Darlington Safeguarding Partnership

Protecting Children and Adults

Management of Sudden Unexpected Death in Childhood Procedure and Practice Guidance (SUDIC)

November 2017

(rebranded Sept 2019 to reflect DSP arrangements)

Policy Document Control Sheet

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Table of Revisions

Date	Section	Revision	Author
December 2008	revised	Inclusion of role and responsibilities of the Designated Paediatrician for Child Deaths Child Protection Register no longer in use: children now ‘subject to child protection plans’ Inclusion of Child Death Review process and relevant paperwork. Notification process to RMSO	
January 2010	revised	Title changed to Guidelines for the Management of Sudden Unexpected Death in Childhood (SUDC) rather than ‘… in Infancy (SUDI)’ Sponsoring Director is now Dr Hilton Dixon, Executive Director of Clinical Quality. Senior Nurse Child Protection changed to Named Nurse Safeguarding Children throughout document. Layout of document amended to correct policy document format. Amendments to numbering of each section. Legal and Statutory Duties and Responsibilities updated. Heads of service with responsibilities include Designated Doctor for Child Deaths. References made to Rapid Response Nurse throughout document. Contact details for Designated Doctor and Rapid	

		Response Nurse added. Title of section 3.3 changed to Community Practitioners: Health	
April 2011	revised	Visiting, School Nursing and Children's Community Nursing Guidelines. Additional text to section 3.4. Title of section 3.6 changed to Paediatric or Rapid Response Nurse Assessment. Additional text added to this section. New section inserted at section 3.8. This is now 'The Rapid Response Process'. Numbers of sections following this have changed accordingly. Amendments made to section 3.9. Forms in appendices A, B, C, D and E updated in line with national templates available on Every Child Matters website. New appendix inserted as appendix H. Numbers of appendices following this have changed accordingly. History Proforma inserted as appendix M. Page numbers in contents amended accordingly along with any references made throughout the document. 4 7 April 2011 Amended section 4 to reflect new Board arrangements	
2017	Full revision	Full policy revision in collaboration with Durham & Darlington LSCB, County Durham Constabulary and CDDFT to reflect the changes in legislation and practice	Nnenna Cookey, Designated Paediatrician Child Death Review process; Catherine Hodgkiss, Rapid Response Manager

Contents

1 Introduction

1.1. Working Together to Safeguard Children 2015 lays out statutory guidance on how organisations should work together to safeguard and promote the welfare of children. Within this guidance is a requirement for Local Safeguarding Children Boards to undertake reviews into all deaths of children under 18 years of age who are normally resident in their area. In order to make this process as effective and informative as possible Durham LSCB and Darlington SCB have agreed to a joint process, sharing resources and information to improve the quality of outcomes. As a Joint Child Death Overview Protocol it is to be adhered to by all agencies.

1.2. The death of a child is a traumatic time for everyone involved. The family will be experiencing extreme grief, and where the death is unexpected, the family will also be in a state of shock. Professionals will need to support the family in understanding what has happened and why.

1.3. An unexpected death, for the purposes of this process, is defined as a death that was not anticipated as a significant possibility, for example 24 hours before the death, or where there was a similarly unexpected collapse or incident leading to or precipitating the events that led to the death.

1.4. The majority of unexpected child deaths occur as a result of natural causes or accident and are a tragedy for each family. A minority of unexpected deaths is the result of abuse or neglect or has such abuse or neglect as a contributing 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 and other family members, and consider any lessons that can be learnt to safeguard other children in the future.

1.5. In all cases of sudden and unexpected deaths, following the history and examination of the case, a note of opinion/referral of death is to be sent to the Coroner by the Consultant Paediatrician dealing with the case. See appendix 3

1.6. Child Death Overviews will seek to identify patterns and trends in child deaths that may be used to safeguard children in the future.

1.7. County Durham and Darlington Child Death Overview process will be supported by a Rapid Response Team (RRT) for unexpected deaths. The CDOP Co-ordinators will be responsible for collating the minimum data set, and information from other agencies involved with the child, and feeding this information into the Child Death Overview Panel (CDOP) for reviews to be undertaken.

1.8. Linked to this Joint Protocol is a set of working practices for each agency to ensure the information regarding child deaths is properly recorded and collated to inform the review process.

1.9. This version supersedes any previous versions of this document.

2 Purpose

2.1 From April 2008 there is a statutory responsibility for Local Safeguarding Children's Board (LSCB's) to review all child deaths (Chapter 5, Working to Together to Safeguard Children 2015).

2.2 **There are two processes:**

- Process 1 - A rapid multi-agency response to investigate the unexpected death of a child (less than 18 years).
- Process 2 - An overview of all child deaths by a Local Child Death Overview Panel (CDOP).

2.3. Key messages will be disseminated by the CDOP and information fed into a national dataset.

2.4. County Durham & Darlington arrangements :

- Durham and Darlington Local Safeguarding Children Boards have agreed common practices and procedures to be followed in the event of the death of a child.
- County Durham & Darlington Rapid Response Team (RRT) will lead in the coordinated response to an unexpected death of a child in County Durham and Darlington.
- There is a shared CDOP for County Durham and Darlington LSCBs. This Panel will sit in County Durham on a bi-monthly basis and is chaired by a Consultant in Public Health – County Durham.
- The CDOP has a fixed core membership and other co-opted members.
- CDOP seek to provide guidance for Emergency Department (ED) and paediatric medical and nursing staff and the RRT on the initial and early response when infant or child dies unexpectedly.
- CDOP seek to promote high quality, consistent care with emphasis given to the needs and welfare of the family.

3 Scope

3.1 These guidelines apply to all clinical staff working within County Durham and Darlington.

3.2 The aim of this document is to provide good practice guidelines in order to assist in identifying the cause of death, ensure support is provided for the bereaved family when a child dies and to help health staff to cope appropriately with this difficult and painful situation.

3.3. This procedure is not intended to cover all aspects of sudden unexpected death but endeavours to provide direction to practitioners who are confronted with these tragic circumstances. In most cases the process will be led by the Rapid Response Manager unless there are suspicious circumstances, in which case the police will take over. It is acknowledged that each death has unique circumstances and each professional involved has their own experience and expertise which will be drawn upon in their handling of individual cases.

Nevertheless, there are common aspects to the management of a sudden unexpected death that it is important to share in the interests of good practice and achieving a consistent approach for every child no matter what the circumstances.

4 Definitions

4.1 The guidelines are applicable to all unexpected deaths of children up to the age of 18 years.

5 Duties

5.1 The Designated Paediatrician for Child Deaths County Durham and Darlington NHS Foundation Trust on behalf of the Clinical Commissioning Groups. The role of the Designated Dr for Child Deaths is to provide a lead for the management of sudden unexpected deaths of all children.

5.2 The role of the Rapid Response Manager (or deputy) is to lead and co-ordinate the joint investigation of sudden unexpected deaths of all children.

6 Main Content of Policy

Sudden unexpected death of a child admitted from the community

6.1 If a child dies suddenly or unexpectedly at home or the community, the child should normally be taken to an Emergency department (ED) rather than a mortuary (Working Together to Safeguard Children 2015). This will facilitate a detailed history, and examination to be undertaken, and help with family support.

<u>Guidelines for Immediate Action to be taken on arrival of the child at the Emergency Department</u>

6.2 **NB: In each Emergency Department and/or Children's Ward there is a SUDIC box containing a copy of this protocol, the history proforma (appendix 1), chain of evidence forms (appendix 2), sample bottles and other equipment with which to take samples. It is the responsibility of the Department to ensure anything used is replenished.**

6.3 **Ensure that the child is taken to the resuscitation area of the Emergency Department.**

6.4 If appropriate, resuscitation should be commenced in line with the resuscitation protocol; call the duty resident Paediatric Team and Consultant Paediatrician.

6.5 Whilst resuscitation is taking place, the Sister/Charge Nurse present should:

- allocate an experienced nurse to look after the family and stay with the family.
- give the parents the option of being present during resuscitation. The allocated nurse should always stay with them to continually explain and support parents.
- obtain information from the ambulance service staff.
- ascertain the child's name.
- document the names of the people who have come with the child, their relationship to the child, and establish who has parental responsibility.
- ensure a brief history is taken of events preceding admission, including the child's past illnesses and recent health, and any resuscitation already attempted.
- clearly document details of clothing; any clothing not removed should remain on the child. Gloves should be worn when handling clothing. All bed linen, clothing, including the nappy on admission, need to be given to the Police and fully detailed in the hospital notes including the location of the clothing. (If for any reason the Police do not require any items of clothing, document fully in the notes and handover to parents. If parents are not present document the location of the bagged clothing).

6.6 If a child is medically certified as dead, the Senior ED Clinician/Paediatrician should ensure the Police are informed immediately (101). The Rapid Response Nurse must be informed immediately (01388 455126) and will take responsibility for informing all the relevant people/agencies.

6.7 Ambulance control may have contacted Police, but do not assume and the Clinician should contact Police.

6.8 Any equipment used in resuscitation, including cotton wool and swabs, need to be given to the Police and fully detailed in the hospital notes.

6.9 Where abuse or neglect is suspected to be a factor, the Rapid Response Nurse will notify designated professionals accordingly.

6.10 If the child is moved from the Emergency Department to the Paediatric Ward there must be careful consideration of forensic issues:

- The child should be taken to the Paediatric Ward by a trained nurse from the Emergency Department and/or a Senior Nurse from the Paediatric Ward.

6.11 When it is required for the deceased child to be transferred to another department or mortuary, the hospital portering service are to be contacted. Arrangements will be made for the body to be transported in the carrying case (newborn size) accessed via the mortuary and for older children, arrangements will be made for the body to be transported using the porters concealment trolley. This will remove any chance of bodies being inadvertently stopped during transfer by visitors. Any transfer needs to be done with absolute discretion and managed so that parents and family do not witness transfers.

6.12 The consultation with the parents by Rapid Response Nurse/Consultant Paediatrician should cover the following:

- An initial history should be taken and fully documented in health records carefully indicating who the history was taken from.

6.13 Do Not Wash the Child.

6.14 If there are any concerns that the death may be suspicious, ensure that family members do not have any unsupervised contact with the child until police give permission.

6.15 The Rapid Response Nurse will provide parents with the following:

- an explanation that any sudden death of unknown cause has to be reported by the Police to the Coroner, who will decide whether a post-mortem examination is carried out.
- an explanation that the information will be shared with other agencies and information will be sought from: GP, Primary Care Services and Durham/Darlington Children's Services.
- an explanation that there is a statutory responsibility for all child deaths to be reviewed which is led by the Designated Paediatrician for Child Deaths.

6.16 The Rapid Response Nurse will offer to contact the following for the parents/carers:

- Other family members or close friends.
- Their employers and explain that they can't get to work and anyone else they would like to contact.
- The child's school and schools of siblings if appropriate.

6.17 Ascertain from the parents if they have a preference within the professional health team they would like to contact to offer support and ensure the health professional is informed to arrange to contact the parents.

Samples from Parents

6.18 If samples are requested from parents by the police it is the responsibility of the senior officer in attendance to arrange the samples to be taken by the Forensic Medical Examiner.

Radiology

6.19 A skeletal survey should be arranged by the Consultant Paediatrician for children 0-2 years due to their vulnerability. It needs to be performed as soon as possible after the death (in daylight hours) as the results of this may inform future action. In children > 2years of age, a skeletal survey would be dependent on circumstances of the history/examination/scene of death.

6.20 The skeletal survey and report are the responsibility of the hospital where the child is initially taken. This is to ensure that there can be no question that an injury occurred while the child is being transported from one hospital to another.

6.21 The Radiology Department will notify the Rapid Response Nurse of the time of the planned skeletal survey. It is the responsibility of the Rapid Response Nurse to inform the relevant department where the child is at the time of the investigation to ensure the child is accompanied by a senior nurse for the procedure. The Rapid Response nurse will inform the Consultant Paediatrician that the skeletal survey has been performed. If the case is thought to be suspicious the Rapid Response Nurse will inform the Police/Coroner's Officer of the arrangements and ensure continuity of the body.

6.22 The skeletal survey should be reported by a Consultant Radiologist as soon as possible. Ideally the report should be provided by a Consultant Paediatric Radiologist. These guidelines acknowledge the fact that there are only a few Consultant Paediatric Radiologists nationally and this may not always be possible. However, where there are clear indicators or suspicions that the child's death is suspicious, the x-rays should always be reported by a Consultant Paediatric Radiologist and will be organised by the Rapid Response Nurse/Radiographer or Radiology Manager.

Initial History

6.23 It is essential that an initial history be compiled although it is acknowledged with extremely distressed parents professional judgement will be required regarding the timing of this. This recognises that clinical consultations have greatest evidential value if it is possible to establish the pattern of consistency and inconsistency in the accounts of the carers.

6.24 It It is important to document all that is said by the family in a precise and non-judgmental fashion.

6.25 Specific questions need to be asked to look for pointers to a diagnosis for the cause of death, starting from the point of Emergency Department contact and working backwards to when the child was completely well and then taking details about the child's life, birth and family.

6.26 The following details need to be recorded:

- Any relevant observations about carers may be important.

- Is there evidence of violence to them apparent, i.e. bruises?
- Is there an odour of alcohol, unsteady gait, slurred speech etc. suggesting intoxication or substance misuse

6.27 Where there are significant gaps in the information obtained the Consultant Paediatrician should liaise with the Investigating Police Officer and Rapid Response Nurse.

6.28 A more detailed history with parents or carers is undertaken jointly by an experienced Police Officer and Rapid Response Nurse.

Examination by Paediatrician / Emergency Physician

6.29 It is essential that this is done with surgical gloves as a thorough inspection of the dead child is required. Important areas not to forget are the scalp, the frenulum and palate, and the anus and genitalia.

6.30 Any external injuries, marks, rash, bruising or staining should be accurately documented using the body charts (see Appendix 1 re History Proforma). Puncture marks from resuscitation or investigations should also be marked on the body chart. The child's general state of cleanliness should be noted.

6.31 There should be an accurate weight and head circumference (where appropriate) taken recorded on the History Proforma.

6.32 A rectal temperature on admission should be recorded on the History Proforma.

6.33 It is a requirement for the Police forensic examination to include swabs, photographs, tapings, etc. Where practicable this will be done at the same time of the Paediatrician examination and where it will not cause delay. The Investigating Officer will arrange for these to be taken.

Investigations

6.34 The Coroner has given permission for the following investigations to be performed, which have been agreed with the paediatric pathologist (see Appendix 2 – copies are held in the SUDIC box):

6.35 Cardiac puncture should be avoided as this may cause damage to intra-thoracic structures and make post-mortem findings difficult to interpret. If it is difficult to obtain a blood sample from venous or arterial puncture then it should be obtained by cardiac puncture (within 30 minutes of the death being declared). This must be carefully documented in the records and included in the Police briefing.

6.36 Consultant Paediatrician should ensure routine samples are taken immediately, after sudden/unexpected deaths in infancy. In the unusual event that post-mortem is to be carried out within 24 hours, the samples can be taken by the Paediatric Pathologist and/or Forensic Pathologist as appropriate.

6.37 These are the investigations that would be performed in ideal circumstances. The specimen request form (Appendix 2) lists the investigations in priority order.

6.38 Samples should be accompanied by a chain of evidence form before being taken in person to the laboratory. The specimen request serves as the SUDIC Chain of Evidence Form and should be signed by the receiving Laboratory Staff and a copy retained for the medical record.

6.39 For sudden unexpected deaths in older children it will usually be appropriate to take similar samples, especially for toxicology and microbiology. It may be helpful to discuss this with the Pathologist.

6.40 It is the responsibility of the Sister / Charge Nurse and Consultant Paediatrician to ensure that any sample bags and clothes bags are correctly labelled.

6.41 In University Hospital of North Durham samples will be taken on the Paediatric ward.

Post-mortem Examination and Pathology

6.42 For babies and young children, post mortems will be undertaken at the Royal Victoria Infirmary. For older children post mortems may be undertaken locally. The Investigating Officer will inform clinical staff of the decision following the necessary consultation and permission of the Coroner.

6.43 The Consultant Paediatrician will be required to submit a report to the Pathologist with a copy to the Coroner as appropriate.

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6.44 The Rapid Response Nurse will advise mortuary staff, wards/departments whether there are any visiting/viewing restrictions by the family following discussions with the police.

6.45 The Rapid Response Nurse should ensure that the results of tests taken prior to autopsy are known to the Pathologist as soon as possible.

Consent

6.46 Consent forms for sharing information and access to medical records for the child, siblings and parents where appropriate should be obtained by the Police and Rapid Response Nurse.

Unexpected death of a child in a ward

6.47 For all children who are found dead unexpectedly whilst in hospital resuscitation should be commenced in line with the resuscitation protocol; call the duty resident Paediatric Team and Consultant Paediatrician.

6.48 The Sister/Charge Nurse present should follow procedure 6.5.

6.49 If there is a known medical cause for the child's death it may not be necessary to continue with the following procedure. This decision should be made by the Consultant Paediatrician with the agreement of the Coroner. A referral should be made to the Coroner in all cases (Appendix 3).

6.50 If there is no known medical cause, e.g. if the child is on a post-natal ward following an uneventful delivery, these guidelines should be followed.

6.51 The Police and Rapid Response Service to be informed and procedures followed from 6.6 to 6.8.

6.52 The Paediatrician or Emergency Physician will take samples as indicated in Appendix 2 sample form.

6.53 There needs to be a detailed external examination of the child undertaken by the Consultant Paediatrician, review of records and consultation with the parents. The consultation should include taking/reviewing the detailed history which should be fully documented in health records, carefully indicating who the history was taken from.

6.54 **Do not wash the child in the event where the death is either suspicious or abuse or neglect is a factor.**

6.55 The Rapid Response Nurse will provide:

- An explanation that any sudden death of unknown cause has to be reported by the Police to the Coroner, who will decide whether a post-mortem examination is carried out.
- An explanation that the information will be shared with other agencies and information will be sought from: GP, Primary Care Services and Durham/Darlington Children's Services.

- An explanation that there is a statutory responsibility for all child deaths to be reviewed which is led by the Designated Paediatrician for Child Deaths.
- Offer to contact Family members/close friends and others on behalf of parents:
- Ascertain from the parents if they have a preference within the professional health team they would like to contact to offer support and ensure the health professional is informed to arrange to contact the parents.

Deaths of Premature Infants

6.56 All deaths of premature babies must be considered as to whether they are deemed Expected or Unexpected, based on the history and information available, in context with the circumstances of the premature birth.

6.57 If a baby dies within 24 hours of birth or shortly thereafter due to an event related to the birth whilst under medical supervision, and there is a clear medical explanation for the death, this should not be treated as an unexpected death.

6.58 If a baby dies within 24 hours of birth in the same circumstances (i.e. whilst under medical supervision), with no immediate medical explanation apparent for the child's death, the situation should be discussed with the Lead Paediatrician. The Lead Paediatrician will make a decision (informed by the circumstances surrounding the death and information available to them within Health) as to whether the case should be regarded as an unexpected death and so fall within these procedures.

6.59 Following the delivery of the baby, further enquiries must be made to identify any concerns regarding the mother or the family.

6.60 After all relevant considerations have been made, if the death is deemed unexpected, then the SUDIC Protocol and Rapid Response process MUST be initiated.

6.61 The placenta must be retained (dry) wherever possible and form part of the post-mortem examination.

6.62 The following flowchart details steps to take for all deaths in hospitals.

Flowchart for Sudden, Unexpected Deaths of Neonate or Child in Hospital

In all cases, the Paediatrician must complete a referral note to the Coroner (appendix 3)

Unexpected
Neonatal/Child Death in Hospital

↓

Consultant Paediatrician/Senior Nurse to phone Rapid Response Nurse on 01388 455126

↓

Paediatrician will contact Coroner's Officer, discuss with Rapid Response Nurse and involve Police if appropriate i.e. in cases where a clinician is unable to issue a death certificate

(Discussion will take place as to extent of investigation required)

↓

Coroner likely to request Police to attend Hospital

(Should be detectives in plain clothing or else a non-uniform jacket to be worn over police uniform)

↓

Rapid Response Nurse to meet Police Officer outside ward and arrange initial discussion with Consultant Paediatrician

↓

Police may wish to speak to parents, other staff or view the child's body according to circumstances

↓

Rapid Response Nurse to explain to parents the role of the Coroner and possible need for post mortem

Care of the Child

6.1 In a private place allow the parents (and other family members) time to hold the child (after the samples have been taken). The allocated nurse should stay with them throughout.

6.2 The allocated nurse should document in detail information about who is present with the child and their relationship with the child.

6.3 If you are concerned for whatever reason that the death may be suspicious, ensure that family members do not have any unsupervised contact with the child until police give permission.

6.4 Intravenous cannula, endotracheal tubes and similar items may be removed, bagged and with the appropriate chain of evidence labels completed.

6.5 **Never discard anything taken from child.**

6.6 Mementoes, i.e. handprints and locks of hair will be discussed with parents and arranged by the Rapid Response Nurse (after post-mortem).

Religious needs of the family at the point of death

6.63 Handling the child: In some religions the handling of the body by anyone not of their faith is to defile that body. It is therefore advisable that staff wear gloves at all times when handling these children.

6.64 In some faiths, notably Judaism and Islam, there is a requirement that the body be buried as quickly as possible, preferably within 24 hours. If this conflicts with the requirement of the law the Coroner should be notified.

6.65 For every religion there are the rites and rituals that are particular to that faith and so it **is important to ask the family about these** and to accommodate them if at all possible in consultation with the Investigating Officer. It cannot be stressed strongly enough the pain inflicted on families if these are ignored or considered unimportant.

6.66 After samples have been taken a baptism or dedication can take place. The child should be dressed in accordance with the parent's wishes. NB. The baptism or dedication and change of clothing should only be carried out after consultation with the police investigating officer.

The Rapid Response Process

6.67 When a baby or older child dies unexpectedly in a non-hospital setting, the Investigating Officer and Rapid Response Nurse should make a decision about whether a visit to the place where the child died should be undertaken. This should almost always take place for infants who die unexpectedly. As well as deciding if the visit should take place, it should be decided how soon and who should attend. It is likely to be a Investigating Police Officer and a Rapid Response Nurse who will visit, talk with the parents and inspect the scene.

6.68 The purpose of a joint home visit is to identify all possible factors that may assist to determine why a child has died.

6.69 Following the visit, an Information Sharing Meeting should be convened involving the Investigating Police Officer, Rapid Response Nurse, GP, Health Visitor or School Nurse and Children's Services representative to review whether there is any additional information that could raise concerns about the possibility of abuse or neglect having contributed to the child's death. If there are concerns about surviving children in the household, the LSCB Safeguarding Children procedures should be followed.

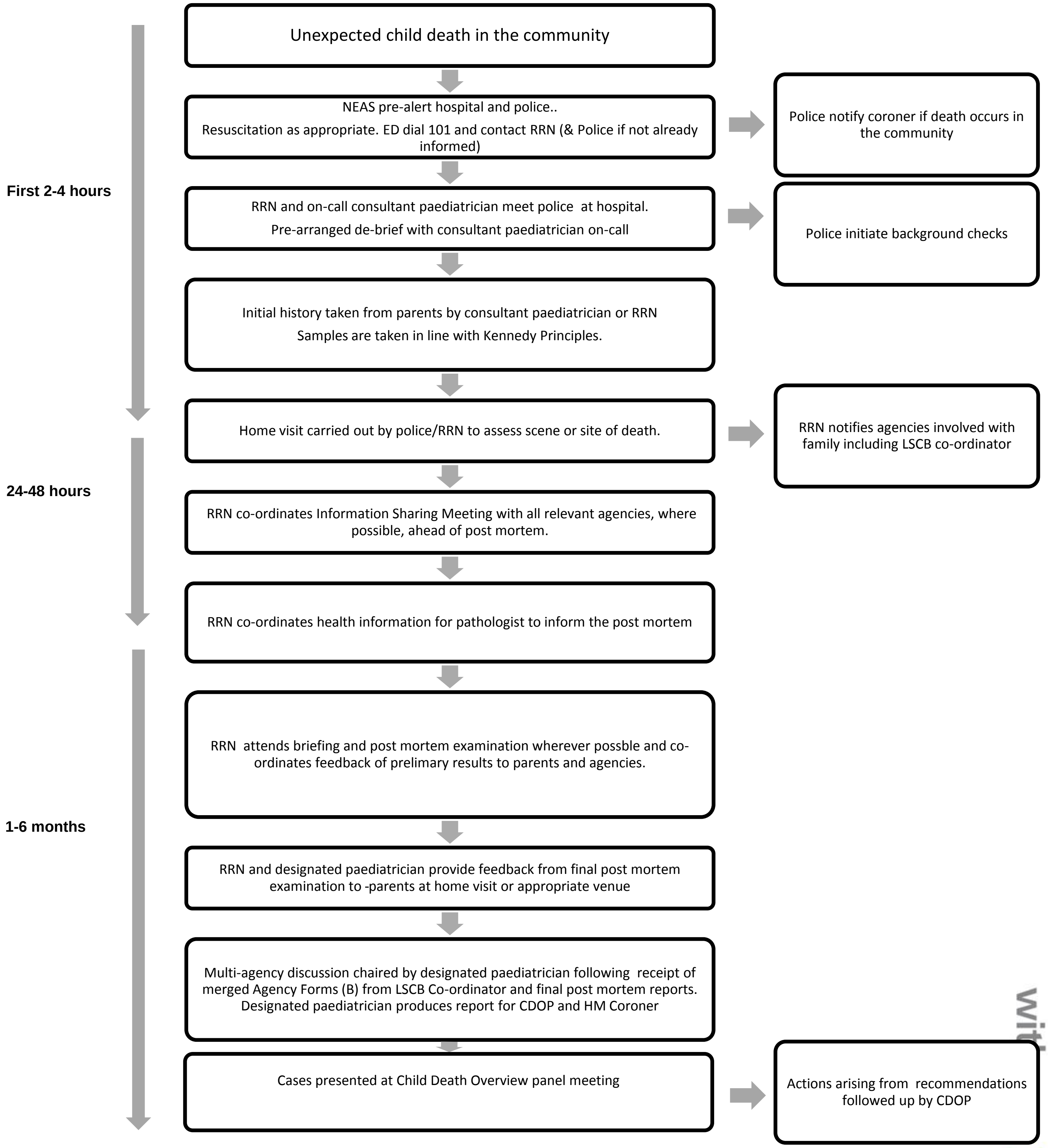
6.70 A detailed interview with parents or carers needs to take place as soon as possible. The venue for the interview will be discussed and will be conducted jointly by an experienced Police Officer and the Rapid Response Nurse and will be recorded. The interviews will be conducted for each parent separately.

6.71 It is essential that a professional and independent interpreter is available for the entire interview if English is not the preferred language. Wherever possible, the family should have the same interpreter in all their contacts with hospital and community staff during the immediate period of bereavement. The interpreter should be well informed beforehand about the situation and the reason for the visit.

6.72 The information to be gathered at the interview and home visits is included in the history proforma.

6.73 The Rapid Response Nurse is responsible for contacting Children's Services/GP/ Health Visitor/Midwife/School Nurse and any other relevant agencies to obtain background information about the child and family.

6.74 A flowchart regarding the Rapid Response process is below:


First 2-4 hours
24-48 hours
1-6 months
Unexpected child death in the community
NEAS pre-alert hospital and police..
Resuscitation as appropriate. ED dial 101 and contact RRN (& Police if not already informed)
Police notify coroner if death occurs in the community
RRN and on-call consultant paediatrician meet police at hospital.
Pre-arranged de-brief with consultant paediatrician on-call
Police initiate background checks
Initial history taken from parents by consultant paediatrician or RRN
Samples are taken in line with Kennedy Principles.
Home visit carried out by police/RRN to assess scene or site of death.
RRN notifies agencies involved with family including LSCB co-ordinator
RRN co-ordinates Information Sharing Meeting with all relevant agencies, where possible, ahead of post mortem.
RRN co-ordinates health information for pathologist to inform the post mortem
RRN attends briefing and post mortem examination wherever possble and co-ordinates feedback of prelimary results to parents and agencies.
RRN and designated paediatrician provide feedback from final post mortem examination to -parents at home visit or appropriate venue
Multi-agency discussion chaired by designated paediatrician following receipt of merged Agency Forms (B) from LSCB Co-ordinator and final post mortem reports. Designated paediatrician produces report for CDOP and HM Coroner
Cases presented at Child Death Overview panel meeting
Actions arising from recommendations followed up by CDOP

Post-Mortem Results

6.75 In all cases, further discussions (usually on the telephone) should take place with relevant agencies very shortly after the initial post-mortem results are available.

6.76 Where the results indicate that there is evidence of abuse or neglect a multi-agency meeting will be convened to discuss the findings and to consider making a referral for a Serious Case Review. The meeting will identify the most appropriate agency to submit the referral for consideration for a Serious Case Review.

6.77 Where abuse and neglect is a factor the Rapid Response Nurse will notify key Trust personnel together with Named and Designated Professionals.

6.78 Following the receipt of the post mortem report from the Coroner's Office the Designated Paediatrician and Rapid Response Nurse (or appropriate professional) will offer the family an opportunity to have a discussion explaining the findings in the report and answer any questions parents may have. Families will be offered a copy of the report (this will be undertaken in collaboration with the Coroner's Office)

Meeting with the parents

6.79 The results of the post mortem examination should be discussed with parents in a timely manner except in those cases where abuse is suspected and/or the police are conducting a criminal investigation. Where there are concerns regarding abuse or neglect, there should be a discussion with the police to agree what information should be shared with the parents and when.

6.80 In most cases it will be the Designated Paediatrician for Child Deaths and Rapid Response Nurse who meet with the parents. However, it may be decided that it would be more appropriate for the family to see the original Consultant Paediatrician responsible for the child's care. This would be arranged by the Rapid Response Nurse.

Multi-Agency Local Case Discussion

6.81 A Local Case Discussion should be convened by the Designated Paediatrician for Child Deaths when the results of the post-mortem tests are known. This will enable a discussion of all the issues and may give the best opportunity to identify the possible cause of death and any contributory factors. The meeting should include those professionals who knew the child and family, and those involved in investigating the death. This is a requirement of the statutory child death review procedure.

6.82 Prior to the meeting the Agency Report Form will be sent to all professionals involved with the child. This should be returned to the relevant Local Safeguarding Children Board within two weeks of the request being received who will then forward the form to the Designated Paediatrician for Child Deaths before the meeting.

6.83 At this meeting all relevant information concerning the circumstances of the death, the child's history and subsequent investigations should be reviewed.

6.84 The main purpose of the meeting is for sharing information to identify the cause of death and/or those factors that may have contributed to the death which includes modifiable factors and then to plan the future care for the family. Potential lessons to be learned may also be identified by this process.

6.85 After the meeting, the Designated Doctor will prepare a summary of the issues discussed, including any factors thought to have contributed to the child's death, lessons to be learned and action points. This summary will be forwarded to Durham/Darlington LSCB for consideration at the Child Death Overview Panel and the Coroner. Analysis Pro-forma will usually be completed after discussion at the Child Death Overview Panel.

Feedback to Parents/Duty of Candour

6.86 Following a child death review and when the full facts are known, feedback to parents will be discussed and feature as one of the outcomes of the review.

6.87 Feedback will be given in an open and transparent way in relation to the care provided to the child.

6.88 It will be carried out as soon as it is reasonably practicable by the respective service/clinicians identified at the review.

6.89 If a Root Cause Analysis (RCA) has been carried out by CDDFT alongside the Child Death Review, the signed off RCA document once agreed by the Patient Safety Committee will be shared with the parents by the respective service/Care Group. A copy of the RCA report should be sent to the CDOP Coordinator to be discussed at CDOP meeting.

6.90 This approach to candour underpins a commitment to providing high quality, understanding and sharing truths about harm and organisational as well as an individual level and learning from child death reviews

Support Staff

6.91 Whenever staff have had to deal with the death of a child, they should receive routine departmental debriefing followed by counselling when necessary. This should be arranged by their Line Manager.

7 Monitoring

7.1 Compliance and Effectiveness Monitoring

Compliance with this policy will be monitored as outlined in the table below.

7.2 Compliance and Effectiveness Monitoring Table

Monitoring Criterion	Incident reports/RCA and Child Death Panel
Who will perform the monitoring?	Consultant Paediatrician and Lead Nurse
What are you monitoring?	Lesson learned
When will the monitoring be performed?	Feedback from RCA and Child Death Panel
How are you going to monitor?	Child death action plans monitored by care group patient safety committee
What will happen if any shortfalls are identified?	Action plan to be developed
Where will the results of the monitoring be reported?	Discussions at Governance meeting
How will the resulting action plan be progressed and monitored?	Discussions at Governance meeting
How will learning take place?	Discussions at Governance meeting

8 Glossary of Terms

CDDFT – County Durham & Darlington NHS Foundation Trust

RCA – Root Cause Analysis

SUDIC – Sudden Unexpected Death in Infancy

CDOP – Child Death Overview Panel

LSCB – Local Safeguarding Children Board

RRT – Rapid Response Team

ED – Emergency Department

GP – General Practitioner

9 Associated Documentation

Include references

10 Appendices

Appendix 1 – History Proforma

CDR History
Proforma July 2017.d

Appendix 2 – SUDIC Specimen/Chain of Evidence Form

SUDC specimen
form.doc

Appendix 3 – Referral of Death to the Coroner

Appendix 1 -
Referral of Death to t

Equality Impact Assessment

Impact assessment.doc