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Managing Child Deaths in Suffolk

CHILD DEATH REVIEW SUFFOLK

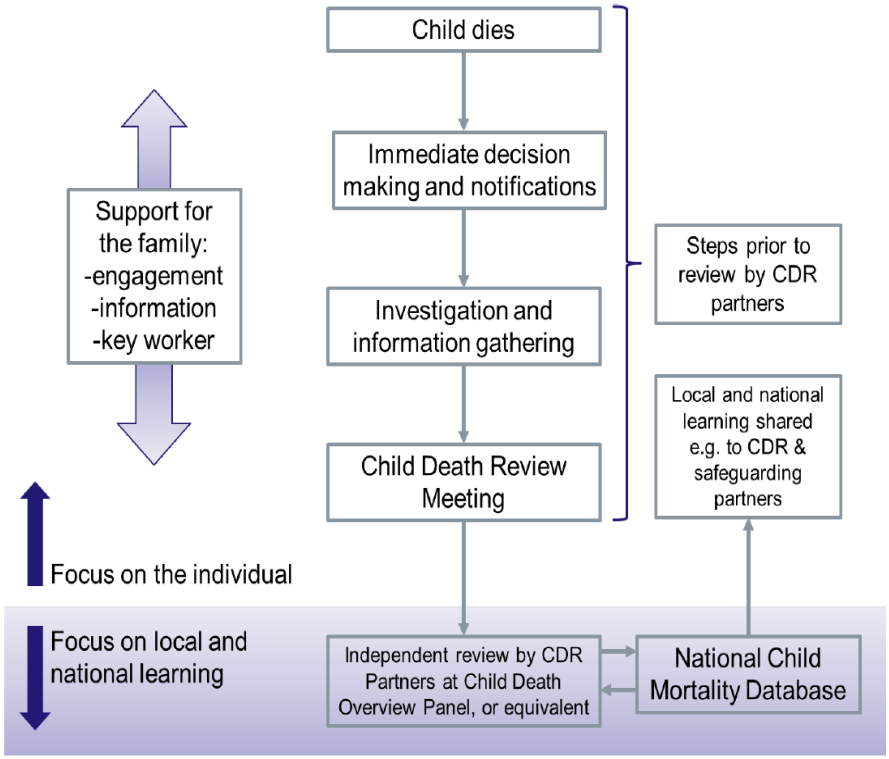
Managing Child Deaths

This guidance sets out the local process that follows the death of a child who resides in Suffolk. This process combines best practice and statutory requirements which must be followed. It is a statutory requirement as set out in Chapter 5 of Working Together to Safeguard Children 2018 that professionals and organisations across all sectors involved in the child death process need to contribute to reviews. Further information on Child Death Review statutory and operational guidance for England (HM Government) can be accessed here.

Acknowledgment and thanks to the Norfolk, Southend, Essex and Thurrock LSCBs for sharing their best practice with Suffolk.

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

Figure 1: Full Child Death Review Pathway



New Forms, Notification, Reporting and Analysis

Three standard forms should be used in the child death review process. Notification and Reporting forms must be completed on eCDOP:

- **Notification Form** (previously "Form A") To notify Suffolk CDOP of a child death please use this link https://www.ecdop.co.uk/NorfolkSuffolk/Live/Public
- **Reporting Form** (previously "Form B") for gathering information from agencies or professionals who have information relevant to the case. Links will be emailed to the appropriate professional to complete on eCDOP.
- **Analysis Form** (previously "Form C") initially drafted at the CDRM and completed at CDOP for evaluating information and identifying lessons to be learned. The Analysis Form is the final output of the child death review process. Analysis form.
- **The Scene Visit: Reviewing the Circumstances of Death - Younger Child** (Appendix 1);
- **The Scene Visit: Reviewing the Circumstances of Death – Older Child** (Appendix 2)

1. Introduction

1.1 Scope

The guidance applies to the death of any child under 18 years or where there is reason to believe they are likely to be under 18 years old whether from natural, unnatural, known or unknown causes, at home, in hospital or in the community and whether expected or not. The scope should include children who normally reside in Suffolk and who may have died abroad or in other areas of the country. Stillbirths and deaths resulting from planned termination of pregnancy carried out within the law are not included in this process.

All deaths will be subject to a child death review by the Suffolk Child Death Overview Panel (CDOP) but only unexpected deaths will be subject to a joint agency rapid response (SUDIC protocol).

The disclosure of information about a deceased child is to enable the Suffolk Safeguarding Partnership and Suffolk CDOP to fulfil statutory requirements related to child deaths.

The process is based on statutory guidance including:

- Children Act 2004 (the Act) as amended by section 24-28 of the Children and Social Work Act 2017
- Child Death Review Statutory Guidance, 2018
- Working Together to Safeguard Children, 2018
- Sudden unexpected death in infancy and childhood; Multi-agency guidelines for care and investigation, 2016.

1.2 Key Principles

- to ensure a thorough, systematic and sensitive approach is undertaken to establish, as far as possible the cause(s) of the child's death focusing on history, examination and investigations, and to identify any potential contributory factors;
- to ensure bereaved families are offered optimal support during a traumatic time, and that sensitivity is maintained alongside objectivity toward the cause/s of death;
- to ensure the safety, wellbeing and welfare of siblings, any other children associated with child, and subsequent children;
- gather information for the Suffolk Child Death Overview Panel (CDOP);
- to preserve evidence;
- to identify learning.

1.3 Categories of Death

This process covers all categories of childhood death, including:

- unexpected deaths from natural causes and from external causes (accidents, homicide, suicide);
- expected deaths, including neonatal deaths up to 28 days or where the baby has never left hospital care.

2. Child Death Review (CDR) Team

The CCGs commissioned a Child Death Review (CDR) Team to ensure a co-ordinated health response compliant with the statutory guidance for all child deaths of children normally resident in Suffolk. To ensure the process is standardised and uniform as much as possible the CDR Nurse will take the role of the lead health professional and key worker, being a point of contact for information sharing and effective communication for the family and professionals. The CDR Nurses will ensure

that every family no matter how their child has died will be offered support throughout the Child Death Review Process. The team is:

For West and East Suffolk:

The CDR Team are available Monday to Friday, 08.00 – 16.00

Contact: 01473 770089 ~~or pager: 07623 951892~~

Outside of these times, all child death notifications will be picked up by the team on the next working day.

For Waveney:

The Norfolk Child Death Review Team provides cover for Waveney and is available Monday to Friday 08.00–18.00.

Contact: 01603 257160

3. Unexpected Child Death Pathway (see SUDIC protocol)

3.1 Unexpected Child Death Definition

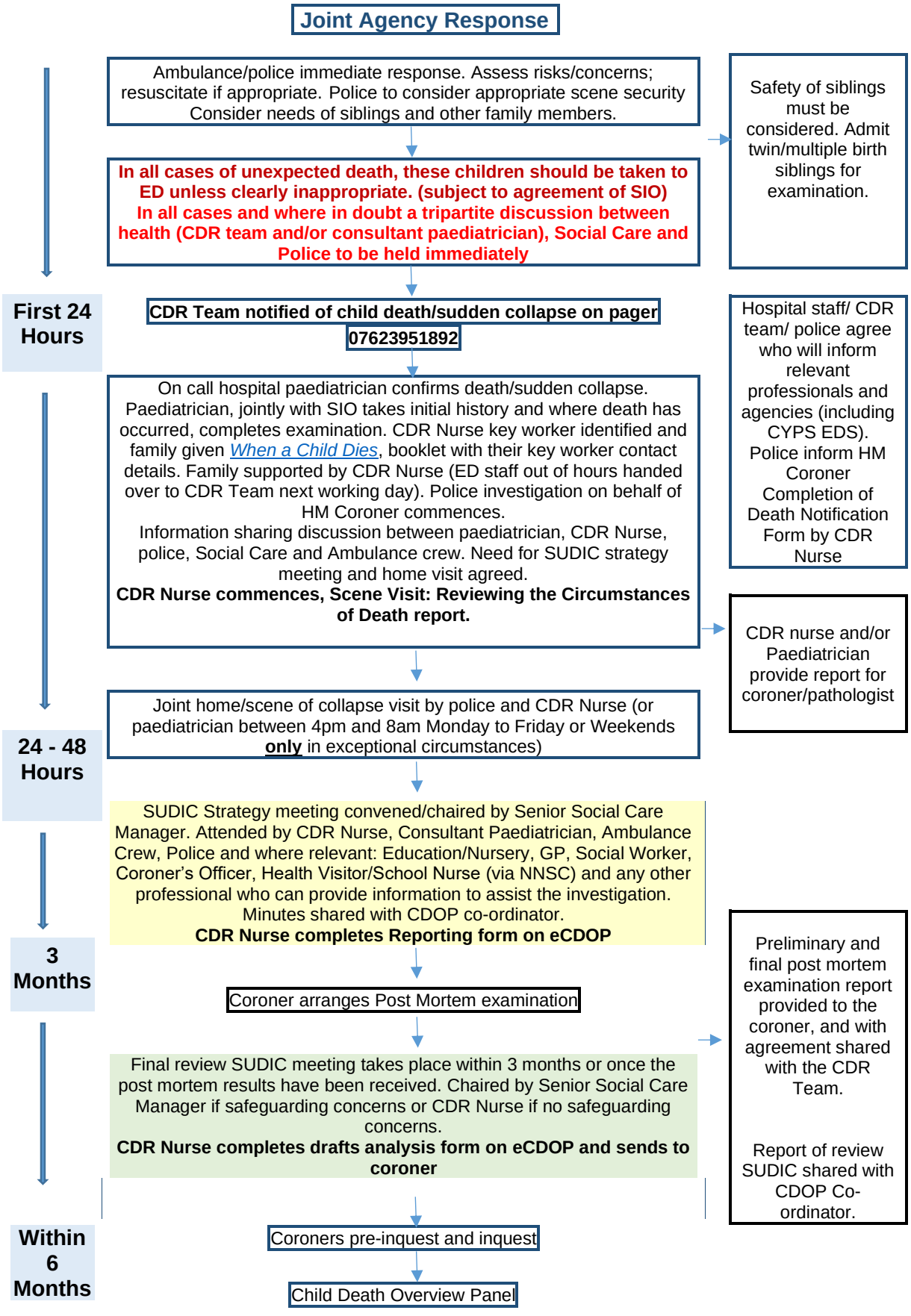
An unexpected death is defined as the death of an infant or child (anyone who had not yet reached their 18th birthday) which;
A SUDIC or Joint Agency Response should be triggered if a child's death:

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

In any of these circumstances, the on-call health professional, police investigator, and duty social worker should be contacted immediately to hold a tripartite discussion so as to agree the joint agency response.

Sudden collapse (Near Death Presentation):
A SUDIC (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.
The protocol excludes those babies who are stillborn and planned terminations of pregnancy carried out within the law.

SUDIC/JAR pathway

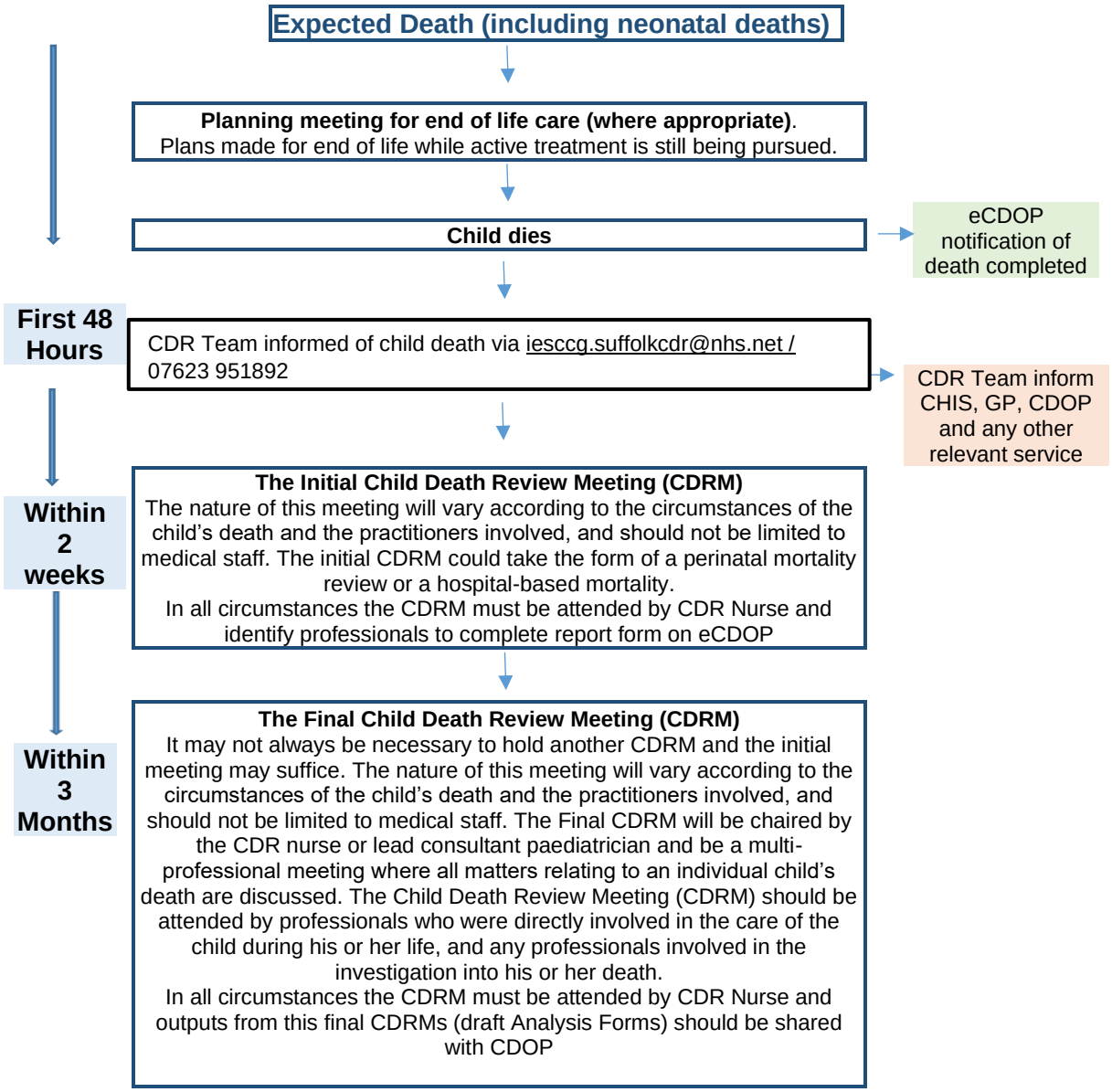


Please refer to the SUDIC protocol for more detail.

4. Expected Child Death Pathway

Expected death is the natural and inevitable end to an irreversible terminal illness or prematurity. Death is recognised as an expected outcome. The decision that death is expected should be clearly documented in the clinical records. Supportive and sensitive communication should have taken place between all those involved, and an end of life plan should be in place. For neonatal deaths there may not be an end of plan but the death is explained through prematurity or medical condition. It is expected that children with a life limiting or life threatening condition will die prematurely although, it is not possible to anticipate when, or in what manner they will die. In these cases we use the 'expected' death pathway if the cause of death is natural and a known risk of the baby or child's pre-diagnosed condition as indicated at presentation or known risk from any treatment.This is not the case where the sudden collaspe or death has no known cause but a medical is found post mortem.

Figure 3: Expected Child Death Pathway



4.1 Initial End of Life Care Planning Meeting preceding the Child's Death

An initial planning meeting for end of life care should be convened and chaired by the consultant paediatrician. Representation should include CDR Nurse, relevant Nurse Specialists, Nurses, allied health professionals, children's social care, East Anglia's Children's Hospices (EACH), educational setting, critical incident lead officer, general practitioner, parents/carers and any other relevant professionals. The relevant professionals will be invited to further meetings including initial information sharing and gathering meetings and child death review meetings. The purpose of the meeting should be to coordinate care of the child and family, to ensure appropriate symptom management, develop an end of life care plan including resuscitation plans and to coordinate communication and liaison with other professionals such as ambulance etc. At the meeting the consultant paediatrician should agree the frequency of on-going end of life care multi-disciplinary meetings. A key worker for the family should be identified and agreed (first point of contact) and the plan should include, emergency telephone numbers, personnel responsible for verification and certification of death.

4.2 Initial Response to an Expected Child Death at Home, a Hospice or a Hospital

The child may be declared dead in situ and will not normally be resuscitated or transferred to an A&E department. Death may be verified by a trained professionals such as an EACH Nurse/clinical Nurse specialist. Ambulance and police will not usually attend an expected death unless suspicious circumstances are identified or family have called 999. It is important that this is communicated to the family in the End of Life Planning meeting as calling 999 will trigger an emergency response.

It is the responsibility of the GP/other professional declaring the death of a child to make a notification if required, to the coroner. It is important that GPs and other medical professionals are aware of the causal history of the child's medical condition prior to completing a Medical Certificate of Cause of Death (MCCD). If necessary the child's consultant paediatrician should be contacted for advice.

Professionals need to make reference to end of life plans, particularly if the life limiting condition is a result of injury sustained earlier in childhood. In these cases, the plan should include coronial and police engagement.

The GP or other declaring professional is responsible for notifying the death to the CDOP administrator by completing the online notification form. The coroner's office should check with the CDOP administrator that a notification has been submitted by the GP or other declaring professional.

If the child dies in a hospital setting the consultant paediatrician will consider whether the death meets the expected or unexpected death pathway. If in any doubt a tripartite strategy discussion should be immediately convened by phone on Teams to include Police, social care and if in hours the CDR team. (see SUDIC protocol)

4.3 Initial Information Gathering and Sharing Meeting

The meeting should be convened by the lead professional (e.g. hospital paediatrician, hospice, GP). The purpose of the meeting is to coordinate support to the family, coordinate information sharing, complete Reporting Form or agree time for its completion, coordinate support and debrief to the team involved in the care of child, coordinate notifications to other organisations. The minutes of the meeting should be sent to all agencies involved in the meeting and the completed Reporting Form should be sent to the CDOP administrator. On conclusion of this meeting a final child death review

meeting date should be considered in 12 weeks and the lead professional/membership of this meeting agreed. This meeting must always include a member of the CDR Team.

4.4 Post Death Discussions with Parents/Carers

The lead professional should discuss the following points with parents/carers as follows:

- opportunities to hold their child;
- have relatives or friends contacted if requested;
- opportunity to collect mementos, such as a lock of hair, photograph, hand and footprints etc.;
- details of relevant support agencies and a copy of the *When a child dies* leaflet for parents and carers should be made available.

4.5 Final Child Death Review Meeting: 12 Weeks after the Child's Death

The CDR Nurse will coordinate this meeting and the CDR Nurse or designated doctor for child death or lead paediatrician will chair this meeting. Clear guidance has been provided regarding the purpose and structure of these meetings in accordance with the Child Death Review Statutory Guidance, 2018. This meeting will provide an in-depth discussion regarding the child's death and events leading up to it. This meeting will also inform discussions with parents.

4.6 Child Death Review Meeting with Parents/Carers – 12 Weeks after the Child Death

The lead professional will offer to meet with the parents/carers after the child's death. The purpose of the meeting will be to respond to the family's questions or concerns and identify any additional support required by the family and to discuss the cause of death.

5. General Guidance

5.1 Child Death Overview Panel (CDOP)

All child deaths are subject to a multi-agency review by the CDOP. The purpose of the CDOP is to review information on all child deaths to inform local strategic planning, identify any modifiable/ contributing factors and consider any lessons to be learned.

CDOP provides independent scrutiny of each child death from a multi-agency perspective and differs from the child death review meeting in that the information is anonymous and the panel is made up of senior professionals who have had no involvement in the case.

CDOP has a specific responsibility to consider whether each death falls into a category whereby a serious case review would be a requirement and, if they identify a case to refer, to consider why this has not been done previously.

Any professional who becomes aware of a death of a child which they believe has not already been appropriately notified should contact the CDOP administrator and complete a notification using the following link: https://www.ecdop.co.uk/NorfolkSuffolk/Live/Public. Notifications should include children normally resident in Suffolk who may have died abroad or in other areas of the country.

5.2 Serious Case Review (SCR)

Serious case reviews are statutory reviews conducted by LSCBs when a child has died and abuse or neglect are known or suspected to be factors within that death.

If at any stage in the review of a child's death information arises that suggests that the above circumstances apply then the Designated Nurse or Doctor for Safeguarding Children should be alerted who will then liaise with the relevant partner(s) regarding referring the case for consideration of an SCR.

5.3 Serious Incident Procedures

In addition to following the processes outlined in this process in respect of child deaths, all agencies should also follow their nationally and locally agreed procedures for reporting and handling serious incidents. This includes serious childcare incidents, serious untoward and patient safety incidents.
Where notification of an incident results in a local or external review or investigation being undertaken the results of these investigations should be made available to CDOP and will be used to inform the child death review. The findings of the rapid response and CDOP cannot be finalised until these reviews are concluded.

5.4 Cross Border Issues

- Children dying in Suffolk who are normally resident outside of the county
- Children normally resident in Suffolk dying elsewhere

Following the initial response and on receipt of a death notification for a child not normally resident in Suffolk, the CDOP administrator should make contact with their counterpart for the area where the child is normally resident. An agreement should then be reached on who should take the on-going responsibility for the review. Liaison should occur between the relevant designated professionals to inform this decision making.

Decisions on who should take responsibility for the review following the initial response should be made on a case by case basis. For most unexpected deaths occurring in Suffolk to non-resident children it would be expected that the CDOP will lead the review of the circumstances of the incident. However, Suffolk would rely on the area where the child was normally resident to undertake a full review of the case incorporating all background and historical information held within the area in relation to that child. Suffolk would expect the reverse to apply for deaths of a Suffolk resident child occurring out of county due to the incident happening elsewhere.

Should a child normally resident in Suffolk die elsewhere in the UK it is expected that contact will be made with the Suffolk CDOP administrator by the Board for the area in which the child died. Information will be obtained as to the rapid response that has already been undertaken by that area and of the circumstances of the death. A decision will be made by the CDOP administrator in conjunction with the designated professional and the other Board regarding the transfer of review of the case to Suffolk. The CDOP administrator should make the necessary arrangements to obtain the relevant records and paperwork from the other Board.
Decisions made on which Board should have responsibility for the review should have regard to the area in which any inquest is to be held and consultation with the coroner should form part of the decision making process.
In some circumstances reviews may be undertaken jointly by both Boards in which case, feeding back the results of the reviews to the parents/carers should be carefully coordinated.

Should a child normally resident in Suffolk die abroad, the CDOP will be reliant on any professionals becoming aware of this death to notify the CDOP administrator. Decisions will be reached on a case

by case basis by the designated professional for child deaths as to how the reviews for these children should proceed. Relevant professionals should make efforts through the normal channels to obtain information from foreign authorities as to the circumstances of the death and feedback to the rapid response/child death review process via the CDOP administrator.
In the case of the death of a child in care, the Safeguarding Partnership for the area of the local authority looking after the child should exercise lead responsibility for conducting the child death review, involving other Safeguarding Partnerships with an interest or whose local agencies have had involvement as appropriate.

5.5 Consideration of Transplanting Organs

In cases where a child's death is within a hospital and is controlled (i.e. imminent death is expected following the withdrawal of life sustaining treatment such as mechanical ventilation), organ donation should be considered. Organ donation is possible in children following a controlled circulatory death and in those certified dead using neurological criteria (i.e. completion of brain stem death tests). This includes all children from 37 weeks corrected gestational age.

5.6 Notifying the CDOP Administrator

Any professional who becomes aware of a death of a child should notify the CDOP administrator by completing a notification using the following link within 48 hours:
https://www.ecdop.co.uk/NorfolkSuffolk/Live/Public

5.7 Databases and Record Systems

Professionals receiving the notification should ensure databases and record systems are updated to record the child as deceased. Health professionals must notify the child health information department (CHIS) on 0300 303 2676. All steps should be taken to ensure that communications and mailings such as appointment letters are not sent out for children who have died.

On receiving the information of a child death, health care staff (GP surgeries, Healthy Child Programme, other community health care professionals) should liaise with the CDR Team who will coordinate on-going provision of bereavement support to the family.

Appendix 1

eCDOP Case Number:

The Scene Visit: Reviewing the Circumstances of Death - Younger Child

This form should be used as a guide for the scene visit of a younger child (up to the age of 2 years). This form should be provided to the CDR Team and the Coroner's Service.

Please return the completed form by secure email to iesccg.suffolkcdr@nhs.net.
Telephone Contact: 01473 770089.

Name		Date of death	/ /
Date of Birth	/ /	Date of Scene Visit Time	/ /
Professionals conducting Scene Visit			
Police Child Protection Officer	Name		
	Address Telephone		
	Email		
Paediatrician or other nominated healthcare professional	Name Address		
	Telephone		
	Email		
Social Care Representative	Name		
	Address Telephone Email		
Other	Name		
	Address		
	Telephone Email		
Family member(s) present:			
Name/Relationship to the child			

Name/Relationship to the child	

A. Review of the history

Builds on the initial history taken in the emergency department, allowing the circumstances leading up to the death to be explored in depth

Narrative account of the events leading to the death over the last 24 - 48 hours
Places the child and their parents/carers have been
People the child has come into contact with
All activities undertaken

When and where the child was last seen or heard alive
Presentation of the child during the last 24- 48 hours – their mood, disposition and health
Indicate anything that represents a change from usual practice Include exposure to infection, alcohol, smoking (both prescription and elicit), drugs or other harmful substances
Family History **Include ages, occupations, relevant medical history and social background of household members including the child.** History of illness, disease, substance misuse, violence, presence and temperament of pets/animals.

B Environment where the child died

Evaluation of the scene where the child died: where the child has died at home, the room and environment can be observed. In other situations this may involve a separate visit to the scene of the death.

The Room	
Size of the room	
Is the room cramped?	
Is there room for an adult to stand beside the cot/bed?	

What is the size of the room?	
What is the orientation of the room (East/West facing etc.)	
Contents of the room	
Is more than 50% of the floor space visible?	
Is there at least one clear surface?	
What are the contents of the room?	
What is the position of the furniture and cot in relation to the heaters and radiators?	
Ventilation in the room	
What windows, doors and other openings are there?	
What sources of heat/cooing are in the room?	
When are these switched on and off?	
What temperature are they set at?	
What is the current temperature?	
What is the temperature taken from inside a drawer to estimate the temperature hours before?	
Cleanliness of the room	
Is there rubbish on the floor/surfaces?	
Is there an accumulation of unwashed dishes or food?	
Is there excrement on the floor?	

Hazards in the room	
Is there a smell of gas?	
Is there damp or mold?	
Are there any faulty appliances or fixings?	
Any evidence of cigarette, alcohol or drug use?	
Parents/carers should indicate any changes that have occurred in the room in the time between the child being found collapsed/dead and at the time of the visit	
Is there any evidence of neglectful care?	
The sleep environment	
Over-wrapping or over-heating	
Is there evidence of over wrapping or over heating?	
How many layers was the baby wrapped in?	
Potential restriction to ventilation or breathing	
Is the sleeping space cluttered?	
Is there adult size bedding or pillows?	

Is there any risk of smothering?	
Potential Hazards	
Is the cot, moses basket or pram on a secure base?	
Are there gaps in the mattress?	
If a pushchair was used, was the baby strapped in securely and safely?	
Is there anything overhanging the sleeping space other that a cot mobile?	
Are there any other hazards in the room?	
Sleeping position	
What position was the child placed down to sleep in?	
What position was the child found in?	
What were the positions of other persons in the sleeping environment?	
Was there any potential or actual obstruction to the airways?	

C Diagram of the environment

Parent/carer information and support		
Parents aware of purpose of the home visit	**Yes** ☐	**No** ☐
Parent aware of how the information collected will be stored and used	**Yes** ☐	**No** ☐
Parents aware of the follow support available to them	**Yes** ☐	**No** ☐

Appendix 2

eCDOP Case Number:

The Scene Visit: Reviewing the Circumstances of Death – Older child

This form should be used as a guide for the scene visit for the death of an older child – 2 years and above.

Please return the completed form by secure email to iesccg.suffolkcdr@nhs.net.
Telephone Contact: 01473 770089.

Name of child		Date of death	/ /
Date of Birth	/ /	Date of Scene Visit Time	/ /

Professionals conducting Scene Visit

Police Child Protection Officer		Name	
		Address	
Present at visit?		Telephone	
Yes	No	Email	
Paediatrician or other nominated healthcare professional Present at visit?		Name	
		Address	
Yes	No	Telephone	
		Email	
Social Care Representative Present at visit?		Name	
		Address	
Yes	No	Telephone	
		Email	
Other Present at visit?		Name	
		Address	
Yes	No	Telephone	
		Email	

Other Present at visit?		Name	
		Address	
Yes	No	Telephone	
		Email	
Family member(s) present:			
Name/Relationship to the child			
Name/Relationship to the child			

A. Review of the history

Builds on the initial history taken in the emergency department, allowing the circumstances leading up to the death to be explored in depth

Narrative account of the events leading to the death over the last 24- 48 hours
Places the child and their parents/carers have been
People they have come into contact with

All activities undertaken

When and where the child was last seen or heard alive

Presentation of the child during the last 24 - 48 hours – their mood, disposition and health

Indicate anything that represents a change from usual practice

Include exposure to infection, alcohol, smoking (both prescription and elicit), drugs or other harmful substances

Family History

Include ages, occupations, relevant medical history and social background of household members including the child.

History of illness, disease, substance misuse, violence, presence and temperament of pets/animals.

B Environment where the child died

Evaluation of the scene where the child died: where the child has died at home, the room and environment can be observed. In other situations this may involve a separate visit to the scene of the death. In some circumstances where an older child has died it will not be practical to undertake a home visit due to suspicious circumstances or the location of the event.

The Scene	
Describe the scene? This should include, type of environment, condition of the environment and objects in the environment	
Specific Observations of the scene	
Where did the incident occur?	
Does the scene of death/collapse match with the events leading up to the death?	
Is there any evidence of neglectful care?	
Is there any evidence of self-harm/suicide?	
Information related to the people present at the scene?	
Evidence of hazards or potential risks at the scene?	
Access to computers including social networking sites, if applicable?	
Access to emergency services, if applicable?	
Environmental factors, including weather conditions?	

If the child died is believed to have died as a result of a fall, comment on the nature of the fall.	
If a pushchair, wheelchair or other device was used, was the child strapped in securely and safely?	
Access to potential harmful substances? Is there rubbish on the floor/surfaces?	
Is there an accumulation of unwashed dishes or food? Is there excrement on the floor?	
Is there a smell of gas? Is there damp or mold? Are there any faulty appliances or fixings?	
Any evidence of cigarette, alcohol or drug use?	
Parents/carers should indicate any changes that have occurred in the room in the time between the child being found collapsed/dead and at the time of the visit	
Are there any suspicious circumstances?	

C Diagram of the environment

Parent/carer information and support		
Parents aware of purpose of the home visit	**Yes** ☐	**No** ☐
Parent aware of how the information collected will be stored and used	**Yes** ☐	**No** ☐
Parents aware of the follow support available to them	**Yes** ☐	**No** ☐