confidentiality and data protection protocols, ensuring that sensitive information related to child deaths is safeguarded at all times.

8. Attention to Detail: The chair should pay close attention to detail when reviewing case information and ensuring that all relevant

aspects are considered during the review process.

9. Cultural Sensitivity: Understanding and respecting cultural diversity is crucial. The chair should be sensitive to cultural differences and be able to guide discussions and decisions that consider the unique needs of different populations.

10. Commitment to Prevention: The chair should be dedicated to the CDOP's primary goal of preventing future child deaths. This commitment should guide their decisions and recommendations.

11. Team Player: While the chair has a leadership role, they should also be a team player, actively engaging with and valuing the input of all panel members. Collaboration is essential for the CDOP's success.

12. Continuous Learning: A good chair is open to continuous learning and stays informed about best practices in child death reviews, child protection, relevant laws and regulations, and emerging trends in child welfare.

13. Advocacy Skills: Advocacy may be necessary to ensure that the CDOP's recommendations are implemented. The chair should be skilled in advocating for the panel's findings and promoting child welfare improvements with relevant agencies and authorities.

14. Stakeholder Engagement: The chair should be adept at engaging with external stakeholders, including government agencies, community organizations, and advocacy groups, to foster a collaborative approach to child welfare.

15. Emotional Resilience: Child death reviews can be emotionally challenging. The chair should possess emotional resilience to cope with the difficult subject matter and provide support to panel members when needed.

16. Transparency and Accountability: The chair should uphold principles of transparency and accountability in the CDOP's activities, ensuring that the panel operates with integrity and is accountable to the public.

17. Analytical thinking: The Chair should be able to draft, review and draw inferences from analytical products, and be able to write concise reports for various audiences.

Conclusion

In all child deaths irrespective of any individual's background, job and other external factors, local protocols should be adhered to and the following principles should always be respected:

- Sensitivity
- Open minded/balanced approach
- Sharing of information
- Appropriate response to the circumstances
- Preservation of evidence
- Use of an appropriately skilled interpreter or communicator should always be considered

It must be remembered that all staff across the agencies involved in these sad events could potentially be distressed; each agencies' own counselling and post traumatic incident policies should be followed.

The following routes of communication to Agencies and Trusts are recommended.

- Police – Detective Inspector, Public Protection Bureau
- Social Care – Heads of Service, Children and Young People
- Gloucestershire Hospitals NHS Foundation Trust –Divisional Nursing & Midwifery Director, Women and Children, Head of Midwifery and Named Nurse for Safeguarding Children
- Gloucestershire Health and Care NHS Foundation Trust – Named Doctor for Safeguarding Children
- Gloucestershire Integrated Care Board – Executive Nurse Lead Head of Quality
- Ambulance Trust – Safeguarding Lead/Named Professional Clinical Standards Manager
- HM Coroner – HM Coroner / Coroner's Officers
- Education – Safeguarding Manager
- Early Years – Early Years Safeguarding Lead
- Children in Care – Strategic Lead for Children in Care
- GSCP – Business Manager
- Any other agency that may be relevant to the case.

Recording and Sharing Information in relation to the investigation of the child death

All professionals involved with the child at the time of death must record the history, timings of events and background information given by parents in as much detail as possible.

Staff from all agencies need to be aware that on occasions, in suspicious circumstances, the early arrest of the parents may be essential in order to secure and preserve evidence.

The Coroner and/or Police may require documentary information held by other agencies, which should be made available in the format agreed by individual agencies. Release of this information is permitted by Data Protection Legislation for the Prevention or Detection of Crime, or in pursuance of statutory functions. Professionals from all agencies must be prepared to provide statements of evidence promptly if required.

Recording and Sharing Information in relation to the child death case discussions

The information discussed at the Initial Case Discussion and Final Case Review is confidential and a record of these meetings will be retained on the child file withing the CDRT. Notes will only be produced if a further review is considered or a request is made through the Designated Doctor. The exception to this is Police and Coroners Officers who are also permitted to take notes for investigation/inquest purposes.

A Summary of the Final Case Review will be produced and circulated. This Summary document can be retained in the child's notes and can/will be shared with the family (if appropriate). This will become the documented evidence of the discussions for all agency records. The full meeting notes will only be kept by the Child Death Review Team.

On occasions information may be discussed at the meeting which may not be relevant to include in the child death case summaries. For example; child protection concerns for previous children in the past or previous involvement with the Police. It is essential this information is shared at the meeting in order to fully assess all factors in the child's background. Occasionally further investigation may be required in order to document these elements of discussion and confidential meeting notes of the meeting will be held securely.

Legislation underpinning this process is from the Children Act 2004 (Updated 2017) which states-

(1) Any of the child death review partners for a local authority area in England may, for the purpose of enabling or assisting the performance of functions conferred by section 16M, request a person or body to provide information specified in the request to –
(a) The Child Death Review partner or any other Child Death Review partner for the area, or
(b) Another person or body.
(2) The person or body to whom a request under this section is made must comply with the request.

(3) The Child Death Review partner that made the request may enforce the duty under subsection (2) against the person or body by making an application to the High Court or the County Court for an injunction.

(4) The information may be used by the person or body to whom it is provided only for the purpose mentioned in subsection (1) of the Act.

Registrars

(Births, Deaths and Marriages)

Registrars of Births and Deaths (Section 31 of the Children and Young Persons Act 2008):

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

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

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

His Majesty's Coroners Office (HMCO)

Pathologists and Post Mortem

Coroner/Pathologist and Post Mortem

The Coroner must be notified of all unexpected deaths in childhood and after the death is pronounced the Coroner has control of the body, mementoes and any medical samples (Appendix 5).

For sudden unexpected deaths in infancy/children who require radiological investigations post death, upon referral to the Coroner will typically provide consent and the Coroner's Officer will e-mail the GH Radiology Department ghn-tr.x-raysecretaries@nhs.net providing appropriate Coronial consent for the investigation/s. *See Flowchart under Hospitals Trust*

In non-suspicious cases the pathologist is chosen by the Coroner. In police led cases the police and/or Coroner will decide on the level of PM required which in most cases will be a Home Office forensic led examination.

The Post Mortem together with ancillary or additional investigations that become appropriate during the procedure should be performed to the current Royal College of Pathologists guidelines. If during the standard Post Mortem process a Pathologist becomes at all concerned that there may be suspicious circumstances, s/he must halt the Post Mortem and a Home Office Pathologist must be contacted.

If the Coroner has any concerns, having been made aware of all the facts, that the death may be of a suspicious nature, then the Home Office Pathologist will be used in conjunction with a Paediatric Pathologist. In such circumstances, the agreed protocol will be followed in addition to any necessary forensic investigations.

Both the Coroner and the Pathologist must be provided with a full medical history at the earliest possible stage. This will include a full medical history from the GP Practice where the child is registered, any relevant background information concerning the child and the family, and any concerns raised by any agency. The Investigating Officer is responsible for ensuring that this is done.

The Coroner's Officer must ensure that all relevant professionals are informed of the time and place that the Post Mortem will be conducted as soon as it is

known. A Crime Scenes Manager, Scenes of Crime Officer and the Investigation Officer must attend all Post Mortems conducted by a Home Office Pathologist.

In the event that the pathologist has to take samples to further the investigation, the parents must be informed that the samples have been taken and that they will be retained for further investigation. Once it is decided that the samples are no longer required as part of the investigation, the parents will be given the choice of whether the samples are sensitively disposed by the pathologist or returned to them for formal disposal.

Immediately following the completion of a Post Mortem, the interim or final findings should be provided to the Coroner and the Senior Investigating Officer/CDRT. The provisional interim findings may well be “awaiting histology/virology/toxicology” etc.

The final PM result will be notified in writing to the Coroner as soon as it is known.

Typically the Coroner will authorise the Coroner’s Officer to forward copies of the Post Mortem report to the lead Investigating Officer and Designated Doctor to pre approved email addresses. Any further disclosure to be discussed with the Coroner.

Final Post Mortem reports may be shared with the family by relevant health professionals unless criminal proceedings are continuing where consent to share is required from HMCO. The GP will receive a summary of the findings.

Medical Examiner

The Role of the Medical Examiner (ME)

The role of the Medical Examiner (ME) became law in 2024 which means MEs must be involved in scrutinizing the medical circumstances of all deaths across Gloucestershire. This also includes children who die within the county irrespective of place of residence.

The ME service is coordinated by officers known as MEOs whose role is to support MEs and deliver the service.

The duty ME can be contacted through the Bereavement Office during normal working hours on 0300 422 6982 where a voicemail can be left if no one is immediately available.

However, if a medical professional needs to discuss a case directly with the ME outside of normal working hours, the on-call ME can be contacted via GHFT Switchboard on 0300 422 2222. This out of hours service is restricted to 17:00-21:00 weekdays and 09:00-21:00 weekends and Bank Holidays.

Please note that the duty ME during the day will not be the same person covering the out of hours service so please only contact the Switchboard outside of normal working hours for the appropriate ME to speak to.

Moving a body

Outside working hours where the family wish to move the deceased's body e.g. to the hospice, consent must be gained directly from an ME. The duty out of hours ME is restricted to 17.00-21.00 weekdays and 09.00-21.00 weekends and Bank Holidays. Where a Medical Certificate of Cause of Death (MCCD) can be completed this should be forwarded to the Bereavement Office so that they can log and process the legal documents correctly.

Ghn-tr.bereavement.service@nhs.net

Following on from processes implemented during the Coronavirus Act, the MCCD is no longer given to the family and it must be scanned to the Registrar of Births and Deaths which the Bereavement Service can do the next working day. Do not give the MCCD to the family under any circumstances.

Inform/liaise with family and complete eCDOP notification Form (see hospital action cards).

Expected deaths

1. Complete death notification on eCDOP www.ecdop.co.uk/gloucestershire/live/login
2. Contact the Bereavement Office (See above for details)

Unexpected Deaths

1. Follow unexpected child death protocol working with consent from police and coroner's officer
2. Complete death notification on eCDOP www.ecdop.co.uk/gloucestershire/live/login
3. email cdop@gloucestershire.gov.uk
4. Contact the Bereavement Office (See above for details)

Neonatal Deaths

Medical cause identified

1. MCCD can be completed following agreement with the duty ME
2. Complete death notification form on eCDOP www.ecdop.co.uk/gloucestershire/live/login

Medical cause uncertain

1. Contact the Bereavement Office (See above for details)

Medical cause not known

1. Medical post mortem will need to be requested which will need to be discussed/endorsed with the duty ME (HMCO PMs only).
2. Consent is only required from parents for hospital PMs (forms are kept in Delivery Suite Bereavement Midwife's office)
3. Verbal handover of case to be given to medical secretary
4. Complete death notification form on eCDOP www.ecdop.co.uk/gloucestershire/live/login
5. Contact the Bereavement Office (See above for details)

Medical secretary contacts -

GRH mortuary (0300 422 5271)
Alexander Burn Funeral Director (01242 245 350)
St Michael's mortuary (01173 425 428)

No cause identified

1. Discuss with the duty ME who will support referral to the Coroner for investigation.
   NOTE - if suspicious or where an MCCD cannot be issued then the baby must be referred to the Coroner for autopsy to determine the cause of death. Please use the coroner's e-referral form and send to both email addresses on the top of the document so that the Bereavement Office is aware. (can this be embedded in the document?
2. Complete death notification form on eCDOP
   www.ecdop.co.uk/gloucestershire/live/login

Gloucestershire Constabulary

The responsibility for the investigation for unexpected child death lies with the Public Protection Unit and their Detective Superintendent. In all cases of sudden unexpected death in infancy or childhood, whether or not there are any obvious suspicious circumstances, a senior investigator should be tasked to immediately take charge of the investigation. This is likely to be the duty inspector, or on-call Senior Investigating Officer (SIO).

Children are not meant to die, and the police investigation into the sudden unexpected death of a child must be influenced by this basic fact. That means that even when there are no apparent suspicious factors, the police contribution to the investigation must be detailed and thorough.

Police investigating unexplained, but apparently natural deaths, are acting on behalf of HM Coroner, and it is important to stress this to the bereaved family at the earliest opportunity. In all cases the Coroner's Officer must be notified as soon as possible, via Fire Service Control Room if out of hours. Their knowledge and experience in dealing with any sudden deaths and bereaved families will be invaluable in explaining to the parents what will happen as the enquiry progresses, and in particular what will happen to their child's body and why.

The investigating officer and Coroner's officer should maintain a close liaison throughout the investigation, to ensure that information is shared effectively. Investigating officers should always adopt an investigative mindset, using evaluations and developing hypotheses where necessary to establish what has occurred. All Police action therefore needs to maintain a careful balance between consideration for the bereaved family, and the potential of an investigation. The direction and conduct of the police investigation will be the responsibility of the SIO.

When dealing with a sudden unexpected death in childhood, investigators need to follow five common principles, especially when having contact with family members:

- A balanced approach between sensitivity and the investigative mindset
- A multiagency approach
- Sharing of information
- An appropriate response to the circumstances
- Preservation of evidence

If the police are the first professionals to attend the scene they must consider whether urgent medical assistance is required, and contact the ambulance service (SWASFT). The primary role is to safeguard, and so a dynamic risk assessment should be carried out to assess any safety issue to any person present in all circumstances.

It is best practice that the child/young person is taken to Gloucester Royal Hospital Emergency Department. The child may be accompanied by family if appropriate, but a police officer should remain with the child until the lead investigator has assessed the circumstances or they are relieved under the direction of that investigator.

If the child is still at the home address at the time of attendance they should be taken to Gloucester Royal Hospital Emergency Department as soon as practicable. It is here where the local facilities are in place to support the initial stages of the joint agency response, to include an examination and appropriate immediate medical investigations.

Scene Management

The Police should always keep attendance to a minimum. It is most likely that any initial response will be from response officers. In many cases scene security can be achieved by a low-key discreet presence. Particular consideration should be given to the use of police radios and mobile phones in the presence of the bereaved family and friends. In all cases all officers should be signposted for TRIM referrals.

Unless there are clear forensic reasons to do so, the environment within which the infant died should be left undisturbed so that it can be fully assessed jointly by the Police and Health professionals, in the presence of the family. This will allow the best understanding of what may have happened and will also result, in those few cases where it is appropriate, and necessary, in the preservation of the scene for forensic investigation. Non-forensic removal of bedding and other objects destroys the scene and prevents full investigation of what happened - both medical and forensic.

The police should use sensitive language and avoid inappropriate language or Police jargon such as 'scene' and 'deceased'. Professionals present should use the child's name. Using inappropriate terminology may be misunderstood or distressing for the family.

In all cases contact with a Crime Scene Manager (CSM) is required, who will designate a Crime Scene Investigator to support the lead investigator in the management of the scene and any forensic recovery. This will include the identification and seizure of key exhibits, obtaining samples from the scene, and the taking of any photographs and imagery.

As soon as possible after arrival, officers should commence a scene log which will record all persons present. This will be discreet. Permission to remain at the scene should be obtained and recorded. This can be verbally given and recorded in an officers pocket note book, the SUDIC book, or investigation day book, but must be by the person(s) who have possession or control of the address.

Police should remain open minded and child-centred throughout their attendance, with an investigative mindset, at all times.

The preservation of the scene and the level of investigation will be relevant and appropriate to presenting factors. Consider the following tasks:

- Confirmation of the child's identity (required by the Coroner) –this can be done by recording the verbal confirmation from a family member in your day book, noting the time and manner of the identity.
- Record details of all persons present, and those that usually reside at the location.
- Consider any safeguarding issues, especially in regards to any other children affected. Where there is suspicion consider the impact on the children there and use appropriate powers to keep them safe, making clear records of the decisions made and why.
- R.O.L.E (Recognition of Life Extinct) – a record of the professional who declared death and the time of death should be obtained.
- If the child remains at the scene consider whether there are any obvious signs of injury or other concerns.
- The scene should be preserved, with a visual check of the environment, consider the lived experience of the child, noting any factors such as the temperature, condition of the accommodation, general hygiene, and the availability of food/drink/medication.
- Establish whether the child's body has been moved, making sure to record current position and any preceding or subsequent movement.
- When considering preservation; Make a note of the location of the child's nappy (if appropriate), feeding bottles, NHS red book, medication, equipment used in the resuscitation of the child, blankets, bedding, clothing removed, and any other items that may retrieved after consultation with the CSM & SIO. Such consideration may be influenced by the presence of clear forensic material, such as blood, vomit or other biological residue.
- Obtain an early account from any persons present, including a record of the events leading to the report being made, the details of the child's recent health, and any concerns that may wish to be raised.
- If it is considered necessary to remove items from the premises, do so with consideration for the parents and family. Explain that it may help in understanding why their child has died, and that they will be returned later.

Before returning items the family should be asked if they in fact want them returned. The family should be told that items may be returned in the condition in which they were seized. Any wishes or representations should be recorded, and the Police should be accommodating to the family's wishes as best as they can. The return of property should be properly planned and consideration should be given to engaging the most appropriate key professional in this process.

Hospital Procedure

It is recommended that the lead police investigator attend the location of the body to liaise with the lead clinician, and other medical practitioners. Early effective cooperation and liaison between the police and paediatricians is very important.

The lead health professional should take a detailed and careful history from the family. Where possible this should be carried out with a police investigator to avoid the need for repeated questioning. It is important to openly explain the process of investigation with the family using sensitive language. Consider the use of alternative phrasing to explain those processes such as 'medical examination' instead of 'post mortem' etc.

In some circumstances the paediatrician or health staff may have already collected information around the death, health and childcare information. This account should be sought by investigators. Consider any comparison in information, as any conflicting accounts should raise suspicion, but it cannot be forgotten that any bereaved person is effected by shock and possible confusion. Listen carefully and appreciate their demeanour as part of your assessment. Positive discussion between the paediatrician and police is essential in working together.

A physical external investigation should be undertaken by medical staff and police at the earliest opportunity in order to record any suspicious or unidentifiable marks. Any such marks should be recorded by a trained police photographer.

It is natural for families to want to hold or touch the dead child. A professional should be present, such as a police officer, a nurse or social worker. It should be allowed in most cases as it is highly unlikely that forensic evidence would be lost. If however the death has by this time been considered as suspicious, the SIO and the coroner must be consulted and their agreement sought.

The medical staff will obtain samples in line with the 'Kennedy' recommendations. The police should make a record for the coroner what has and has not been obtained. These will include toxicology samples, which will be screened at the hospital following the physical examination.

In all cases the police should ensure the paediatric pathologist carries out a post-mortem examination. A full skeletal survey should also be requested and also where relevant, MRI scans.

Where there is any suspicion, a discussion should take place between the senior investigating officer, the coroner and the consultant paediatrician to agree a home office forensic post-mortem.

In some investigations into childhood death, any drug or alcohol content in the carer's blood may be sufficient when trying to determine the cause of death, or any contributing factors. If a carer's ability to properly look after a child is impaired, this needs to be taken into consideration, and if there is evidence that the carer has taken illegal drugs this should be considered.

Agency Specific Information

Upon notification of a sudden unexpected death in childhood (U18) the police will:

- If first attenders, ensure that urgent medical assistance is requested as a priority
- Utilise the use of the Constabulary IT systems to gather information and inform initial decision making (i.e. Domestic Abuse/Child Protection/Mental Health and Substance misuse information)
- Obtain and secure the 999 call to the emergency services and review the content.
- In situations where an accident is the cause of death, consideration needs to be given to whether the accident reflected inadequate care of a child and therefore this protocol will apply. Supervisory attendance will be fundamental to that decision-making
- A Senior Detective of at least the rank of Inspector must make early contact with the on- call Paediatric Consultant to discuss their thoughts on whether or not the death could be suspicious. This will inform any subsequent Police action i.e. the seizure of bedding, declaration of potential suspects etc.
- Ensure the Senior Detective takes charge of the investigation and in conjunction with the Consultant Paediatrician meets with the family at the earliest opportunity
- Ensure that death is certified and the Coroner is notified if not already completed
- Consider the use of a Family Liaison Officer in accordance with national practice and guidance
- Evidence any apparent factors of neglect
- Designate potential crime scenes – including initial location of child, hospital, vehicles etc.
- Minimise the use of uniform staff

- Ensure that Children's Social Care are informed if not already done by medical staff.
- Ensure that the eCDOP notification is completed, notifying the Safeguarding Partnership and beginning the process of installing a joint agency response (JAR) meeting.
- Contribute to any multi-agency JAR or strategy meeting to determine further action
- If the child is not already at the hospital ensure that s/he is accompanied to the hospital casualty department by ambulance to ensure continuity.
- Complete, with medical staff, a physical examination recording observations in addition to use of photographs
- Consider the use of HQ photographic department to record digitally in 360 format the home address and or other relevant scenes. This is in addition to the use of Scenes of Crime Officers (SOCO)
- Consider requesting/obtaining blood and/or urine samples from carers where appropriate to investigation (as per ACPO 'A Guide to Investigating Child Deaths').
- Agree suitable Paediatric Pathologist in conjunction with hospital Paediatric Consultant and the Coroner. If the death is obviously suspicious then a Home Office Pathologist will be requested to work with the Paediatric Pathologist
- Ensure that a full skeletal survey and CT Head, if appropriate (Consultant to request on ICE and Coroner's Officer to confirm by email to radiology) and extensive toxicology tests are completed
- Consider relevant lines of enquiry dependent on the age of the child with the minimum information collected to include (ACPO guidance on Investigating Child Abuse and Safeguarding Children 2009):

a) Person(s) who saw the child last and at the time
b) Any action taken prior to the arrival of the emergency services and who contacted the emergency services
c) Child's last feed, including time, food given and by whom, e.g., whether the child was breast or bottle fed
d) Who put the child to bed and where they were sleeping, e.g., in the same room or bed as the parent, in a cot, the sleeping position of the child
e) Who found the child and who else was in the house at the time
f) Child's condition when found, e.g., their colouring, breathing, level of consciousness
g) Temperature of the room where the child was found and details of clothing or wrapping on the child, e.g., whether bedding was tucked in, whether an electric blanket was used, how the room and house were heated
h) Whether an infant intercom was in place

i) Who was with the child in the 24 hours before the death
j) Child's behaviour and health 72 hours prior to death
k) Whether parents, carers or other members of the house smoke and whether there are any restrictions on smoking in the house
l) Details of any previous child deaths or acute life threatening events in that or the extended family
m) History of child abuse
n) Details of parents' or carers' previous relationships where they have had children and significant events in the lives of the children
o) Details of the child's birth, e.g., method of delivery, whether they were born prematurely and the birth weight, details of any special treatment required for the child and whether the child was discharged from hospital with their mother
p) Details of the child's health (and any other siblings) since birth, e.g., whether they have seen a doctor or been admitted to a hospital or clinic or received medical checks, including dates of appointments, history of injections and any details of unsuitable feeding
q) Details of advice received by parents from health care professionals with regard to the prevention of sudden infant death
r) Contents of the child health record detailing medical checks, examinations and development which is given to every parent and is also known as the 'red book'
s) Details of family members such as siblings and foster children, including history of illness and standards of care given by the parents
t) Any records of the family on PNC, INI, force intelligence systems, crime recording systems, command and control records, domestic abuse logs and whether the child is or has been the subject of a child protection plan.
u) Any records of the children, parents or carers held by Children's Social Care or other agency.

In cases where there is a suspicion that the death is unlawful, The Murder Investigation Manual (ACPO 2006) is to be followed, together with supplementary ACPO Guidance 'A Guide to Investigating Child Deaths'.

Gloucestershire Royal Hospital NHS Foundation Trust (GRH)

Insert AC1

Insert AC1

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KENNEDY SAMPLES

- It is recognised obtaining samples may be difficult and problematic. Attempt as best you can from a venous or arterial site (avoid cardiac puncture).
- Single attempt at; LP, urine catheter preferable to suprapubic aspiration, and venepuncture (avoid cardiac stab aspiration)
- CSF should only be taken from the spine (avoid the head).
- List samples taken in notes and those not possible

SAMPLES CLEARLY LABELLED AS KENNEDY SAMPLES

*Kennedy minimum standard recommendations are starred (July 2017)

Investigation	Bottle type	Sample	Tick if taken	Result
*Toxicology	Red	Blood		
Genetics save sample	Purple (EDTA)	Blood		
Urea and electrolytes	Green (Lith Hep)	Blood		
Liver function tests	Green (Lith Hep)	Blood		
Glucose	Grey	Blood		
FBC	Purple (EDTA)	Blood		
Clotting	Blue (Citrate)	Blood		
*Culture	Paediatric Culture Bottle	Blood		
Metabolic screen	Blood spot screening card (Guthrie)	Blood		
PCR meningococcal / pneumoccal	Purple (EDTA)	Blood		
*Microscopy and culture	Universal White Pot	Urine		
Toxicology	Universal White Pot	Urine		
*Inherited metabolic disease	Universal White Pot	Urine		
PCR respiratory extended panel	Green viral	Swab		
Bacterial throat swab	Charcoal	Swab		
Skin lesion if suspicious	Charcoal / Green viral	Swab		
Protein & Glucose	Universal White Pot (2)	CSF		
PCR HSV / VZV / Enterovirus / Meningococcal / Pneumococcal	Universal White Pot (3 or 4)	CSF		
*Microscopy and culture	Universal White Pot (1 & 3)	CSF		
Culture and virology (Fluid if passed naturally)	Blue pot	e.g. Stool		

Additional samples to be considered after discussion with consultant paediatrician

- Skin biopsy for fibroblast culture in all cases of suspected metabolic disease
- Muscle biopsy if history is suggestive of mitochondrial disorder
- In suspected carbon monoxide poisoning, blood sample for carboxyhaemoglobin

Forensic considerations;

- Ensure the coroner has given permission to take samples.
- All samples taken must be documented and labelled to ensure there is an unbroken ‘chain of evidence’, using an appropriate ‘chain of evidence’ proforma.
  I.e. handing samples to a police officer directly, or having the laboratory technician sign upon receiving them in the laboratory.
- Ensure that samples given to the police or coroner’s officer are signed for
- Record the sites from which all samples were taken.

NB: Many postmortem sample results are grossly deranged. Responsible consultant to chase up results and relay to coronial Service

ACTION CARD	
TITLE: Information to be given to Parents in the Event of a Child Death	**REF NO AC6**
FOR USE BY: Medical and Nursing Staff attending the death of paediatric and neonatal patients	**LIAISES WITH:** Parents/Guardians, Patient's GP, Bereavement Office, Medical Examiner

Rationale: To provide sensitive and helpful information to parents and guardians on the practicalities surrounding a child death.

Written information is important and valuable to the family as they will not be able to take in all the information given verbally. It is important that the family are provided with relevant and up-to-date information, but are not overwhelmed by this.

Information leaflets/ websites

Depending on the circumstances around the death offer the parents the following booklets/leaflets

- Gloucestershire Hospitals Bereavement booklet (All families)
- Child Bereavement Advice and Information leaflet (All families)
- A guide to Coroner Services for Bereaved People booklet
- NHS family booklet - "When a Child Dies, A Guide For Parents and Carers.
- Lactation-after-loss-leaflet.pdf (liverpoolwomens.nhs.uk) (If breast feeding parent)
- 2wish information leaflet
- The Lullaby Trust produces a comprehensive leaflet, When a Baby Dies Suddenly and Unexpectedly

For SUDIC, the family should be clearly informed of the names and contact details of the lead professionals responsible for the joint agency response, including the lead health professional, police investigator and coroner's officer.

- CDOP Information for Parents, Families and Carers leaflet (All Families)

Consideration should be given to any practical support needs the family might have, for example, housing or employment-related needs, and support with any anxiety-related symptoms such as sleep disturbance Many of these issues will be best addressed through the primary care team.

Further resources can be found on the Trust intranet Paediatric Palliative Care.

Gloucestershire Hospitals NHS Foundation Trust

A. For a child brought to the Emergency Department.

Expect two possible responses:

1.
- 999 call to SWASFT triggers Paramedic response.
- If full resuscitation is required Ambulance Service notifies Police of case (via control room).
- At home resuscitation started.
- Child and Family brought to the Emergency Department (ED) Gloucestershire Royal Hospital.
- Gloucestershire Royal Hospital alerted by Ambulance and Paediatric Crash Team call to ED raised.

2.
- Child brought by family to ED (rare cases)
- Paediatric Crash call
- Resuscitation started

Procedures

- Resuscitation continued.
- Nurse allocated to the Family.
- Profoma commenced – brief history of events obtained and documented.
- Senior Medical Officer on-call, or Emergency Department Consultant determines when to stop resuscitation.
- Child pronounced dead.
- On confirmation of death the Senior Medical Officer should;

    - Alert the Police if the child was brought into hospital and the Police are not already present.
    - Take a full detailed history of life of child including details surrounding events leading to child's demise preferably this will be performed jointly with a Police Officer. This should be accompanied by a full and detailed examination of the child noting evidence of haemostasis. If any suggestions of non-accidental injury urgently refer to Children's Social Care/Police.

Gloucestershire Hospitals NHS Foundation Trust

- Obtain consent for investigations (good practice to discuss with family but Police/Coroners Officer can consent). For unexpected death in infancy ensure that a request for a full skeletal survey and CT Head is entered on ICE. SUDI investigation boxes (available in ED departments) should be completed.

- Notify Coroner's Officer of case (01452 305661 or for out of hours Fire Control Room 01242 959023).

- Notify the Statutory Reviews Coordinator cdop@gloucestershire.gov.uk

- Make notification via eCDOP using the link https://www.ecdop.co.uk/gloucestershire/Live/Login

- Explain the Child Death Review process and the need for a Post Mortem with the family. *Please inform family it may take several months before final reports are available.*

- Provide the family with the Gloucestershire Child Death Overview Panel Leaflet

South West Ambulance Service Foundation Trust (SWAST)

SWASfT operates a single unified approach to the management of child resuscitation and child death across the entire region of operations. Within Trust policy, a child refers to any person under the age of 18.

Summary of key procedures:

1. The Police will be informed or any unexpected death of a child or where clinicians are undertaking full resuscitation of the child by the Emergency Operations Centres.
2. A Duty Officer must be notified of as a minimum, and deployed as appropriate to any serious injury, illness or death of a child.
3. A Duty Officer will be dispatched to any incident of presumed Sudden Unexpected Death in Infancy (SUDI).
4. An Officer will be informed of any incident involving the serious injury or death of a child.
5. The resuscitation management of cardiac arrest in any child under 18 will delivered in accordance with the Resuscitation Council UK Guidelines and Joint Royal College Ambulance Liaison Committee guidelines (JRCALC).
6. Cessation of resuscitation and Recognition of Life Extinct must be undertaken by an appropriately qualified member of staff in accordance with the criteria detailed within Trust guidelines.
7. Cessation of resuscitation at scene outside of criteria may only occur if agreed by the Resuscitation Advice Line, a Doctor or the Senior Clinical Advisor On-call or Specialist Practitioner on scene.
8. All deceased children must be transported to an Emergency Department, unless instructed otherwise by a Senior Police Officer or if there is evidence on scene of abuse, neglect or maltreatment. A courtesy call must be provided to the ED department. In cases where a child is left at the scene to facilitate a police investigation, the Trust will transport the body when subsequently requested to do so by the Police. Use of the duty undertaker may also be appropriate.
9. Following an incident involving a child death, an Operations Officer must meet with the Ambulance Clinicians involved and complete a detailed statement. The statement should include a description of the environment, interactions with relatives and professionals on scene, and any background history obtained.

SOPs to be inserted once approved by SWASFT

Gloucestershire County Council
Children's Social Care (CSC)

GCC Children's Social Care

In all cases of sudden unexpected child death, Children's Social Care or if out of normal office hours, the Emergency Duty Team. will be contacted for any information they may hold about the child and/or family. A tripartite (Health, Children's Social Care and Police) discussion will always take place where there are other children of the family, or there is information held about the family or child who has died. See Flowcharts for phone numbers.

Children's Social Care may become more directly involved either where there are specific support needs if there are other children in the family, which cannot be met by other services, and always where there are child protection concerns arising from the circumstances of the death.

Where Children's Social Care have had no previous involvement with the child or family, and are not needed to be involved in the investigation, they should still be invited to the Initial Case Discussion meeting and be notified of the outcome for future file reference.

Where suspicious factors around the death have been identified and there are other children, there will be a formal child protection strategy meeting in relation to the other children lead by Children's Social Care. This meeting should ideally be face to face, and should include a Senior Police Officer; a Paediatrician and a senior representative from the relevant Children's Social Care team or Emergency Duty Team (EDT). It should also include other relevant professionals

GCC Children's Social Care

When a child dies unexpectedly there will be an immediate information sharing and planning discussion between the lead agencies (i.e. Police, Health and Children's Social Care) to decide what should happen next and who will do what.

Single point of contact to –

Children and Family Social Care Services
MASH 01452 426565 childrenshelpdesk@gloucestershire.gov.uk

During out of hours (inc weekends and Bank Holidays)
EDT 01452 614758

As soon as The Front Door or EDT are aware of a child death they must notify the Child Death Review Team

For notification of a child death please
Complete eCDOP Notification Form using this link
https://www.ecdop.co.uk/gloucestershire/Live/Login
and
e-mail cdop@gloucestershire.gov.uk)

A referral will be made to the MASH with the child and family details. Out of hours this will be actioned by EDT.

During these initial telephone discussions any safeguarding or child protection concern will be explored and appropriate actions taken if necessary for other children in the family. Children's Social Care will take the lead.

The sharing of information between relevant agencies at an early stage following the report of a sudden child death is vital. It will assist in assessing the level of any suspicions and in deciding upon the direction and level of investigation, practice, procedures, the timing and personnel involved in any home visits, ensuring appropriate support for the family, and in determining the overall strategy to be adopted.

In all cases of an unexpected child death, a formal *Initial Case Discussion* will be held up to 48 hours following the child's death, or if safeguarding issues are raised a meeting will be held at the request of lead agencies the same/next day.

GCC Children's Social Care

A representative from Children's Social Care will attend to participate fully in all discussions relevant to the child and family. This will be chaired by the Lead Nurse for Child Death review. If at any time safeguarding concerns are raised in relation to other children in the family, Children's Social Care will take the lead and a Strategy meeting arranged as appropriate. The Strategy meeting will not impact on the initial case discussion meeting but will be held separate to and may follow directly on from this meeting.

Children's Social Care will be kept updated by the Statutory Reviews Coordinator / Lead Nurse for Child Death as to the outcomes of any investigations during the Child Death process and as to the date of the Final Case Review.

Gloucestershire Health and Care NHS Foundation Trust (GHC)

GHC Process for Child Death Review Nurse

1. Notification will be received from Child Death Review Coordinator via e-CDOP.
2. Child Death Review Nurse will review the records of the child, and family members if necessary. Any required information will be provided to the Child Death Review Coordinator.
3. Child Death Review Nurse to contact service leads of relevant GHC services to inform them of the child death, and enable managers to support practitioners through the child death review process.
4. Child Death Review Nurse to contact GP, and request GP information (Full Clinical Summary) be sent to Child Death Review Coordinator by email.
5. Child Death Review Nurse to chair Initial Case Discussion (ICD).
6. Once ICD is complete, Child Death Review Nurse will request all open GHC referrals be discharged, and the child be marked as deceased on SystmOne and/or Rio.
7. A Datix incident reporting form will be completed following the review for all unexpected child deaths.
8. Child Death Review Nurse will attend Final Case Discussion (FCD) once this has been arranged.

GHC Process for Frontline Practitioners Working with Children

1. Service leads relevant to the child's history are notified by the Child Death Review Nurse of a child death. Service Leads will contact frontline practitioners involved with the child, advising them of the death and offering them support with the process.
2. If frontline practitioners become aware of a child death that they have not received a notification for, this must be reported to CDOP via the eCDOP Notification Form (Click here, link also available on Child Death pages on GSCP website) at the earliest possible opportunity.
3. Practitioners identified as working with the child to attend the Initial Case Discussion, sharing their agency information regarding the child and/or family. Practitioners are asked not to make their own records during this meeting, an official record will be produced as part of the CDOP process. Any records made by the practitioner during the meeting as a reminder of any actions taken must be securely disposed of once these actions are complete.
4. Following the ICD, practitioners will be asked to complete online reporting forms via e-CDOP. This must be done promptly once the request has been received.
5. Practitioners will be supported by their managers to prioritise and attend the child's Final Case Review.

LeDeR

Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)

LeDeR is an NHS service improvement programme which focuses on people with a learning disability and autistic people.

The lives and deaths of everyone with a learning disability over the age of 4 years and autistic people over the age of 18, with an official diagnosis, are reviewed.

The aim is to find areas of learning in care and treatment, opportunities to improve and examples of good practice.

The purpose of LeDeR is to improve health and wellbeing, reduce the number of preventable deaths and ensure that people with a learning disability and autistic people are offered the best care and support from services.

Previously in Gloucestershire when CDOP were notified of a child death and if the child was known to have a learning disability, the Child Death Review Team would make a referral to LeDeR and the Senior LeDeR Reviewer would be included in the Child Death Review meetings for that child. Recent changes to the process now eliminate the need for CDRT to refer into the LeDeR programme as all data from these reports is directly uploaded from the CDOP submission to NCMD. This change was made by NHSE to ensure that the deaths of children with a learning disability and autistic children are reviewed by the national mandated processes that look at the deaths of all children. Autism was added to the national child mortality review child notification which will enable more in-depth analysis of the deaths of autistic children and young people for the first time.

There will be greater opportunity for the analysis of the deaths of children with a learning disability and autistic children – via the NCMD and via the LeDeR programme, working with our academic partners. The NCMD have been commissioned to do a thematic review of children with a learning disability and autistic children which is expected to be published in Autumn 2024.

There will be a data sharing agreement between NCMD and KCL so data will still flow to LeDeR and it can be included in the annual report for analysis. Relationships between LeDeR governance and child death review panels should be strengthened with agreements in place which enable the sharing of learning to improve services for people with a learning disability and autistic people of all ages.

Gloucestershire's Senior LeDeR Reviewer continues to be involved, where appropriate, in individual child death reviews, in order to share areas of learning and is a member of the CDOP panel.

Educational Settings

Educational Settings

The death of a student can be traumatic for both school staff and pupils.

Upon notification of a death in childhood the Gloucestershire Safeguarding in Education Partnership will be notified by the Statutory Review Coordinator.

The GSEP will then:

- Make contact with the most senior person in the educational setting. In most cases this will be the Head Teacher/Manager to inform them of the death and to guide them through the process.
- The Gloucestershire Safeguarding in Education Partnership will contact the setting if they are part of the Traded Services Agreement and follow up with the Guidance document and any further support that may be required.
- The Gloucestershire Safeguarding in Education Partnership will also notify Director of Education (GCC) and Head of Education Outcomes and Intervention (GCC), Educational Psychologist (GCC) and Gloucestershire Healthy Living and Learning.
- The CDRC will email the Guidance document to any other setting not covered by the Traded Services Agreement and offer any further support needed.

The Gloucestershire Safeguarding in Education Partnership can be contacted via email gsep@gloucestershire.gov.uk

The Child Death Review Coordinator can be contacted via email cdop@gloucestershire.gov.uk

Educational Psychology Services in partnership with Gloucestershire Safeguarding Children Partnership and Gloucestershire Safeguarding in Education Partnership have produced a pack for schools, Guidance for Educational Settings When a Child Dies, which can be downloaded via the GSCP website www.gloucestershire.gov.uk/gscp

Educational Psychology Services for Schools

When a child dies and is of school age or siblings attend an educational setting the Educational Psychology Service (GCC) will be informed.

They will then make contact with that setting to offer support and advice to the professionals to ensure they can provide the best and safest support to siblings, friends and other pupils within that setting.

Educational Psychology Services in partnership with Gloucestershire Safeguarding Children Partnership and Gloucestershire Safeguarding in Education Partnership have produced a pack for schools, Guidance for Educational Settings When a Child Dies, which can be downloaded via the GSCP website www.gloucestershire.gov.uk/gscp

CDRT Meetings

Meeting set up

CDRC and Designated Doctors (twice weekly + extra if required)

CDRC and LNCD (weekly)

Child Death Review Team (bi-weekly)

Neonatal Themed Review (quarterly + extra of required)

Neonatal CDOP Panel (bi-annually + extra of required)

Child Death Overview Panel – CDOP (bi-monthly)

Child Death Review Team – CDRT Meetings

The Child Death Review Team (CDRT) will hold regular meetings to ensure that all members are updated with any progression in cases, are open to discuss any issues, confirm any actions (from Action Plans) and for supervision.

The meeting is open to the following –

Designated Doctor/s
Child Death Coordinator
CDOP Chair
GSCP BU Manager
Child Death Nurses

Roles of the Child Death Review Team

Designated Doctor for Child Deaths (DD)

A role key to the whole process. This person will be expected to provide an overview of the whole process and ensure:

- Notification of all child deaths is received.
- The immediate Joint Agency Response Team is well co-ordinated.
- Relevant professionals are aware of the child's death e.g. Police, Coroner, GP etc.
- If the child is from a different county ensure liaison occurs with local designated professionals for child death.
- All relevant information is shared appropriately and outcomes from Child Death Reviews are actioned, implemented and audited.
- Once the initial Post Mortem report is available contact all the relevant agencies, to decide whether a second case discussion meeting is required.
- Final Case Review meeting (when final Post Mortem results are available) is chaired appropriately by him/herself/delegate.
- Attendance at Child Death Overview Panel (CDOP).
- Report to Director of Nursing, Gloucestershire Clinical Commissioning Group.
- Close liaison with the QIIP sub group.
- Input provided to the CDOP Annual Report.
- Provide advice support and training as required to other professionals.
- Be a member of the National Designated Professionals Forum

Lead Nurse for Child Death Review (LNCD)

- Receive notification of child death via Child Death Review Coordinator.
- Contact GP directly to advise of death and request relevant Clinical Summary and documentation.
- Contact the relevant professionals e.g. Health Visitors/School Nurses and other GHC Services to inform them of the child death and obtain relevant background information
- Chair the Initial Case Discussion and ALTE meetings.
- Identify and support the Key Worker to liaise with the family and provide support.
- To follow up on any actions identified from these meetings through the CDRT Action plan
- Provide advice, support and training as required to other professionals.
- Facilitate, Support and debrief professionals involved in Child Death and ALTE Processes.
- Gather and disseminate learning from local and national case reviews as well as National reports and alerts
- To contribute to the Annual Report.
- With the Child Death Review Team to review of cause of death data in all three categories to better identify any trends or anomalies to highlight to CDOP panel.
- Attend National and regional network meetings.

Child Death Reviews Coordinator (CDRC)

- Receive notification regarding a child death and record information appropriately.
- Notify Designated Doctor/s and Lead Nurse for Child Deaths.
- Support the Lead Nurse for Child Death to contact the relevant professionals e.g. Health Visitors/School Nurses, GPs, Education to inform them of the child death.
- Collate confidential and sensitive information for Initial Case Discussion and Final Case Review meetings.
- Co-ordinate and set up Initial Case Discussion and Final Case Review meetings liaising with professionals to ensure maximum attendance/representation at short notice.
- Send attendance list and contact details to all attendees by the next working day following the Initial Case Discussion to ensure that contact between professionals can be made if required.
- Take notes and summaries of these case discussion meetings.
- Any Actions, Recommendations and Lessons Learned from Child Death Reviews are to be entered into the Child Death Review Team Action Plan.
- Action plans to be reviewed by the CDRT on a regular basis for updates and exception reports provided to the CDOP Panel for overview, or if requested at any time by the Panel.
- To review any Case for Consideration for an ALTE review
- To coordinate and set up ALTE review meetings, or attend strategy meetings for the purpose of gathering information for an ALTE review.
- Present findings from ALTE/strategy meeting to Designated Doctor and GSCP Business Manager for review
- Coordinate any further Practice Review to be undertaken for an ALTE as per the GSCP Safeguarding Practice Review Process.
- The SRC will maintain a close link to the GSCP.
- To maintain Gloucestershire eCDOP.
- To produce regular reports on child deaths and will produce the Annual Report.
- To ensure recommendations/outcomes following CDOP are regularly reviewed, monitored and completed.
- Liaise with the Designated Doctor for Child Deaths on all cases and communicate weekly review meetings with DD and LNCD.
- To facilitate the sharing of information between all agencies e.g. Health, Police, Social Care, Education and HM Coroner's Office.

- As a named Professional on the support leaflets given to families/professionals following a death, be prepared to receive contacts from families wishing to discuss the deaths of their children.
- Attend National and regional network meetings.
- Maintain and/or create links into National Network and Annual CDOP, South West network meetings as well as national CDOP offices.
- To provide resources and actively promote Child Accident Prevention Week reflecting learning and recommendations from reviews of child death's locally and nationally.
- To provide strong and accurate administrative link between Child Death Review Coordinator and CDOP.
- Produce anonymized reports for case reviews at CDOP panel.
- Arrange all aspects of the CDOP panel meeting including invites, papers and reports.
- Ensuring reviewed cases are entered and completed on eCDOP
- Ensuring data is sent to National Panel (NCMD) at appropriate intervals.
- Provide advice support and training as required to other professionals

Major Incident Planning
(inc. Pandemics)

Major Incident Planning

For the purposes of this protocol the definition of a major incident will include the deaths or Acute Life Threatening Events (ALTEs) of a number of children in the same event i.e. RTC, a major illness outbreak, death by contamination (list not exhaustive).

In the event of a major incident the Child Death Review Team, Police, GSCP BU Manager and CSC along with any other relevant agency involved will come together (either face to face or virtually) and discuss an action plan for the incident taking instruction from the lead agency (e.g. Police, Health etc.).

Pandemics

Covid

The National Child Mortality Database (NCMD) is an NHS-funded project that gathers information on all children who die across England, with the aim of learning lessons from child deaths to save lives in the future. Never has this been more important than now…

How can you help?

The data that NCMD collects will be of enormous significance in the fight against COVID-19, if child deaths relating to the virus are reported as a matter of urgency. While NCMD needs to be notified of all child deaths as usual, they are asking that clinicians, CDOPs and others working in Child Death Review (CDR) pay particular attention to deaths potentially involving COVID-19, informing them within 48 hours of the following:

- Children who die with symptoms of COVID-19, whether confirmed or suspected (please record as potential cause of death)
- Those who die of any cause, but show signs of undiagnosed infection in the weeks leading up to death
- Children known to have the virus but who might have died of something else
- Any child who meets the criteria for a Joint Agency Response (JAR) where the cause of death is unknown, but infection is considered as a significant possibility and the child or other member(s) of the household had a fever or cough within the preceding 14 days
- Babies who are born and then die where the mother was known or suspected to have had COVID-19
- Child deaths where the COVID-19 pandemic might have contributed to the death (eg issues with access to services or staffing capacity, inflicted injury or child suicide).

In all cases, where infection is present, please request samples and subsequently notify NCMD of the results (including maternal infection).

What will happen to the data?

In this unprecedented situation, NCMD is uniquely placed to gather data quickly from the whole of England. They will monitor cases in real-time and collate the information before passing it on immediately to NHS England and Public Health England to inform national strategy in order to combat COVID-19. For further information, go to: www.ncmd.info/2020/03/20/covid19.

ALTE
Acute Life Threatening Event

Defined as -

Any sudden/unexpected collapse of an infant or child (0 up to 18 years) requiring some form of active intervention/resuscitation and subsequent intensive care/high dependency unit admission. (Excluding children already in a hospital setting by admission unless the reason for collapse remains unknown)

ALTE's are to be referred to Gloucestershire CDOP by email via cdop@gloucestershire.gov.uk

Each case will initially be discussed with the referrer for clarification of the situation and information. It will then be presented to the ALTE Panel for consideration of criteria.

I. Initial phone call then email to be sent to cdop@gloucestershire.gov.uk with full details of incident/event from referrer

II. The Child Death Review Team (Child Death Review Coordinator, Nurses and Doctors), the GSCP Business Manager and if required Police/CSC will review the referral and consider if it meets criteria or if further information is required. This can be done via email in the first instance but if no agreement is met then a face 2 face (MS Teams) meeting will be held.

III. If criteria met, the Child Death Review Coordinator will arrange an ALTE meeting following the same process as an Initial Case Discussion for Child Death.

IV. If criteria not met, the Child Death Review Coordinator will log the request on the ALTE Spreadsheet.

V. If there is to be strategy discussion, the Child Death Review Coordinator should be contacted by the Chair of the Strategy Discussion to discuss holding a joint meeting ensuring that all professional required for both meetings are invited.

VI. If at any point there is to be a strategy discussion where a child is in hospital unexpectedly, the Child Death Review Coordinator is to be informed at the outset so an initial consideration for referral can be made.

VII. The ALTE meeting will be followed by the strategy meeting allowing all information to be shared at the start. Professionals can then remain or leave once the ALTE meeting has concluded depending on their involvement with the strategy meeting.

VIII. Notes from the ALTE/Strat meeting will be taken by the Child Death Review Coordinator, approved by the Safeguarding Nurse or Designated Doctor in attendance then shared with the Child Death Review Team and the GSCP Business Manager. Papers will be held on file in accordance with the Child Death Process.

ALTE records cannot be logged or stored on eCDOP unless the child dies so will be stored with the GSCP Business Unit.

Information collated through this process will be shared with the GSCP Business Unit Manager. If any previously unidentified safeguarding risks are identified this may instigate a return contact to MASH.

A Need to Know notification may be disseminated within agencies by CSC. This notification may include a copy or summary of the notes of the meeting if deemed necessary and approval has been given.

Where significant risks are identified as a result of agency failings the information obtained will be fed into a referral for Rapid Review and or LCSPR

The process will involve parents and carers through communication of the outcome of the meeting in a letter from the Designated Doctor including a summary of the ALTE meeting and offering an opportunity to meet with key professionals to discuss the ALTE meeting.

Child Funeral Information

Many, though not all, local Funeral Directors in Gloucestershire offer a free basic package for a child's funeral. This will not cover everything that a family may wish for their child's funeral. Funeral Directors should be contacted direct for further information.

HM Government provide The Children's Funeral Fund for England which can help to pay for some of the costs of a funeral for a child under 18 or a baby stillborn after the 24th week of pregnancy.

This is not means-tested: earnings and savings will not affect what is received.

The burial or cremation must take place in England.

The Children's Funeral Fund for England can help pay for the:

- burial fees
- cremation fees, including the cost of a doctor's certificate
- coffin, shroud or casket (up to a cost of £300)

More information on The Children's Funeral Fund for England can be found on the HM Government website -

https://www.gov.uk/child-funeral-costs

Useful Contacts

The Lullaby Trust
www.lullabytrust.org.uk
0808 802 6868

Stillbirth and Neonatal Death Society (SANDS)
www.uk-sands.org.uk
0808 164 3332 (National Helpline)

Miscarriage Association
www.miscarriageassociation.org.uk
01924 200799 (National Helpline – M-F 09.00-16.00)

Child Death Helpline
www.childdeathhelpline.org.uk
0808 800 6019 (National Helpline – M-F 10.00-13.00 & T&W 13.00 – 16.00 & 19.00-22.00)

Child Bereavement UK
www.childbereavementuk.org
01494 568900

Compassionate Friends
www.helpline@tcf.org.uk
0345 123 2304 (National Helpline – 7 days 10.00-16.00 & 19.00-22.00)

CRUSE Bereavement Care
www.cruse.org.uk
01242 252518 (Local helpline)

Useful Contacts

Winstons Wish
www.winstonswish.org.uk
General Enquiries: 01242 515157

Survivors of Bereavement by Suicide (SOBS)
www.uk-sobs.org.uk
0300 111 5065 (National Helpline 7 days)
01452 371945 (local support group)

Meningitis Trust
www.meningitisnow.org
Helpline: 0808 801 0388

The UK Sepsis Trust
www.meningitisnow.org
Support Line: 0800 389 6255

Sunflowers is founded by people who know the pain and trauma of losing a loved one to suicide.
Tel: 01453 826990

info@2wish.org.uk
tel:01443853125