London Borough of Sutton

Child Death Review

Operating Protocol and Guidance

Owner: Sutton CCG and Sutton LBS

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Key Contact Details for Child Death in Sutton

eCDOP Child Death Notifications

www.ecdop.co.uk/Sutton/Live/Public

Sutton Child Death Single Point of Contact

Suzanne Whyton esth.spoc-cdop.sutton@nhs.net 0208 296 4857

Designated Doctor for Child Death

Dr Ogeah bogeah@nhs.net

Specialist Nurse Child Death Reviews Coordinator

Jenni Davidson jenni.davidson@nhs.net 07919013749

Sutton Children's First Contact Service (Children's Social Care)

020 8770 6001

childrensfirstcontactservice@sutton.gov.uk

Metropolitan Police – Sutton

101 (999 in emergency) Please ask for CAIT/Safeguarding team

Designated Nurse for Safeguarding Children

Sarah Galvin sarah.galvin@nhs.net 07342 058212

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Glossary

Abbreviation / Word	Definition
CCGs	Clinical Commissioning Groups
CDOP	Child Death Overview Panel
CDR	Child Death Review
CDRM	Child Death Review Meeting
Child	A person from the time of live birth (irrespective of gestation) to their 18th birthday
ED	Emergency Department
HSIB	Healthcare Safety Investigation Branch
JAR	Joint Agency Response
Late foetal loss	Where a pregnancy ends without signs of life before 24 weeks gestation
Lead Health Professional	The most senior attending health professional at the time of death – usually a Consultant Paediatrician
LeDeR	Learning Disabilities Mortality Review Programme
LSCP	Local Safeguarding Children Partnership
MBRACCE – UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
MCCD	Medical Certificate of Cause of Death
Medical Lead	The child's named paediatrician, or in the case of a neonatal death, consultant obstetrician and neonatologist
NCMD	National Child Mortality Database
PMRT	Perinatal Mortality Review Tool
ROLE	Recognition of Life Extinct
SPOC	Single Point of Contact
Stillbirth	Baby born without signs of life after 24 weeks gestation
SWL	South West London

1. Introduction

This protocol provides supplementary local guidance to professionals responding to the death of a child in Sutton or whom normally resides within Sutton. The protocol explains and augments the relevant sections of Working Together to Safeguard Children 2018[1] and Child Death Review: Statutory and Operational Guidance 2018[2].

The Protocol builds on the SWL CDOP arrangements as agreed by the six SWL CCGs and Local Authorities (Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth)[3].

This protocol should be followed by all professionals responding to a child death in conjunction with all relevant policies, procedures and protocols within their own agencies.

2. Legal and Policy Context

The statutory responsibility for undertaking child death reviews moved from Local Safeguarding Child Boards (now LSCPs) to the CDR partners following a revision of the Children Act 2004[4]. The CDR partners are the local NHS CCG and Local Authority for any given area. This change takes effect from 29th September 2019.

Working Together to Safeguard Children[1] Chapter 5 outlines the new requirements with the Child Death Review: Statutory and Operational Guidance[2] giving further explanation of the processes required. There are two interrelated processes for all child deaths: a local response focused on the individual by key professionals for all child deaths and regional response undertaken by the SWL CDOP maintaining an overview of the trends, themes and learning from child deaths cross the Region.

The overall aim of the Child Death review is the learning that will contribute to the reduction of preventable childhood deaths, serious and permanent impairment to health and development of children and young people.

SWL CDOP will review the deaths of all children who normally reside in the six boroughs.

Purpose

The purpose of this protocol is to provide operational guidance to all professionals following the death of a Sutton Child/ren from any cause, including bereavement support for the child's family.

The processes set out in this protocol commence at the moment of the child's death and should be followed through to the final closure of the case at the SWL CDOP.

3. Definition of child death

As set out in the national Guidance[2], the child death review process must be followed for the death of any child from birth up until midnight before their 18th birthday.

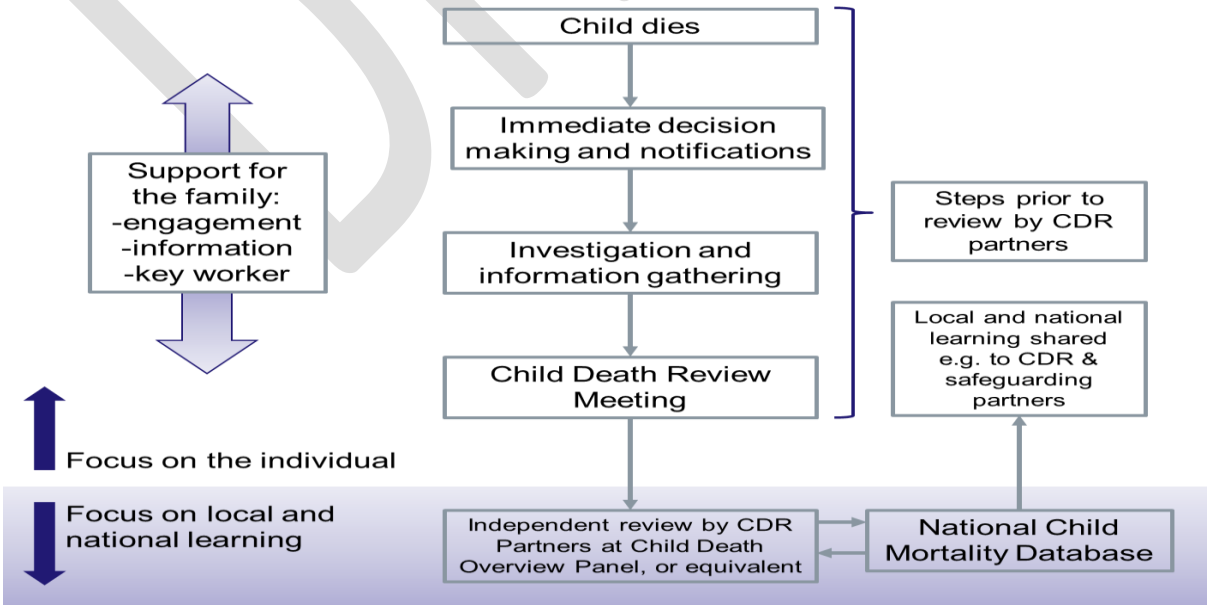
The review process must be conducted regardless of the cause or place of death. Included within this process is the death of any live-birth infant, regardless of gestation, where a birth and death certificate has been issued.

For the avoidance of doubt, it does not include stillbirths with a health professional in attendance, late foetal loss, or terminations of pregnancy (of any gestation) carried out within the law.

Cases where there is a live birth after a planned termination of pregnancy carried out within the law are not subject to a child death review.

The process does include infants stillborn where no health professional was in attendance.

4. Overview of the Child Death Process



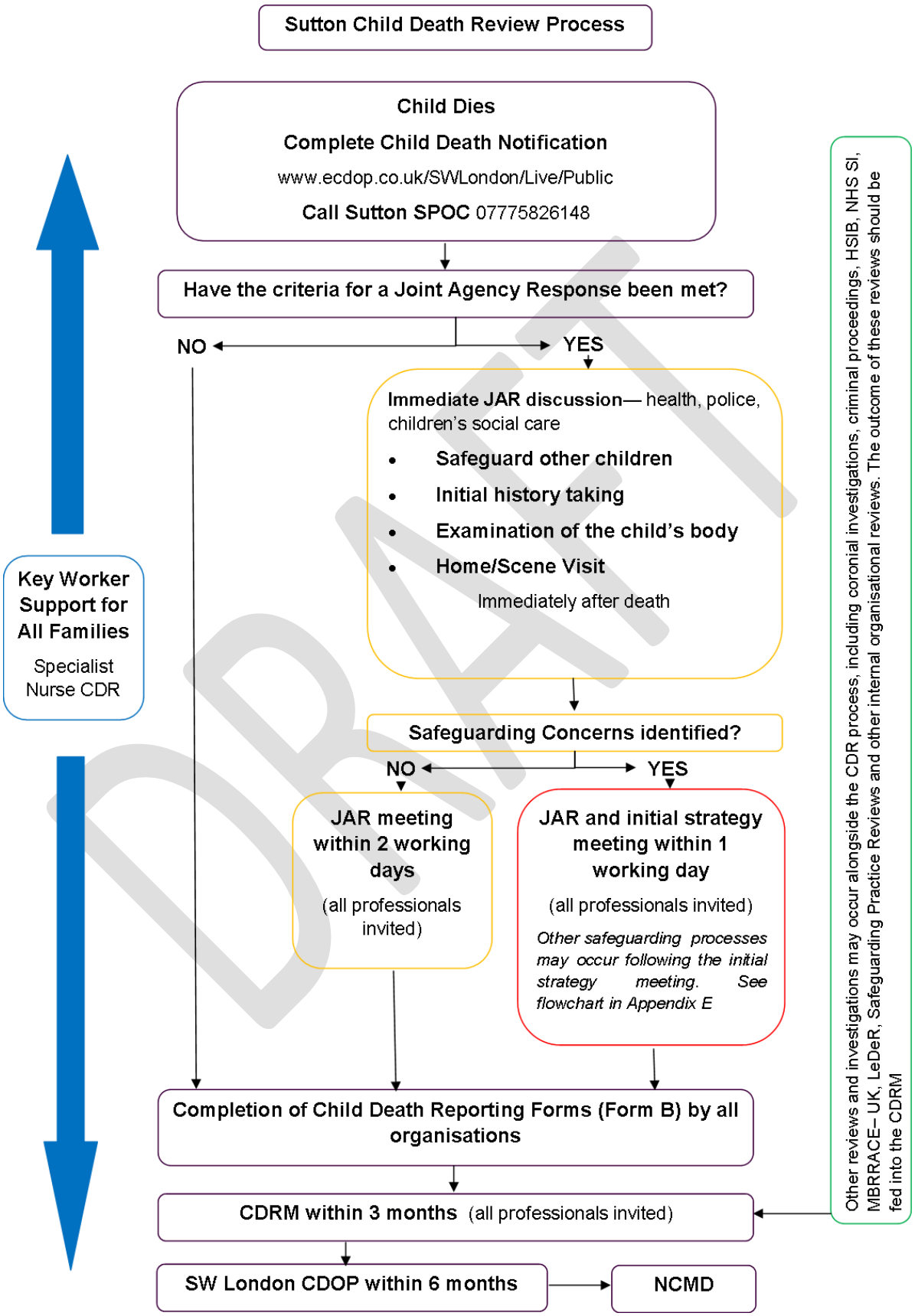
The CDR process has four key steps that must be undertaken following the death of every child;

- Immediate decision making and notifications
- Investigation and information gathering
- CDRM
- CDOP

These will be explored further within this protocol with additional requirements dependent on the circumstances of death, e.g. JAR.

These steps are undertaken alongside other statutory and non-statutory processes, including Coronial investigations and reviews specific to certain circumstances of death, e.g. LeDeR. Care should be taken not to jeopardise any criminal and coronial investigations whilst working collaboratively with other review processes to reduce duplication and potential increased distress of parents.

Sutton CDR process flowchart



5. Immediate Decision Making and Notifications

All child deaths – Decision Making

The following decisions need to be made by professionals within 2 hours of the child's death:

- determine whether the death meets the criteria for a Joint Agency Response, and if so contact the on-call representatives for the police, children's social care (duty social worker or duty social work manager out of hours) and health so as to initiate the joint agency response.
- determine whether an MCCD can be issued, if not, consider whether the death should be referred to the coroner.
- determine whether an issue relating to health care or service delivery has occurred or is suspected and therefore whether the death should be referred to the coroner and/or a serious incident investigation
- identify how best to support the family;
- determine whether any actions are necessary to ensure the health and safety of others, including family or community members, healthcare patients and staff.

An immediate decision making discussion face to face or by telephone should be held to review the above items between:

- Lead health professional attending the child at the time of death
- Senior Nurse, Midwife, Health Visitor or Specialist Nurse CDR
- Police (if appropriate)
- Duty Social Worker (if appropriate)
- Coroner's Officer (if appropriate)
- A member of the patient safety team when there are concerns around care or treatment (if appropriate)

The Immediate Decision Making proforma in Appendix A should be used to record this and stored in the patient's local health record.

Where the criteria for JAR are considered to have been met an immediate decision making discussion must be had between professionals – see JAR for further details.

Death of a child in the community – immediate actions

This section covers the death of any child within a community setting including but not limited to, a private residence, hospice, public place, other community healthcare facility.

All children who have died in a community setting (e.g. home or public place) should be transported to an Emergency Department by ambulance except if:

- The police are managing the death as suspicious and require the body to remain at the crime scene
- There are catastrophic injuries making transfer to an ED inappropriate e.g. decapitation or hemicorporectomy
- The child's body has established signs of decay
- There is an agreed end of life care plan – see below for more details

For all children not transported to hospital the Ambulance Service and Police should make contact by phone with the Sutton Designated Doctor for Child Death to discuss the need for a Joint Agency Response, followed up with a child death notification completed on Sutton eCDOP at www.ecdop.co.uk/sutton/live/public within 24 hours.

Children with an end of life care plan

If there are any concerns that the child's death may meet the JAR criteria, the child must be transported to the nearest ED for the CDR JAR process to commence.

If called, and where they pronounce ROLE, the ambulance service must confirm with the child's lead health practitioner that they are able to complete the MCCD and that the lead health practitioner has no concerns that the JAR criteria may be met, prior to transferring the child to a mortuary or leaving the scene.

Where the ambulance service pronounce ROLE at home for a child with an end of life care plan and the JAR criteria are not met, they should complete a child death notification completed on Sutton eCDOP at www.ecdop.co.uk/sutton/live/public within 24 hours.

Where the child dies in a hospice setting or at home attended to by their General Practitioner, Palliative Care Team or other health professional, it is the responsibility of the person confirming life extinct to notify Sutton eCDOP at www.ecdop.co.uk/sutton/live/public within 24 hours. This may not necessarily be the same person who completes the MCCD.

Death of a child within Acute Healthcare Settings – immediate actions

This section covers the death of a child within an acute healthcare facility.

On receiving a deceased child via ambulance, ceasing resuscitation or confirming life extinct, the lead health professional, usually the paediatric consultant, should

consider the need for a JAR. Advice can be sought form the Specialist Nurse CDR, Designated Doctor for Child Death or Children's Social Care (duty social worker or duty social work manager out of hours).

A small number of deaths will occur within the acute setting but outside the ED, that will meet the criteria for a JAR .

If a JAR is required, the Specialist Nurse CDR should be contacted for support and will attend the department where possible.

For all deaths a child death notification completed on Sutton eCDOP at www.ecdop.co.uk/sutton/live/public within 24 hours.

Deaths of Children in Adult Settings

A small number of older children die in adult care settings. The usual child death notification and process should be undertaken with the following caveats;

- The Specialist Nurse CDR will liaise with the Trust team to identify paediatric health professionals who should be represented at the adult mortality and morbidity meeting
- The Specialist Nurse CDR will attend the adult mortality and morbidity meeting and support the completion of the draft Child Death Analysis form (Form C)
- If appropriate, a multi agency CDRM will be held with appropriate information and draft Child Death Analysis form from the adult mortality and morbidity meeting being shared. This may require attendance of other professionals to give expert input, for example LeDeR reviewers.
- The hospital should undertake a specific mortality case review (a 'Structured Judgement Review') and share this and the mortality and morbidity meeting minutes with the SPOC, for review at the CDRM.
- Where a separate CDRM is not held, the adult mortality and morbidity meeting is responsible for completing a draft Child Death Analysis form and sharing this with the SPOC.

Deaths of Children within Inpatient Mental Health Settings

All deaths of children in inpatient mental health settings will trigger a JAR and should be reported to the Coroner. This applies to all children whether they are treated **voluntarily or detained** under the *Mental Health Act* [MHA] *1983*. The death should be reported following the JAR process.

When a child dies while detained under the MHA, there should also be a safeguarding practice review.

Deaths of Children in Custody

The Coroner and The Prisons and Probation Ombudsman (PPO) are responsible for investigating the death of a child in custody and of a child accommodated in a secure welfare placement. The CDR Partners for the area where the most learning can be captured should conduct the CDOP review with contribution from others agencies as required.

NHS providers should inform the 'home' CDR partners via the SPOC where the child was normally resident of the death of any child in custody. The 'home' CDR Partners remain responsible for ensuring a CDOP review is carried out, and will liaise with the CDR Partners where the death occurred. The CDOP where the death occurs should receive the outcomes of the PPO and Coronial investigations. The 'home' CDOP if necessary should conduct their own review of the case and findings.

Notifications

Child Death Notifications should be made to the Sutton SPOC via eCDOP. In the event of eCDOP being offline, a paper notification can be completed and emailed to the SPOC (Appendix B)

Where a child dies locally who is not normally a resident of Sutton, the Lead health professionals should notify the CDR partners for the area the child normally resides in. A list of contacts for all the CDR partners in England can be found at www.gov.uk/government/publications/child-death-overview-panels-contacts

(NB it is recommended that the contact list is not printed as it is updated regularly)

Advice can be sought from the Sutton SPOC about how and where to complete the Child Death Notification if required.

For residents of Sutton within one working day of notification, the SPOC and Specialist Nurse CDR, will then notify the following professionals if not already done so by other professionals:

- GP
- Health Visitor/School Nurse
- Other NHS health professionals known to the child
- Designated Doctor for Child Death
- Children's Social Care
- CDR Partners
- SWL CDOP
- Child Health information Service
- Other agencies/organizations as appropriate
- National Child Mortality Database via eCDOP

Gaining parental consent should be considered prior to notifying other organisations, for example education and private healthcare services. However, in the event of a JAR and/or safeguarding concerns for surviving children this is not an absolute requirement. Advice can be sought from the Designated Nurse for Safeguarding Children where there are concerns about information sharing.

When appropriate, notifications should be made to other review boards and processes. Local processes should be followed and these notifications remain the responsibility of the local organization. The list below is not exhaustive and other agencies will have internal review processes. The SPOC should be informed of all other notifications made as they may need to feed into the CDR process.

Notification	Explanation
Coroner	Reasons for referral to the coroner are as follows: • the cause of death is unknown • the deceased was not seen by the certifying doctor either after death or within 14 days before death • the death was violent or suspicious • the death was unnatural • the death may be due to an accident (whenever it occurred) • the death may be due to self-neglect or neglect by others • the death may be due to an industrial disease or related to the deceased's employment • the death may be due to an abortion • the death occurred during an operation or before recovery from the effects of an anaesthetic • the death may be a suicide • the death occurred during or shortly after detention in police or prison custody • the death occurred while the deceased was subject to compulsory detention under the Mental Health Act or a Deprivation of Liberty Safeguards authorisation (DoLS) • for any other concerning feature. Individual coroners may have their own reporting requirements.[2]
HSIB	All term babies (at least 37+0 completed weeks of gestation) born following labour when the baby died within the first week of life (0-6 days) of any cause (excludes babies with congenital abnormalities)[5]
LeDeR	Deaths of all children over the age of 4 years with a known or suspected learning disability[6]
MBRACCE-UK	All neonatal deaths up to 28 days after birth[7]
NHS SI Investigation	Patient Safety incidents as outlined in the Serious Incidents Framework[8]

Post mortem	The Coroner may request a post mortem for a death referred to them, parental consent is not required. For deaths not referred to the Coroner a hospital post mortem may be undertaken with parental consent.

Immigration Enforcement's National Command and Control

The Immigration Enforcement's National Command and Control Unit (NCCU) should be notified if the child or their family have had interactions with the Borders, Immigration, and Citizenship System (BICS). The NCCU can be contacted with requests for a chronology of BICS involvement, to attend review meetings or to respond to specific requests.

The NCCU can be contacted 24 hours a day, seven days a week at 03000 134 999 or CommandandControlUnit@homeoffice.gov.uk

6. Investigations and Information gathering

Joint Agency Response

A Joint Agency Response should be triggered if a child's death:

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

A Joint Agency Response should also be triggered if such children are brought to hospital near death, are successfully resuscitated, but are expected to die in the following days. In such circumstances the Joint Agency Response should be considered at the point of presentation and not at the moment of death, since this enables an accurate history of events to be taken and, if necessary, a 'scene of collapse' visit to occur[2].

In the event of a death meeting the JAR criteria the lead health professional present at the time of death must contact the Specialist CDR Nurse (in working hours), Police and Children's Social Care within 2 hours.

A multiagency JAR will be led by the lead health professionals within working hours, alongside Specialist Nurse CDR, Police, Duty Social Worker and other professionals involved with the family. Out of hours the Lead Health Professional, usually the Consultant Paediatrician on-call, will be responsible for initiating the JAR and handing over to the Specialist Nurse CDR at the earliest opportunity.

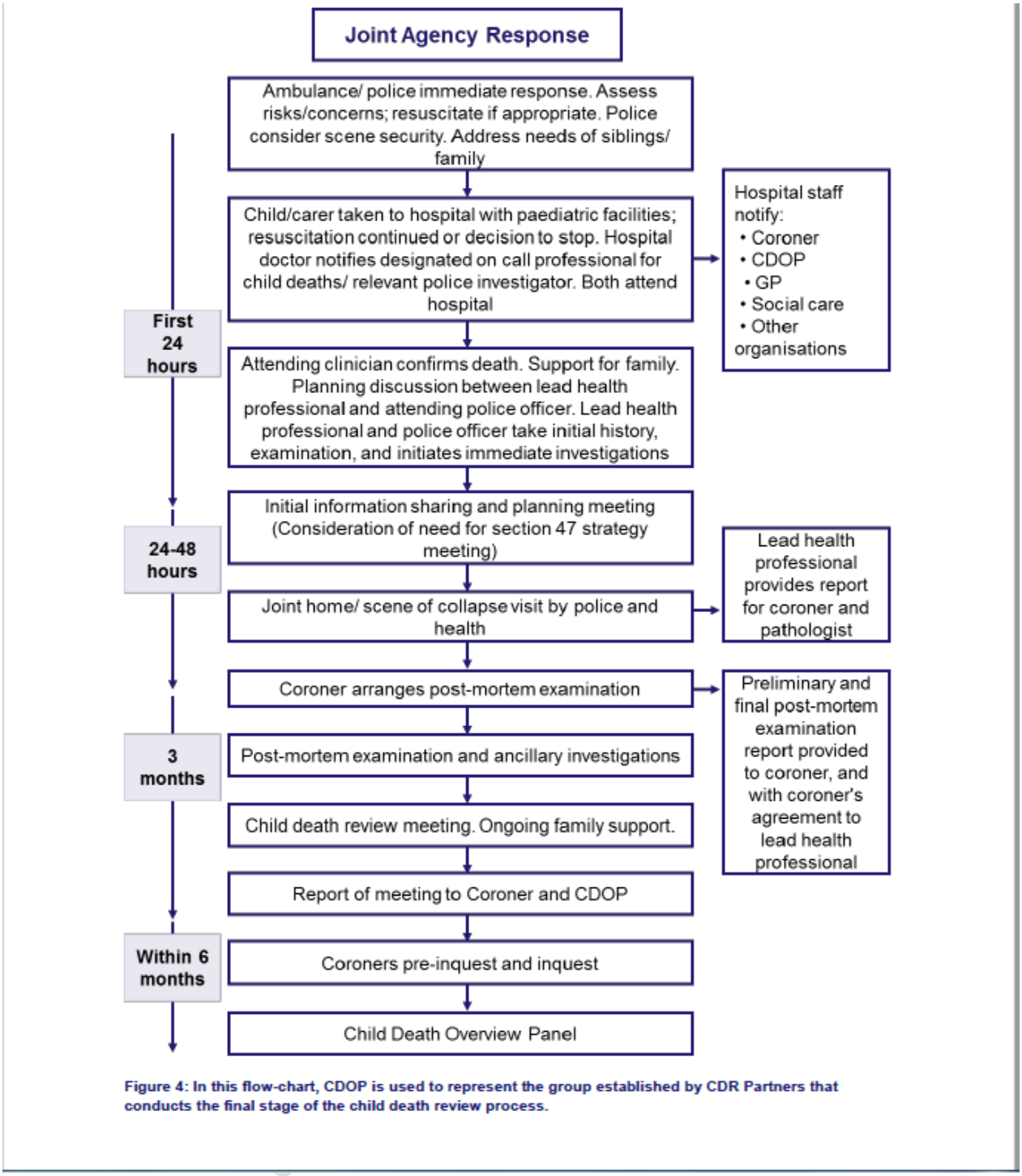


Figure 4: In this flow-chart, CDOP is used to represent the group established by CDR Partners that conducts the final stage of the child death review process.

The JAR process as outlined above will be followed for all cases meeting the JAR criteria.

Initial history taking

Whilst the child and family remain in the hospital the lead health professional, usually a Consultant Paediatrician, alongside Police will take an initial detailed history from the family. The purpose of this initial history is to:

- Understand the circumstances of the death as fully as possible
- Identify and respond to any concerns for surviving children or the general public
- Support the family through the CDR process and understanding of the circumstances of their child's death
- To obtain a detailed immediate account of events that can be compared with future statements. A history taking proforma or the medical notes can be used to document the history, with a copy kept within the medical notes and a copy shared with Police and the CDR SPOC.

Examination of the body

The Lead Health Professional, usually a Consultant Paediatrician and Police will undertake the examination of the body, following the local Trust policy. Body maps should be used to record any findings including but not limited to;

- Bruising, redness, changes to skin
- Cuts/abrasions
- Birth marks
- Marks from medical interventions (e.g. venipuncture attempt wounds)
- Medical equipment to remain in situ (e.g. IO needles, ET Tubes)

A copy of the body maps should be kept within the medical notes and a copy shared with Police and the CDR SPOC.

Post Mortem samples and skeletal survey x-rays may be undertaken in line with the SUDI/C guidelines[9] with the agreement of the Coroner. It should be clearly documented in the medical notes which samples have been taken and where they have been sent for processing. This should also be shared with the Coroner, along with the results of samples tested within the hospital.

Joint Home Visit

Joint Home Visits, defined as visit of the scene of collapse by police and health by those with appropriate forensic training, are not currently being undertaken in the London Borough of Sutton. Home visits are to be undertaken by an appropriate Senior Police Officer who will feed back to the JAR meeting. The Senior Police Officer may seek advice if needed from the Designated Doctor for Child Death or Specialist Nurse CDR regarding anything seen of concern in relation to health and the circumstances of the death.

Ideally, the full purpose of this visit will have been explained to the parents before they leave the hospital by Police and Health professionals. It is to try to understand why the child died, what might have contributed to the death and to provide support

and information to the child's parents. Proformas may be used to record the content and findings of the visit, this includes the Metropolitan Police Project Indigo Forms (Form 90/91). Once completed the police and the Specialist Nurse CDR should retain copies and a copy supplied to the Coroner. A copy will be retained within the Case File on eCDOP.

The home visit should occur **as soon as possible** after death and **within 24 hours of death.**

Ideally prior to the visit, the lead health professional, usually a consultant paediatrician, with the Police Investigator will review the key elements of the history taken in ED. They will identify any aspects of the history that they wish for the family to elaborate on or clarify, or any information missing from the initial history.

If present at the time of the home visit , the family should be allowed for the visit to go at their pace, with professionals respecting that family members may find it difficult to talk through the events or go into the room where the child has died.

The Police will be responsible for also

- Assessing the need for photographic or a video capture of the scene of the infant's death,
- Retaining items for further forensic investigation.

There may be circumstances when an infant's cot or other personal items need to be taken for further examination. This should only be taken after the visit, so all items can be seen first in situ.

The findings of the home visit should be discussed with the family, taking care not to jeopardise any further investigation.

The Police will be responsible for collating information from the home visit and sharing this with the pathologist and Coroner.

The Specialist Nurse CDR will collate any other information gathered and will share this with the Coroner. This may include;

- The history taken in ED
- The outcome of any investigations undertaken whilst the child was being actively resuscitated

The Police and/or Coroner's Officer should ensure that the pathologist has this prior to the child's post mortem.

JAR meeting

A JAR meeting will be held within 48 hours of death, usually administered and coordinated by the SPOC and chaired by the Designated Dr for Child Death Lead Paediatrician or Specialist Nurse CDR.

Where the circumstances of the death identify safeguarding concerns and the need for an initial strategy meeting arises, the JAR and initial strategy meeting will be held in succession. The JAR will be held first chaired by Health and with the strategy meeting held second chaired by Children's Social Care Head of Service.

The meeting will is held within normal working hours to facilitate the attendance of other multi-agency professionals with knowledge of the child and family.

The purpose of this meeting is;

- To review with all professionals known to the child and family the circumstances of the child's death as they are currently known
- Review and address any safeguarding concerns for surviving children
- Review the bereavement support for the family, surviving siblings and wider community
- Identify any additional investigations that need to be undertaken
- Identify any immediate learning that needs urgent action by the CDR Partners and other relevant agencies.

Professionals or services to be invited to a JAR meeting include:

Designated Doctor for Child Death	Specialist Nurse CDR
Paediatrician who cared for the child at the time of death	Ambulance Service
Named Nurse or Doctor for Acute or Community Services	Designated Nurse for Safeguarding Children
Health Visitor or School Nurse	GP
School/Nursery	ED/Ward nursing staff
Police	Children's Social Care

This is not an exhaustive list and other professionals will be invited as required.

The SPOC will provide minutes from the JAR within 5 working days and record on eCDOP. Minutes will be shared with the relevant Coroner.

Child Death Reporting Forms

The SPOC will request child death reporting forms from all services known to the child and family before and at the time of death. Identified individuals will be given an

eCDOP login to complete this form securely. Services are required to complete forms **within 2 weeks of receiving the request.**

Supplementary child death reporting forms will be added to the main child death reporting form on eCDOP by the SPOC as required.

The Specialist Nurse CDR will be responsible for consolidating, reviewing, and amending any inconsistencies from the Child Death Reporting Forms.

Child Death Analysis Form

The Specialist Nurse CDR is responsible for producing a draft, anonymised child death analysis form for discussion at the CDRM alongside the consolidated Child Death Reporting forms. The draft Child Death Analysis Form on completion of the CDRM is sent to the SWL CDOP

Safeguarding Children and Rapid Reviews

It remains the responsibility of all professionals to act on any safeguarding concerns they may have in line with Working Together to Safeguard Children (2018).

If new concerns arise about the safety or wellbeing of siblings or other children living in the household during the CDR process including Key Working , and no referral has already been made to Children's Social Care, the Specialist Nurse CDR will make a referral to the relevant local Children's Social Care Service.

Where the child's death may trigger the criteria for a Safeguarding Practice Review this will be discussed at the JAR and the Chair will make a recommendation for the LSCP to consider.

Social care assessments and Safeguarding Practice Reviews can run in parallel to the CDR process. Close liaison should be maintained between the named social worker and the Specialist Nurse CDR.

Please refer to local guidance on Rapid Review Meetings to be conducted with 15 days of a child's death, or national guidance available at www.gov.uk/government/publications/child-safeguarding-practice-review-panel-practice-guidance

Other Investigations and Reviews:

NHS Serious Incident Investigations

All NHS Trusts should follow their procedures for declaring and investigating SIs and inform the SPOC. Should the Specialist Nurse CDR feel an SI review should be undertaken a discussion will be had with the Trust Mortality lead and Head of Service.

The NHS Trust will provide the SPOC with an anonymised copy of the signed off SI report as soon as possible, for review at the CDRM.

MBRACCE-UK and PMRT reports

In the rare instances where a hospital based CDRM is not integrated within the PMRT meeting, the hospital trusts will provide the SPOC with a copy of the finalised PMRT and MBRACCE-UK reports as soon as possible, for review at the CDRM.

HSIB

Hospital trusts will send the final HSIB report with any Trust action plan created in response, to the SPOC as soon as possible for review at the CDRM.

Post Mortem Reports

The SPOC will request a copy of the final post mortem report from the Coroner (or hospital trust if a medical post mortem is undertaken) for review by the lead health professional and sharing at the CDRM.

Inquest Outcomes

CDRMS will usually be held prior to Inquest, in order for the outcomes of the CDRM to feed into the Coronial Inquest process.

The SPOC will request a copy of the Coroner's verdict following an Inquest and any Regulation 28 Prevention of Future Death Reports. Any issues of concern or recommendations from the Inquest will be shared at the SWL CDOP review.

Un-redacted copies of JAR minutes and reports, as well as CDRM minutes will be shared directly with the relevant coroner. The Designated Doctor for Child Death will review these prior to sharing to consider if a request for redaction should be made to the Coroner before onward disclosure to Interested Persons (including the bereaved family) in the case.

The Specialist Nurse CDR and SPOC will remain in close contact with the Coroner's Officer regarding the outcome of both CDR and Coronial processes.

Deaths leading to a police investigation or other criminal proceedings

A police investigation does not prevent the triggering of JAR or discussion of the death at CDRM. However, the Specialist Nurse CDR will liaise closely with the Police to avoid prejudicing any criminal investigation or proceedings. The Police Officer identified at the JAR meeting will be told of any information which comes to light through the CDR process which might be relevant to the investigation.

LeDeR for child deaths aged over four years with learning disabilities
The Learning Disabilities Mortality Review (LeDeR) programme describes a review process for the deaths of people aged 4 years and over with learning disabilities in England.

The LeDeR programme defines 'learning disabilities' to include the following:

- a significantly reduced ability to understand new or complex information and to learn new skills (impaired intelligence), with
- a reduced ability to cope independently (impaired social functioning), which
- started in childhood with a lasting effect on development.

For children, their learning disability can be formally diagnosed or suspected to meet the criteria for referral to LeDeR.

It is the responsibility of the organising confirming the death to also report to LeDeR as required. The SPOC will liaise with the LeDeR local area contact to confirm notification has been received. Consideration will be given to appropriate expertise about learning disabilities being available at any JAR, CDRM or CDOP meeting. Following closure at CDOP, the SPOC will share the completed child death analysis form with LeDeR local area contact.

7. Child Death Review Meeting (CDRM)

Investigations will be different for individual children however every child's death should be discussed at a CDRM .

The CDRM is a multi-agency/multi-professional meeting which should take place **within 3 months** of the child's death, following the completion of any outstanding investigations but before any Inquest is held. The need to wait for any outstanding reports, including post mortems, will delay some CDRMs beyond 3 months.

It is the responsibility of the organisation responsible for the declaration of death to arrange the CDRM.[2] The exception to this is when a Joint Agency Response has occurred, in which case responsibility defaults to the lead health professional.[2]

The SPOC is responsible for ensuring the CDRM for any child who dies within Sutton is arranged by the appropriate organisation.

For Sutton residents who die outside the Borough, the SPOC or Specialist Nurse CDR will discuss with the local CDR team/Trust who is best placed to host the CDRM.

The Specialist Nurse CDR is responsible for the draft completion of the Care Pathway form and Child Death Analysis (Appendix C) during the CDRM. Minutes will be recorded by the SPOC.

The CDRM should be chaired by the lead professional for the child death review process within the organisation where death was declared, or the lead health professional in a Joint Agency Response. If the lead professional also had overall clinical responsibility for the child, the role of chair should be delegated to another colleague to avoid any perceived conflict of interests. At the beginning of each meeting the Chair should inquire as to conflicts of interest among the attendees.[2]

Parents will be informed of the CDRM date and have the opportunity to contribute their views and questions via the Specialist Nurse CDR. The outcome of the CDRM will be shared with the parents by the Specialist Nurse CDR and/or the Medical Lead i.e. child's paediatrician, or in the case of a neonatal death, obstetrician and neonatologist.

CDRM after neonatal unit or labour ward deaths

For neonatal deaths the perinatal mortality review group meeting will act as the CDRM. The PMRT should be used to support this review meeting.

The Specialist Nurse CDR will attend the local perinatal mortality review group meeting meeting so they can:

- support the analysis and learning from the deaths reviewed
- support the completion of the Care Pathway form and Child Death Analysis form
- represent the voice of the family at these meetings

Depending on the circumstances of a neonatal death, it be more appropriate to hold a CDRM. This will be agreed between the Designated Doctor for Child Death and Specialist Nurse CDR on a case by case basis.

CDRM Aims

In all cases the aims of the CDRM are to:

- review the background history, treatment, and outcomes of investigations, to determine, as far as is possible, the likely cause of death

- ascertain contributory and modifiable factors across domains specific to the child, the social and physical environment, and service delivery
- describe any learning arising from the death and, where appropriate, to identify any actions that should be taken
- review the support provided to the family and to ensure that the family are provided with the outcomes of any investigation into their child's death
- review the support provided to staff involved
- ensure that CDOP and, where appropriate, the Coroner is informed of the outcomes of any investigation into the child's death

The CDRM will send a draft death analysis form of each individual case to inform the independent review at the CDOP.

CDRM attendees

Professionals invited to the multi-agency CDRM will be determined by the CDR Team on a case by case basis. Typically these will include;

- hospital or community healthcare staff involved with the child at the end of his/her life, and those known to the family prior to this event
- pathologist, if a post-mortem examination has taken place, or placental histology has been reported in the case of a neonatal death
- other professional peers from relevant hospital departments and community services
- patient safety team if a SI investigation has taken place
- coroner's officer, if the case has been referred to the coroner
- senior investigating police officer, if there is a JAR
- other practitioners for example social work, ambulance and fire services, primary care clinicians, school nurse, head teacher, nursery staff, representatives from voluntary organisations.

This list is not exhaustive.

8. SWL Child Death Overview Panel

The Purpose of the SWL CDOP is:

- To identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety
- To consider whether action should be taken in relation to any matters identified.
- To prepare and publish reports on:
    - what has been done as a result of the child death review
    - how effective the arrangements have been in practice;

The SPOC and Specialist Nurse CDR will ensure all relevant information has been gathered prior to presenting a case for review at the SWL CDOP. When required the Specialist Nurse CDR will attend the SWL CDOP.

The Designated Doctor for Child Death and the Specialist Nurse CDR are responsible for sharing information regarding trends, themes and learning from the SWL CDOP with the Sutton CDR partners and local organisations.

9. The Team Around the Family

The team around the family exists to support families through the CDR process and includes the;

- Key Worker
- A Medical Lead
- Other professionals known to the child and family before and at the time of death

Keyworker

The Specialist Nurse CDR will be the key worker for all families resident in Sutton. The Specialist Nurse CDR will liaise closely with other CDR Teams/Partners for children resident elsewhere who die at Epsom and St Helier NHS Trust or elsewhere in Sutton to determine who is best placed to support the family through the Key Worker role.

Families should be informed of the Specialist Nurse CDR contact details immediately after the death or prior to leaving the hospital, and be informed that the Specialist Nurse CDR will contact them in working hours.

Where another professional is best placed to undertake the key worker role, e.g. bereavement midwife, the Specialist Nurse CDR will liaise closely with this professional to offer them support and to ensure all elements of the Key Worker role are being offered to the family as outlined below.

As part of the Key Worker role the Specialist Nurse CDR will:

- be a reliable and readily accessible point of contact for the family after the death;
- help co-ordinate meetings between the family and professionals as required;
- be able to provide information on the child death review process and the course of any investigations pertaining to the child;
- liaise as required with the coroner's officer and police family liaison officer;

- represent the ‘voice’ of the parents at professional meetings, ensure that their questions are effectively addressed, and to provide feedback to the family afterwards; and
- signpost to expert bereavement support if required.

Details of Local and National bereavement services can be found in Appendix D. Any professional supporting a bereaved parent, sibling or family member can direct them to the services listed or liaise with the Specialist Nurse CDR for advice and support.

The Medical Lead

Identified for every case this will usually be the child’s paediatrician, or in the case of a neonatal death, consultant obstetrician and neonatologist, who can liaise closely with the Specialist Nurse for Child Death and arrange:

- follow-up meetings at locations and times convenient to the family; and
- provide clinical expertise to be able to
    - answer questions relating to the medical, nursing or midwifery care of the child;
    - explain the findings, where relevant, of the post-mortem examination and /or other investigations
    - report back the outcome from the CDRM

Education

Members of staff from education settings are often the professionals with the most consistent and long term contact with a family. Families will often contact nursery’s, schools and other education setting directly to inform them of the death of their child. It is important that education professionals contact the CDR SPOC to confirm the details of the death before taking any other actions, including informing the wider school/setting community.

Occasionally, members of staff from education settings are the first professionals to become aware of the death of a child. This may be due to the death occurring whilst the child is in the care of the education setting or from the family informing them when the death has occurred outside England. In these circumstances it is important for professionals to contact the CDR SPOC and complete a Child Death Notification form as fully as possible at www.ecdop.co.uk/sutton/live/public . In these circumstances the Designated Doctor for Child Death will consider if a JAR is required and will chair the CDRM for any case where the death occurred outside England.

For children attending an education setting, Child Death Reporting Forms will be requested from that setting via eCDOP. Representatives from education settings will be invited and expected to contribute to any JAR meeting and the CDRM.

Bereavement support for education settings, their staff and students is available from educational psychology services as well as local and national bereavement services. Child Bereavement UK have a number of resources for education settings and a Schools Information pack (covering early years through to secondary education) available on their website www.childbereavementuk.org

Other professionals

At the time of a child's death, other professionals may also provide vital support to the family; these include (but are not limited to) the GP, clinical psychologist, social worker, family support worker, midwife, health visitor or school nurse, palliative care team, chaplaincy and pastoral support team.

In all cases, it is the responsibility of the Specialist Nurse CDR to ensure that:

- there is clarity regarding each professional's role;
- the family does not receive mixed messages
- communication is clear.

10. Cross Border Issues

Children Resident in Sutton who Die Elsewhere

Where a child normally resident in Sutton dies elsewhere the Designated Doctor for Child Death and Specialist Nurse for Child Death Reviews will liaise with the lead professionals where the child died to negotiate who is best placed to provide the initial response, JAR (if required), CDRM and final CDOP review. Usually this will be the area where the greatest learning is likely to be achieved.

Children Resident Elsewhere who Die in Sutton

The Designated Doctor for Child Death and Specialist Nurse for Child Death Reviews will liaise with the lead professionals where the child is normally resident to negotiate who is best placed to provide the initial response, JAR (if required), CDRM and final CDOP review. Usually this will be the area where the greatest learning is likely to be achieved. For children who normally reside outside of England, Sutton CDR partners will be responsible for undertaking the review.

Children Resident in Sutton who die Overseas

Any agency or professional who becomes aware of the overseas death of a Sutton resident should complete an eCDOP Child Death Notification form and liaise with the Sutton SPOC. It is customary practice for the Foreign and Commonwealth Office (FCO) to also notify the relevant CDR partners and CDOP where the child was normally resident, if a UK address is provided to them. The FCO will only be aware of a death if the family, local authorities or other interested party notifies them. The

CDR process continues as outlined for a death occurring in Sutton, as far as possible, including JAR if required. A key worker will be identified for the family on their return to the UK.

The SPOC and Specialist Nurse for Child Death will seek further information from the Coroner (if the child is repatriated) and the Foreign and Commonwealth Office to support the CDR process. It is recognised that it is often difficult to obtain detailed information to inform the review of a child's death which has occurred overseas. This will be taken into consideration when undertaking the CDR process and final child death analysis.

11. Retention of Records and Information Governance

Records will be retained on eCDOP until the child's 27th birthday as per the guidance in Records Management Code of Practice for Health and Social Care (2016)[10]. Paper and other e-copies will be securely disposed of once the case is completed by the SWl CDOP and there is an auditable trail ensuring that all information is present on eCDOP.

Should the CDR partners choose to no longer use eCDOP, all stored data will be requested from the system provider, QES, in a useable format.

Access to eCDOP is restricted by the SPOC, giving individuals specific types of access dependent on their role and the cases they are involved in. Access rights to eCDOP will be monitored by the SPOC, with individuals being 'locked out' after completion of the case they are involved in.

12. Confidentiality and Information Sharing

At the commencement of every JAR and CDRM, professionals present will be reminded by the Chair of the confidentiality guidelines and will be required to sign a confidentiality agreement. Due to the nature of JARs and CDRMs, and the requirement to invite professionals who knew the child before and at the time of death information will not be anonymized at these meetings.

Information shared with and discussed at the SWL CDOP meetings will be anonymised prior to the meeting. However due to the nature of the cases, the potential involvement of the media and involvement of some Members of the CDOP

panel in prior case discussions and meetings, individuals details may be known to those at the meeting.

All Members must 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 and GDPR.

CDOP Members will all be required to sign a Confidentiality Agreement before participating in the CDOP. Any ad-hoc or invited or Co-Opted Members and Observers will also be required to sign the Confidentiality Agreement. At each meeting of the CDOP all participants will be required to sign an Attendance Sheet, confirming that they have understood and signed the Confidentiality Agreement.
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.

Information shared with and by the CDR partners will be done through secure email or using the online platform Sutton eCDOP (hosted by QES).

13. Media Enquiries and Freedom of Information Requests

Media enquiries should be directed to Sutton CCG Press Office in the first instance on 0203 880 0302 or pressoffice@swlondon.nhs.uk who will liaise with the Designated Nurse for Safeguarding Children and Designated Doctor for Child Death.

Freedom of Information Request should be directed to the FOI team using the contact details below. The FOI team will liaise with the Designated Nurse for Safeguarding Children and Designated Doctor for Child Death when considering the request and response.

Freedom of Information Team,

NEL CSU,

1 Lower Marsh,

Waterloo,

London,

SE1 7NT

nelcsu.foi@nhs.net

14. CDR Partner Updates and CDR Process Evaluation

The Specialist Nurse CDR will produce quarterly reports for the CDR partners updating them on any new and outstanding cases, as well as the adherence to timescales as outlined earlier in this Operating Protocol and Guidance.

An annual report will be produced for the CDR partners highlighting the deaths that have occurred over the previous financial year and the child death reviews completed at the SW London CDOP

Local Learning

A log of learning from Sutton cases will be maintained to support the understanding of and learning from local deaths. The log will be used to inform the local CDR partner annual report, including local recommendations and actions to prevent future child deaths and support bereaved families.

Compliments and Complaints

A log on compliments and complaints about the local CDR process will be maintained and shared by the CDR Specialist Nurse with the CDR partners on a quarterly basis. The CDR Specialist nurse will respond to any complaints in the first instance, seeking guidance form the Designated Doctor for Child Death as required.

Key Performance Indicators

The following measures will be used to evaluate the Sutton CDR processes.

Outcome	KPI	Target
1. The CDR process commencing in a timely manner	a) Child Death Notifications completed by referrers within 24 hours of death	100%
	b) Acknowledgement of the Child Death Notification by the SPOC within one working day	100%
2. To meet JAR requirements for all appropriate cases	a) JAR immediate decision making initial discussion undertaken by Health, Police and Children's Social Care within 2 hours of death	100%
	b) Joint history taken from family by Police and Health	100%
	c) JAR meeting held within 48 hours of death	80%
3. CDRMs to be completed for all cases	a) CDRM to be completed within 3 months for cases not requiring a JAR	80%
	b) CDRM to be completed within 3 months for cases requiring a JAR (*NB Some JAR cases will be delayed due to other investigations e.g. Post mortem reports, criminal investigations)*	50%
4. Cases to be referred to SWL CDOP for final review and completion	a) Cases referred to and closed by SWL CDOP within 6 months of death	80%
5. Families to be supported through the CDR process by a Key Worker	a) Key Worker to make contact with the families within 72 hours of death	90%

Appendix A – Immediate Decision Making Proforma

To be completed with 1-2 hours of death being declared and copy kept in the child's health record

Child's name:				
Address:				
NHS number:				
Decision?		*Circle as appropriate*	**Action**	*Action completed?*
1	**Does death meet criteria for a Joint Agency Response? (death due to external causes, or sudden with no apparent cause, or in custody, or suspicious circumstances, or stillbirth with no healthcare professional in attendance)**	Yes / No	**If Yes, contact on-call health professional, police, duty social worker and request they attend hospital**	Yes No
2	**Can a MCCD be issued?**	Yes / No	**If No or if death meets other criteria for referral to coroner, contact the coroner's office**	Yes No
3	**Has a potential care or service delivery issue occurred?**	Yes / No	**If Yes contact the patient safety team**	Yes No
3a	**In relation to 3: Has a Datix form been completed?**		Yes / No / NA	
3b	**In relation to 3: Have obligations under the Duty of Candour been fulfilled (family informed, offered apology, invited to submit questions)?**		Yes / No / NA	
4	**Are there any immediate actions necessary to ensure the health and safety of others, including family or community members, healthcare patients and staff?**	Yes / No / NA	If Yes describe here:…… …… …… ……	

Describe the approach to supporting the family including name of key worker and end of life medical lead if known:

Key Worker:

Medical Lead:

Name of person completing this form	
Job title	
Date	

Appendix B – Child Death Notification

CDOP Case ID:

The information on these forms and the security for transferring it to the CDR SPOC should be clarified and agreed with your local Caldicott guardian. Please remember it is a statutory requirement to notify CDOP of all child deaths from birth up to their 18th birthday. If there are a number of agencies involved, liaison should take place to agree which agency will submit the Notification. However, unless you know someone else has done so, please notify with as much information as possible

Child's Details

Full Name of Child		
Any aliases		Male / Female
DOB		NHS No.
Address		
Postcode		

Other significant household and family members (parents, siblings, other relevant adults)

Name	**DOB**	**Relationship**	**Address**

Death details:

Date of death	/ /
Where was the child when they died? [1]	
Suspected cause of death	

[1] The place where the child is believed to have died regardless of where death was confirmed. Where a child is brought in dead from the community and no signs of life were recorded during the resuscitation, the place of death should be recorded as the community location; where a child is brought in to hospital following an event in the community and is successfully resuscitated, but resuscitation or other treatment is subsequently withdrawn, the place of death should be recorded as the location within the hospital where this occurs

Case Management:

Is there to be a Joint Agency Response	Y / N / NK
Death discussed with the medical examiner?	Y / N / NK
Death to be investigated by Coroner?	Y / N / NK
Post mortem examination?	Y / N / NK

Notification Details:

Please outline the circumstances leading to notification. Also include if any other review is being undertaken (e.g. internal agency review); and whether any immediate action is being taken as a result of this death.

Details of relevant agency contacts:

Agency	**Name and contact details**	**√ Lead Professional (only one tick is required)**
Community Paediatrician		
Local Paediatrician/ Neonatologist		
Tertiary Paediatrician/ Neonatologist		
Other local or tertiary specialists		
GP		
Midwife		
Health Visitor/School Nurse		
Obstetrician		
Police		
Children's Social Care		
Nursery/School/College/ Local Education Authority		
Others (list all agencies known to be involved)		

Referral details

Date of referral	/ /
Name of referrer	
Agency	
Address	
Tel Number	
Email	

Appendix C – Child Death Analysis Form (CDRM use only)

CDOP Case ID:

This analysis form should be read in conjunction with the collated reporting form, and the PMRT in babies who die on a neonatal unit, to provide relevant information on the child, the circumstances of their death, and factors identified in any of the relevant domains.

Using this form at the Child Death Review meeting

Information gathered from the different agencies should be made available to the Child Death Review meeting by CDOP. Drawing on the intelligence gathered, those present at the child death review meeting should then appraise all the relevant information in order to form an understanding of the circumstances of the child's death, identify any modifiable factors and lessons to be learnt, and any action that will be taken at a local level. The completed form from the Child Death Review meeting should then be submitted to the CDOP.

Child Death Review Meeting date: / /

Individuals/ Departments/ agencies represented* at CDR meeting:

**** Including reports submitted by professionals and agencies unable to attend meeting in person***

The review meeting should analyse any relevant factors that may have contributed to the child's death. In doing so you might take into account those issues that have been highlighted in the Reporting Form. For each of the four domains below, list the factor, and determine the level of influence (0-2):

0 - Information not available

1 - No factors identified, or factors identified but are unlikely to have contributed to the death

2 - Factors identified that may have contributed to vulnerability, ill health or death

This information should inform the learning of lessons at a local level.

Domain A: **Factors intrinsic to the child.** Please list factors in the child (and in neonatal deaths, in the pregnancy). Consider factors relating to the child's age, gender and ethnicity; any pre-existing medical conditions, developmental or behavioural issues or disability, and for neonatal deaths, the mother's health and wellbeing.	**Relevance (0-2)**

Domain B: **Factors in social environment including family and parenting capacity.** Please list factors in family structure and functioning and any wider family health issues; provision of basic care (safety, emotional warmth; stimulation; guidance and boundaries; stability); engagement with health services (including antenatal care where relevant); employment and income; social integration and support; nursery/preschool or school environment.	**Relevance (0-2)**
Please also describe positive aspects of social environment and give detail to examples of excellent care	

Domain C: **Factors in the physical environment**. Please list issues relating to the physical environment the child was in at the time of the event leading to death, and for neonatal deaths, the mother's environment during pregnancy. Include poor quality housing; overcrowding; environmental conditions; home or neighbourhood safety; as well as known hazards contributing to common childhood injuries (e.g. burns, falls, road traffic collisions)	**Relevance (0-2)**

Domain D: **Factors in Service Provision**. Please list any issues in relation to service provision or uptake. Include any issues relating to identification of illness, assessment, investigations and diagnosis; treatment or healthcare management; communication or teamwork within or between agencies; and organisational or systemic issues. Consider underlying staff factors, task factors, equipment, and work environment, education and training, and team factors.	**Relevance (0-2)**
Please also describe positive aspects of service delivery and give detail to examples of excellent care	

Consider whether the Review has identified one or more factors across any domain which may have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future child deaths	CDR Review
Modifiable factors identified – please list these below	
No Modifiable factors identified	
Inadequate information upon which to make a judgement. *NB this category should be used very rarely indeed.*	
List of modifiable factors identified	

In light of your consideration of the case categorise the likely cause of death using the following schema. This classification is hierarchical. **All relevant categories should be ticked if more than one**

category could reasonably be applied. The uppermost ticked category will be recorded as the primary category and others as secondary categories.

Category	Name & description of category	Tick box below
1	**Deliberately inflicted injury, abuse or neglect.** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.	
2	**Suicide or deliberate self-inflicted harm** . This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.	
3	**Trauma and other external factors, including medical/surgical complications/error** . This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Also includes proven medical and surgical complications or errors as the primary cause of death. **Excludes** Deliberately inflected injury, abuse or neglect. (category 1).	
4	**Malignancy.** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.	
5	**Acute medical or surgical condition** . For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.	
6	**Chronic medical condition** . For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.	
7	**Chromosomal, genetic and congenital anomalies** . Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease,cystic fibrosis, and other congenital anomalies including cardiac.	
8	**Perinatal/neonatal event** . Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, necrotising enterocolitis, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).	
9	**Infection** . Any primary infection (i.e. not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.	
10	**Sudden unexpected, unexplained death.** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).	

Cause of death

In light of your review of this case, what is your opinion as to the likely cause/causes of death? Please indicate if this differs in any way from the registered cause of death or that assigned by the pathologist/coroner. Where possible, please express this in terms of the levels provided on the Medical Certificate of Cause of Death (MCCD) /neonatal MCCD.

Learning points and issues identified in the review:

List the learning points identified by the review group. A list of issues may include the absence of certain key persons from the discussion or the lack of key documents.

Actions

Identify any local actions, the department or agency responsible, and the timeline to completion. This should include those interventions deemed achievable that determined contributory factor to be modifiable.

Summary of ongoing support needs and follow-up plans for the family and (where relevant) involved professionals

Appendix D – Local and National Bereavement Support

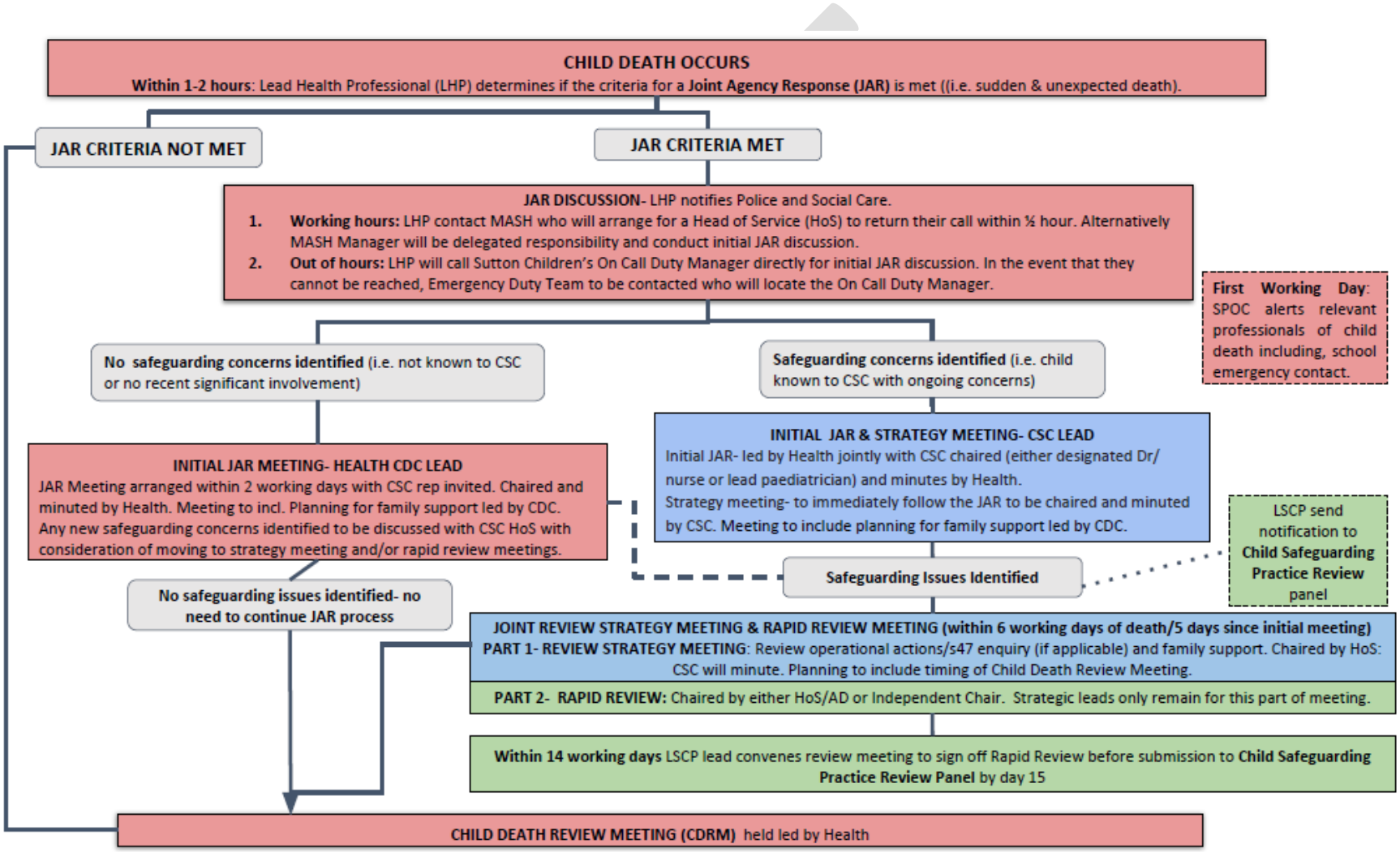
NB. This is not an exhaustive list and families may require specialist support from local mental health services

Name	Service offered	Contact Information
Care for the Family	Bereavement support for Christian Protestant parents and siblings	www.careforthefamily.org.uk/family-life/bereavement-support
Catholic Children's Society	Bereavement support for Christian Catholic parents and siblings	www.cathchild.org.uk/rainbows-bereavment-support-programme/
Child Bereavement UK	National helpline and West London hub. Supporting parents following the death of their child and bereaved children.	0800 02 888 40 www.childbereavement.org West London Hub—020 8960 9476 westlondonsupport@childbereavementuk.org www.childbereavementuk.org/west-london
Child Death Helpline	A helpline that offers support to anyone affected by the death of a child of any age, under any circumstances, however recent or long ago.	0800 282 986 / 0800 800 6019 www.childdeathhelpline.org.uk/
Children of Jannah	Support for Muslim families when a child has died	www.childrenofjannah.com
Cruse Bereavement Care	Local group for people aged 18 and over living in Sutton and a National Helpline	National: 0808 808 1766 Sutton: 07904 056 123 sutton@cruse.org.uk
Grief Encounter	Supporting bereaved children and young people	0808 802 0111 www.griefencounter.org.uk
Jewish Bereavement Counselling Service	Dedicated bereavement	www.jbcs.org.uk/

	counselling for the Jewish community.	
Jigsaw4U	Support for children 5-18 years living in Sutton, Merton and the surrounding areas.	0208 687 1384 www.jigsaw4u.org.uk
Lullaby Trust	Confidential bereavement support to anyone affected by the sudden and unexpected death of a baby or young child.	0808 802 6868 www.lullabytrust.org.uk/bereavement-support/
Sands (Stillbirth and Neonatal Death Charity)	Support group for bereaved parents based in Streatham and a National Helpline.	South West London Sands 0808 164 3332 Support.SouthWestLondon@sands.org.uk www.sands.org.uk/
SLOW (Surviving the loss of your world)	Support group for bereaved parents based in Streatham	South London Groups 07908 937 722 info@slowgroup.co.uk www.slowgroup.co.uk/
SoBS (Survivors of Bereavement by Suicide)	Support group for over 18's bereaved by suicide based in Cheam	0785 142 0526 www.uksobs.org/
Sutton Uplift (NHS)	For people aged 18 and over living in the LB of Sutton or with a Sutton GP. Patients able to self refer.	0800 032 1411 www.suttonuplift.co.uk

The Compassionate Friends	Support group for bereaved parents based in Sutton with a National Helpline	0345 123 2304 www.tcf.org.uk/
Twins Trust	Support for parents or grandparents who have lost babies or children that are twins, triplets or more.	www.twinstrust.org/bereavement.html
Winston's Wish	Support for children and young people after the death of a sibling or parent	0808 802 0021 www.winstonswish.org/

Appendix E –Flowchart for Safegaurding Practice Rapid Review after a Child Death



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