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Related Trust Policies (to be read in conjunction with)	04071 Policy for standard infection prevention precautions 04072 Hand hygiene policy 06036 Maternity record keeping including documentation in handheld records 06031 Receiving and acting on test results in maternity by both hospital and community 06035 Referral to a Tertiary Unit for suspected fetal abnormality 10008 Dissemination of information to patients in maternity 09127A Interpreting and translation policy 09042 Management of patients with pregnancy loss 08071 Child death review and rapid response 07064 Breaking bad news

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2.0	Sharon Pilgrim		September 2012
2.1	Sarah Moon	Clarification to point 12.0	February 2013
3.0	Sharon Pilgrim		4th January 2016
4.0	Sharon Pilgrim	Full review	20th May 2019

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1.0 Purpose

1.1 Although the majority of babies and pregnancies are healthy, in more than 2% of babies, an antenatal test result will diagnose a condition which may or may not be treatable, may be life threatening or life limiting.

1.2 Suspected risk/ fetal abnormality may be identified by health professionals either from current pregnancy, previous obstetric, medical or family history.

1.3 When a diagnosis is confirmed, this can result in the patient and her partner experiencing uncertainty and anxiety, and may require a decision as to continue with or terminate the pregnancy, both of which can be difficult and emotionally painful.

1.4 Although MMBRACE (2016) highlighted continuing national improvements in neonatal mortality, a downward trend in the stillbirth rate and a continuing improvement in these rates for twin births, there continue to be babies who are born with a poor outcome which may result in neonatal morbidity.

1.5 The healthcare professionals should ensure that good care is delivered sensitively with the provision of support and counselling when necessary based on individually assessed needs. This should take into account patients with communication and language needs. Appropriate support can result in significant psychological gain (RCOG 2006).

1.6 It is important that all interactions, discussions and referrals and care implementation are clearly documented in the maternal hand held records to ensure that care is seamless and that memories that parents take with them are as positive as possible.

2.0 Equality Impact Assessment

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix D)

3.0 Provision of appropriate support and information for Parent/s in cases of suspected poor outcome for the Baby

(Refer to 'Dissemination of information to patients in maternity'; register number 10008)**.**

3.1 While normal findings at ultrasound/antenatal examinations have beneficial psychological effects on the pregnant patient and her partner, they are often ill prepared for bad news about the health of their unborn child in case of abnormal findings.

3.2 Where there is a suspected poor outcome identified during the antenatal period either as a result of routine antenatal screening or additional testing or ultrasound scans, the Antenatal Newborn Screening Co-ordinator and Obstetric Consultant should offer and provide support and written information to enable the patient and her partner to

make an informed decision to continue with or terminate the pregnancy. All discussions should be recorded in the healthcare record.

(Refer to 'Receiving and acting on test results in maternity by both hospital and community'; register number 06031; 'Referral to a tertiary unit for suspected fetal abnormality'; register number 06035).

3.3 Referral to a tertiary unit may be necessary and should proceed as outlined in the 'Referral to a tertiary unit for suspected fetal abnormality'; register number 06035.

3.4 At a time when a couple may be experiencing symptoms of grief, including anger, despair or guilt, compounded by the fact that a decision regarding a much wanted pregnancy may have to be made, it is very important that there is appropriate contact with appropriately skilled staff to help facilitate decision making. A referral should be made to the Perinatal Mental Health Midwife to action this process.

3.5 Patients will be given sufficient time and support in an appropriate environment to allow them to come to terms with the situation, the significance of the information and options available before decisions are reached. Every opportunity should be taken to provide the patients and their partners or other relevant family members with the information and support they need. The healthcare professionals should be aware that information may need to be repeated due to the emotional impact of the information given.

3.6 If the patient/couple makes the decision to continue with the pregnancy, this should be documented in the health care records. The patient and her partner should be offered a follow-up with their named Obstetric Consultant to discuss a care pathway for their pregnancy, delivery and postnatal care of their baby, they should be offered the ARC (Antenatal Results and Choices) booklet 'Supporting you throughout your pregnancy'. A neonatal alert form should be completed with a detailed history and a problem summary and forwarded to Paediatric Consultant Lead for Risk Management via the Neonatal Unit. The paediatric team should also be informed at the monthly perinatal forum.

3.7 The patient and her partner should be offered an appointment with a Consultant Paediatrician to discuss treatment and care that the infant may require and to develop an individualised care pathway for their delivery and the postnatal care of their baby.

3.8 A copy of the neonatal alert form, any letters from the tertiary centre and agreed care pathway will be filed and available in the Neonatal Unit (NNU). A further 2 photocopies will be available to place in the Antenatal Newborn Screening Co-ordinator's (based in the Antenatal Clinic) and the Labour Ward Manager's (based on Labour Ward) neonatal alert folders.

3.9 Further support should be offered by the lead midwife providing antenatal care, and the professionals at the Tertiary Unit.

3.10 The paediatric team and the NNU should be informed of the admission of patients with suspected poor outcome who are either in labour or for planned delivery. The alert form should be checked and a member of the team or senior neonatal nurse should liaise with Labour Ward.

3.11 Whenever a poor outcome is suspected, patients and their partners need quality relevant information about the implications of the problem and the options open to them. The information should be provided in a timely fashion in a terminology and language that is understood in a suitable environment ensuring privacy and dignity, and be supported by relevant written information. Information in different languages should be used where available. Interpreting services should be made available where English is not the first language. Relatives must not translate. Patient's religious and cultural beliefs should be addressed. (Refer to 'Interpreting and translation policy'; register number 09127A)

3.12 Effective high quality communication between healthcare professionals and patients, as well as their families, will facilitate effective decision making and enhance the care given.

3.13 All discussions with parents, plans of care and current condition of the baby should be documented within the relevant healthcare records for all healthcare professionals within the multidisciplinary team to access and share during the antenatal, intrapartum and postnatal period.

3.14 In the event of a sick baby, stillbirth, neonatal death or late fetal loss, additional support should be offered. This can be provided by the Trust's Psychotherapy and Counselling Department, the Perinatal Mental Health Midwife or chaplaincy service. This should be arranged through the appropriate healthcare professional i.e. midwifery staff or the neonatal staff.

3.15 Following delivery, the Health Visitor and General Practitioner (GP) should be informed to enable further support.

3.16 The provision of on-going care for the infant will depend on the wishes of the parents and the immediate condition of the infant. Any plan made during the antenatal period should be followed. If it is their wish for the baby to remain with them on the Labour Ward they will receive support from the paediatric team unless the baby's immediate condition initiates a change to the initial care plan.

3.17 Where a patient chooses to terminate her pregnancy, she should be offered the ARC Booklet entitled 'When an abnormality is diagnosed in their unborn child'

3.18 In the event of a stillbirth/fetal loss, information for the relevant support services should be offered and discussed by the midwife responsible for the care of the patient and her partner following the birth and prior to discharge home.

3.19 The checklist following a stillbirth/neonatal death/ late fetal loss should be completed and retained in the healthcare records by the midwife providing care. It is the responsibility of the midwife discharging the patient home to ensure she has the relevant information for her postnatal care, follow up Consultant Obstetrician appointment and support groups with contact numbers.
(Appendix A)
(Refer to 'Management of patients with pregnancy loss'; register number 09042)

3.20 In cases of an adverse outcome, the mother and her partner should be seen as soon as

possible by their named obstetrician involved in her care or by the consultant obstetrician on call.

4.0 Provision of Appropriate Support and Information for Parents in Cases of Unexpected Poor Outcome for the Baby

(Refer to 'Dissemination of information to patients in maternity'; register number 10008)

4.1 If a poor outcome is suspected during labour, the Obstetric Registrar or Consultant should discuss their concerns with the patient and her partner, and a plan of care for delivery should be made and documented in the healthcare records. The paediatric team should be informed as should the NNU.

4.2 Support should be provided by the obstetrician and midwife responsible for the care on a shift basis whilst in hospital both during the intrapartum and postnatal period. Where the baby is an in-patient in the Neonatal Unit, the paediatric and neonatal staff will provide further support to parents.

4.3 Where a baby is admitted to the Neonatal Unit with a provisional diagnosis of an actual or suspected poor outcome, the paediatric team should liaise with the parents promptly to discuss with them the on-going treatment the baby will require and any investigations that will be performed with a time frame for the parents to receive the results.

4.4 All meetings and discussions between parents and medical staff to discuss the baby's plan of care and prognosis will be recorded in the neonatal health care records and agreed plan of care regarding the baby also recorded.

4.5 Any consultant with information contributing significantly to the diagnosis or prognosis will give the results to the parents in person. Parents should be offered information relevant to the diagnosis of the baby.

4.6 It is important to ensure good communication between all members of the multi-disciplinary team and continuity of approach with the parents, to prevent any misunderstanding arising between relatives and staff. Therefore, meetings with parents to discuss withdrawal or withholding treatment should include the lead consultant and the nurse in charge of the ward and/or an experienced nurse who knows the family well. Careful consideration should be given to the relationships between members of staff and parents when identifying the most appropriate staff to lead these discussions. Other professionals may also be involved in the discussions with the parents as appropriate.

4.7 Where it is felt necessary, tertiary units with relevant subspecialties should be contacted and the on-going plan of care discussed. Parents should be informed early of any potential transfer of the baby.

4.8 If the baby is to be transferred to a tertiary unit for on-going care the transfer team will liaise with the parents and fully update them as to the process of neonatal transfer.

4.9 If the decision to withdraw or withhold care is made, this must be clearly documented in the baby's notes and the child and family must, at all times, receive the same standards of care and consideration as any other family and should be dealt with in a kind and

considerate manner. Parents should not be made to feel that the decision to withdraw treatment has already been made or that their child is not valued.

4.10 Most parents will require several meetings over a period of time to come to terms with the diagnosis of poor outcome for their baby especially if it includes the need to withdraw or withhold treatment; this will often be a period of weeks or even months.

4.11 In cases where death of the infant is the final outcome parents will be offered a meeting with the lead consultant 6 weeks following the death to discuss the care and receive any outstanding results such as post mortem results.

4.12 In cases where the baby has a confirmed life limiting or terminal condition and parents wish to take their baby home, referral to the paediatric community nursing team and/or Little Haven Hospice should be made to enable continued support for the family following discharge.

4.13 In the event of a sick baby or neonatal death, additional support should be offered. This can be provided by the Trust's Psychotherapy and Counselling Department or chaplaincy service. This should be arranged through the appropriate health care professional i.e. midwifery staff or the neonatal staff.

4.14 Arrangements for the transfer of deceased out of area babies to their local hospital or undertakers, on the instructions of the parents can be arranged with the support of the hospital contract undertakers. The Bereavement Coordinator will liaise with staff and the parents to ensure that the appropriate statutory paperwork is prepared before the transfer takes place.

4.15 Whenever there is a poor outcome, patients and their partners need quality relevant information about the implications of the problem and the options open to them. The information should be provided in a timely fashion in a terminology and language that is understood in a suitable environment ensuring privacy and dignity, and be supported by relevant written information. Information in different languages should be used where available. Interpreting services should be made available where English is not the first language. Relatives must not translate. Patient's religious and cultural beliefs should be addressed. (Refer to 'Interpreting and translation policy'; register number 09127A)

4.16 In the event of a neonatal death or where parents wish to take their baby home to die, parents must be made aware of the 'Child Death Review' process and its consequences.
(Refer to Appendix B and C)

5.0 Support Groups

5.1 On identification of a suspected or actual poor outcome, the healthcare professional should ensure the patients/parents are informed of and offered support from the relevant support groups.

5.2 Support should include, as appropriate:

- Tertiary unit contact numbers;
- Paediatric referrals with neonatal plan of care;
- Antenatal care – appointments, contact numbers for professionals, additional surveillance;
- Intrapartum plan of care;
- Postnatal plan of care;
- Community based support i.e. Health Visitor, General Practitioner;
- Information and contact details for relevant external support groups/organisations.

5.3 All information discussed, and written information given, should be documented within the health care records by the health care professional at time of provision to ensure a high standard of care is provided to patients/parents at a difficult and highly anxious time.

6.0 Support for Parents who have Communication or Language Support Needs

(Refer to 'Interpreting and translation policy'; register number 09127A)

6.1 At this anxious and potentially devastating time, health care professionals should recognise that this is an additional barrier to effective communication for these patients or parents.

6.2 Effective high quality communication between healthcare professionals and patients and their families will empower them to become active partners in decision-making and their overall care (RCOG 2008).

6.3 The transition to parenthood is seen as a period of growth and adaptation. However there is an accompanied increased level of stress, which is heightened for the patient with language or communication needs, when essential communication becomes a barrier to care.

6.4 The health care professional working in a multi-agency and multidisciplinary team is able to provide support and be responsive to the needs of the patient and family where language difficulty and other barriers such as auditory/sensory loss can result in the patient being socially disadvantaged, where service provision may already be unfamiliar.

6.5 The provision for translation and interpreting service is based on the assessment needs of the patient and may include a combination of both to fulfil her identified needs. (Refer to 'Interpreting and translation policy'; register number 09127A)

6.6 Partners, relatives and children should not act as interpreters (CEMACH 2004); therefore support available must be tailored to parents of babies with identifiable or physical problems. Support then becomes appropriate, timely and is supportive to her partner and other family members.

6.7 Early identification is essential to appropriate support provision, therefore the patient must be referred to the appropriate healthcare professional who should ensure links between other agencies are established.

6.8 In emergency situations, such as intrapartum events, access is gained to interpreting service.
(Refer to 'Interpreting and translation policy'; register number 09127A)

6.9 The environment must be one conducive and respectful of the situation even in an emergency and all relevant information must be documented in maternal hand held record.

7.0 Documentation

(Refer to 'Maternity record keeping including documentation in handheld records'; register number 06036)

7.1 All discussions, decisions and plans of care between the healthcare professional and the patient/parents should be documented within the healthcare records.

7.2 All documentation should be dated and signed by the healthcare professional. Where the documentation is within the antenatal and labour notes, the documentation must also be timed.

7.3 All referrals to members of the multidisciplinary team or tertiary units/specialists must be clearly documented. This should include:

- Date of referral;
- Name of professional/hospital/unit to whom the woman is being referred;
- Reason for referral;
- Any relevant medical, family, social history and interpreting needs;
- Name and status of professional making the referral.

7.4 Information and contact numbers of all relevant support groups given to the patient and her family will be documented in the patient's healthcare records.

8.0 Staffing and Training

8.1 All midwifery and obstetric staff must attend yearly mandatory training which includes skills and drills training.

8.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

9.0 Professional Midwifery Advocates

9.1 Professional Midwifery Advocates provide a mechanism of support and guidance to women and midwives. Professional Midwifery Advocates are experienced practising midwives who have undertaken further education in order to supervise midwifery services and to advise and support midwives and women in their care choices.

10.0 Audit and Monitoring

10.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the 'Clinical Audit Strategy and Policy' (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

10.2 As a minimum the following specific requirements will be monitored:

- Process for providing postnatal support for parent(s) in cases of actual poor outcome for the term newborn;
- Process for providing postnatal support for parent(s) in cases of suspected poor outcome for the term newborn;
- Process for providing support to parent(s) who have communication or language support needs;
- Requirement to document all discussions with parent(s);
- Process for ensuring parent(s) have information about the relevant support groups;
- Process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.

10.3 A review of a suitable sample of health records of patients to include the minimum requirements as highlighted in point 10.2 will be audited. A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.

10.4 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

10.5 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

10.6 Key findings and learning points from the audit will be submitted to the Clinical Governance Group within the integrated learning report.

10.7 Key findings and learning points will be disseminated to relevant staff.

11.0 Guideline Management

11.1 As an integral part of the knowledge and skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

11.2 Quarterly memos are sent to line managers to disseminate to their staff the currently approved guidelines available via the intranet and via clinical guideline folders, located in each designated clinical area.

12.0 Communication

12.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarize themselves with and practice accordingly.

12.2 Approved guidelines are published monthly in the Trust's Focus Magazine that is sent via email to all staff.

13.0 References

Antenatal Results and Choices (ARC) http://www.arc-uk.org/

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NHS England. Saving Babies' Lives: A care bundle for reducing stillbirth. NHS England, 2016.
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National Institute for Health and Clinical Excellence (NICE) (2006). Postnatal Care up to 8 weeks after birth (CG37) London: NICE.
Available at: https://www.nice.org.uk/guidance/cg37

Essex Safeguarding Children Board (2017) Child Death Review and Rapid Response Procedures.
Available at: http://www.escb.co.uk/working-with-children/child-death-reviews/

Appendix A

NHS
Mid Essex Hospital Services
NHS Trust

Neonatal Alert Form

First Name	**Surname**	
NHS No	**Hospital No**	**Referral Date**
EDD	**Gestation**	**Consultant**

Background history & problem summary

Delivery Plans

Broomfield Hospital ☐ Not Decided ☐

Other Hospital _____

Neonatal Alert Form Criteria

Please use the neonatal alert form for the following conditions:

- Multiple pregnancy (higher order > 2 fetus)
- Hepatitis B positive mother
- HIV positive mother
- Previous baby with GBBS sepsis / meningitis
- Significant structural abnormalities diagnosedon ultrasound scan
- All cases that require referral to specialist units for treatment or advice
- Mothers with high antibody titres e.g. Anti-D, C and Kell
- Severe oligohydramnios / IUGR
- Abnormal dopplers
- Genetic / hereditary conditions in the immediate family that may affect the fetus
- Social e.g. drug abuse, alcohol abuse in this pregnancy
- Any other condition that will require paediatric input at birth

Postnatal Plan *(paediatric)*

Designation: Date:

Print Name: Signature:

Appendix B

Child Death Review Process

There are three key stages of documentation to support the child death overview processes:

1. Form A: Initial Notification Form.
2. Form B: Agency Report / Case Record – a case summary to be compiled in a local case review or by the CDOP manager from contributions from individual agencies. This acts as the "input data set" for the Child Death Overview Panel.
3. Form C: Analysis Proforma, output from the Child Death Overview Panel.

The security of any system for transferring the information on these forms must be clarified and agreed with the Caldicott guardian.

1. Form A: Initial notification form. The prompt initial notification of all deaths will be an important part of the process of child death review, whether or not the particular case warrants a "Rapid Response" investigation process. We anticipate that most notifications will be by telephone, and the completion of the notification form will be the responsibility of a member of staff in the local notification office. There is the further option for the notification form to be completed by the notifier and sent by secure fax or email to the CDOP manager. **The security of any system for transferring the information on these forms must be clarified and agreed with the Caldicott guardian.**

Professionals (or occasionally members of the public) who become aware of a child death will be encouraged to contact the office and give whatever information they may have – preferably including the full name, age and address of the child who has died, but people should not be discouraged from informing the notification office of a death because they do not have full information. It is better to receive multiple partial notifications rather than to miss collecting information on a child death.

On receipt of an initial notification of a possible child death the staff in the notification office should promptly attempt to confirm this information by contacting the relevant local agencies who may have been involved. It is important at this stage to obtain as much information as possible – including information on all members of the household, and identifying all key professionals – particularly the child's General Practitioner and paediatrician if one has been involved. Each relevant agency should be contacted, and given information on the identity of the child, and all members of the household, together with any other relevant contacts or family members. This will allow those agencies that may have information on past history, family or household members to check existing records, particularly any information on prior child protection concerns. Great care will be required to ensure accuracy of identification - to avoid duplication and mistaken identities – of the child who has died and of other household members. The use of the child's NHS number as a unique identifier (together with name, address and date of birth) will help minimise the risk of mistaken identity or duplication of notifications.

Having ensured that all relevant agencies are aware of the child's death, and the relevant agencies are providing appropriate support and care to the family, the next stage of the process will be to ensure that all relevant agencies are involved in preparation for any local case review meeting to investigate and review the circumstances of the case, any contributory factors and the ongoing support needs of the family, and to contribute to the Child Death Overview Panel's review.

2. **Form B: The Agency Report Form / Case Record.** This form is sent to agency representatives to enable all relevant information on the case to be collected and collated to form a case summary. This may be compiled in a local case review or by the CDOP manager from contributions from individual agencies. This acts as the "input data set" for the Child Death Overview Panel.

   In order to ensure completeness and accuracy of the information collected and reviewed at the local case review meeting – or to inform the discussions between the relevant key local professionals in those cases in which no local case review meeting takes place, all representative from each key agency should complete as much as they are able of form B, drawing on a review of the agency records and discussions with individual practitioners. Some aspects of the form are specific to individual agencies (e.g. health), but all agencies should be able to prepare summaries of relevant information available to them.

   There are 6 sections to the form:

   A Identifying and Reporting Details

   This section will normally be completed by the CDOP administrator from the notification form (Form A) prior to sending out to agency representatives. This identifying information can be separated from the rest of the form in order to anonymise the case prior to distribution to the CDOP members.

   B Summary of Case and Circumstances leading to the death

   Information is included on the nature and circumstances of the death. For some specific categories of death (e.g. road traffic accidents, apparent suicides, SUDI) further specific information will be gathered as part of the core data set. Additional forms will be distributed as appropriate. As well as the core data items, narrative information on the circumstances leading to the death is included to inform the understanding of the case

   C The Child
   D Parenting Capacity
   E Family and Environment
   F Service Provision

   Each of these sections contains specific data items as well as space for narrative accounts of the relevant factors relating to the child's death.

   In addition to the narrative and questionnaire components, the form should include a brief summary of the relevant positive and negative findings from the post mortem examination (form B-11), (where one has been conducted) as well as a full copy of the final post-mortem report and (for deaths of children in hospital or under the care of a secondary/tertiary care team) a copy of the final discharge / death summary.

   Once all agency reports are received, the CDOP manager should collate the information onto one form, either through a local case discussion, or in discussion with the individual agency representatives. This collated Form B then forms the case summary and input to the Child Death Overview Panel, and can at that point be anonymised. Where there are any discrepancies or disagreements between agencies as to any of the factual information, this should be noted and where possible, consensus reached.

   Recent changes to the coroners' rules will facilitate the sharing of information (particularly police reports and post-mortem reports) at this meeting for those deaths subject to coroners' investigations and/or Inquests. For all such deaths, the coroner or coroner's officer should be invited to attend the local case review meeting (as recommended in Chapter 7 of "Working Together"). The information made available, the discussions, and the outcome of the local case review meeting in such cases will provide potentially valuable information to inform the conduct of the inquest, which in most case we anticipate will take place after the local case review meeting but before the Child Death Overview Panel meeting that review the death. The summary report from

the local case review meeting should, in all cases in which the coroner remains involved be copied to the coroner to help inform the Inquest.

3. Form C: Analysis Proforma

The first page provides for identifying details of the case. These details can be removed and replaced by a unique identifier if the Panel is discussing cases anonymously, and in any event should be removed after the Panel meeting in order to ensure that any outputs from the panel are anonymised.

A summary of the case should be completed, along with any identified or agreed cause of death.

The panel should then consider any relevant factors identified from form B in each of the following domains, considering the degree to which any factors may have contributed to the death.

Factors intrinsic to the child
Factors in the parenting capacity
Factors in the family and environment
Factors in relation to service provision

The third section of the form is a categorisation of the child's death using a scheme developed for the CDOP process. This classification is hierarchical: where more than one category could reasonably be applied, the highest up the list should be marked. This will form part of the national core data set and enable analysis of information in relation to different types of death.

The Panel needs to make a decision on the degree to which each death is considered preventable. It is important to recognise that this categorisation is to inform any efforts to reduce childhood deaths, it does not in itself carry any implication of blame on any individual party, but simply acknowledges where factors are identified which, had they been different, may have resulted in the death being prevented.

The final section of the form allows the Panel to identify any lessons to be learnt, recommendations to be made or actions to be taken in response to the review of the death. It is anticipated that in most cases, any individual action in relation to specific case management will have been identified and addressed through the local case discussion or other related processes; the focus of these actions and recommendations are on lessons to be learnt at a population level. The overview panel will have the advantage of being able to review each individual child death in the context of other deaths of children in their area, and to be able to identify any potentially contributory recurrent themes, circumstances, or possible limitations in service provision by one or more agencies. The main public output from the Overview Panel will thus be in summary form - drawing on the information from individual cases and from the overall pattern of events, contributory factors and service provision in their local area.

This will allow the overview Panel the opportunity to develop local recommendations to help reduce childhood deaths, for inclusion in annual reports, and where appropriate, specific ad hoc recommendations (e.g. dealing with particular road or environmental factors). This information, together with both the factual and opinion-based outcomes of the Overview panel reviews will be aggregated in the regional and national reports on the child Death Review process, which will in turn be able to produce more generalisable sets of recommendations aimed at reducing child deaths.

Appendix C

ESCB Number

Form A - Notification of Child Death

Notification to be reported to CDR Officer at: Email cdr@essex.gov.uk

Secure email* cdr@essexcc.gcsx.gov.uk

Tel 01245 430783

Fax 01245 434715

***if sent from pnn.police.uk, cjsm.net, nhs.net or gcsx.gov.uk.** Further guidance in relation to information transfer using GCSX is available in appendix 3 of the SET CDR procedures available at www.escb.co.uk

The security of any system for transferring the information on these forms must be clarified and agreed with the Caldicott guardian.

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

Full Name of Child					DOB / /	
Any Aliases					Age / / (yy/mm/dd)	
Sex	☐	Male	☐	Female	NHS No.	
Address						
Postcode						
Ethnic group	☐	White	☐	British		
			☐	Irish		
			☐	Any Other White background		

			☐	Traveller of Irish Heritage
			☐	Gypsy/Roma
	☐	Mixed	☐	White & Black Caribbean
			☐	White & Black African
			☐	White & Asian
			☐	Any other mixed
	☐	Asian or Asian British	☐	Indian
			☐	Pakistani
			☐	Bangladeshi
			☐	Any other Asian
	☐	Black or Black British	☐	Caribbean
			☐	African
			☐	Any other black background
	☐	Chinese or other ethnic group	☐	Chinese
			☐	Any other, specify
	☐	Not Known/not stated		
Immigration Status	☐	Asylum seeker		
	☐	Refugee status		
	☐	Exceptional status leave to remain		
School/nursery etc				

Other Significant Family & Household Members

Full Name	DOB	Relationship	Full Address
	/ /		
	/ /		
	/ /		

Details of death

Date & time of death	/ / Time

Location of death or fatal event *	

*place where the child is believed to have died, or where the event directly leading to death occurred. For example, if a child is involved in a road traffic accident, and is resuscitated but subsequently dies, the location of death should be recorded as the site of the collision, rather than the hospital where the child's death was confirmed.

Has a medical certificate of cause of death been issued?	☐	Yes	☐	No

For neonatal deaths Any known cause of death as specified on the death certificate?	☐ a. Main diseases or conditions in infant ☐ b. Other diseases or conditions in infant ☐ c. Main maternal diseases or conditions affecting infant ☐ d. Other maternal diseases or conditions affecting infant ☐ e. Other relevant conditions
For deaths of children aged over 28 days Any known cause of death as specified on the death certificate?	Ia Ib Ic II

Death expected or unexpected?	☐	Expected	☐	Unexpected *

* An unexpected death is defined as the death of an infant or child (aged under 18 years) where there is no prior condition that might be expected to cause the death at that time, and the child dies either immediately or subsequently from the consequences of the precipitating event or collapse.

Rapid Response Team Formed?	☐	Yes	Date:	/ /
	☐	No		Provide reason if the death has been classified as unexpected
Home Visit	☐	Yes	☐	No

RRT Member Responsible to provide links with CDR Officer	Name	
	Telephone	
	Email	

Reported to	Coroner	☐	Yes	Date: / /	
		☐	No	Name:	MS Ref No:

Reported to	Registrar	☐	Yes	Date: / /
		☐	No	Name:
Post mortem examination:		☐	Yes	Date: / /
		☐	No	Venue:
CDR Information leaflet provided to parents/carers		☐	Yes	
		☐	No	Reasons:

Notification Details:

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

Agency	Name, Address & Tel No.
GP	
Midwife/ Health Visitor/ School nurse	

Paediatrician	
Police	
Children's Social Care	
School/ nursery etc	
Others (list all agencies known to be involved)	

Appendix D: Preliminary Equality Analysis

This assessment relates to: Support in Maternity for Parents with Actual or Suspected Poor Outcome (10009)

A change in a service to patients		A change to an existing policy	**X**	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	Answers
1. What are you proposing to change?	Full Review
2. Why are you making this change? (What will the change achieve?)	3 year review
3. Who benefits from this change and how?	Patients and clinicians
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Refer to pages 1 and 2

Preliminary analysis completed by:

Name	Sharon Pilgrim	**Job Title**	ANNP	**Date**	April 2019