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<th>CHILD DEATH REVIEW AND RAPID RESPONSE</th>
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<td>Women and Children’s Services</td>
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<tr>
<td>Author/Contact: (Asset Administrator)</td>
<td>Dr Manas Datta, Consultant Paediatrician</td>
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<td>✓ MEHT ❑ BTUH ❑ SUH</td>
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<td>Sharon Lim, Consultant Paediatrician</td>
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Consulted With:                  Post/ Approval Committee/ Group:                  Date:
Alison Cuthbertson/Miss Rao          Divisional Director for Women’s and Children’s Directorate 26th June 2019
Manas Datta                          Paediatric Consultant, Clinical Director
Ranjith Joseph                       Paediatric Consultant
Aloke Agrawal                        Paediatric Consultant
Muhammed Ottayil                     Paediatric Consultant
Sharmila Nambar                      Paediatric Consultant
Sharon Lim                           Paediatric Consultant
Ahmed Hassan                         Paediatric Consultant
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Rachel Thomas                        Paediatric Consultant
Dean Lethaby                         Paediatric Consultant
Srinivasagam Muthumeenal             Paediatric Consultant
Srinivas Chavakula                   Paediatric Consultant
Sangeetha Pradeep                    Paediatric Consultant
Arindarn Das                         Paediatric Consultant
Krishna Annam                        Paediatric Consultant
Mel Chambers                         Lead Nurse
Mel Hodge                            Senior Sister, Phoenix Ward
Mary Stebbens                        Clinical Facilitator Children’s Acute Care
Ruth Byford                          Warner Library 4th July 2019
Kelly Doran                          Children & Young Person’s Safeguarding Nurse 5th July 2019

Related Trust Policies (to be read in conjunction with) 06059 Care of the Dying and the Handling of and Care of the Deceased

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1.0 **Purpose**

1.0 **Since 1\textsuperscript{st} of April 2008,** Local Safeguarding Children Boards (LSCB) have a statutory requirement as outlined in chapter 7 of 'Working Together to Safeguard Children' to review the death of any child under 18 years whether from natural, unnatural, known or unknown causes.

1.2 The Trust must provide the LSCB with information about all Child Deaths to ensure that information can be collected and analysed about all local childhood deaths (0-18).

1.3 The Child Death Review (CDR) process is required to:

- Identify cases requiring serious case review;
- Highlight matters of concern affecting the safety and welfare of children;
- Identify wider public health or safety concerns arising from a particular death or from a pattern of deaths through the local Child Death Review Panel;
- Undertake a co-ordinated agency response to all unexpected deaths of children.

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. Consideration must be given to the religious and faith beliefs of the families. (Refer to Appendix G)

3.0 **Scope**

3.1 This policy is to be followed by all staff in all areas of the Trust caring for a Child or Young Person under the age of 18 years who dies in the Trust or who is pronounced dead on arrival at the Trust.

4.0 **Definitions and Essex wide Process**

4.1 **An unexpected death** is defined as the death of an infant or child (less than 18 years old) which:

- Was not anticipated as a significant possibility, 24 hours before the death; or
- Where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death. This definition is especially relevant when there is a significant time delay between the collapse of the child and their eventual death.

4.2 Unexpected deaths include those of children with existing medical conditions or disabilities (including those that are life limiting or threatening) whose death at the time that it occurred was not expected as a natural consequence.
4.3 Where there is uncertainty about whether the death of a child falls into the category of an unexpected death this process should be followed up until the notification of the death to the Designated Paediatrician and the Coroner. The Designated Paediatrician should then make a decision on whether or not a rapid response is required based on their professional judgement, the information available to them at the time and liaison with the Coroner.

4.4 If the Designated Paediatrician and Coroner agree that the definition is met, the process below should be followed in full. If it is agreed that the definition is not met, the details of the death should be passed direct to the LSCB CDR Officer by the professional who has contacted the Designated Paediatrician or declared the child’s death. The Officer will then coordinate the response for expected deaths.

4.5 Deaths identified from the outset as falling outside of the definition of an unexpected death (i.e. expected death) need not be subject to the rapid response procedures but must be notified to the LSCB CDR Officer by the professional who confirms the death using the standard form and dedicated nhs.net email address. The Officer will initiate the required response.

4.6 The unexpected deaths of children with life-limiting conditions do fall within these procedures however professionals involved in managing these deaths should use their professional judgement in how they should be applied. Where there is uncertainty, the rapid response team should consider the matter in full and liaise closely and promptly with a member of the medical, palliative or end of life care team who knows the child or family to jointly determine how best to respond to the child’s death. If required the advice of the Designated Paediatrician should be sought.

4.7 If at any stage in the process information arises that suggests concerns about surviving children in the household, then a referral must be made to the relevant Children’s Social Care Service. Once social care services have become involved, a social care representative must become a core participant in the rapid response team.

4.8 Where deaths are subject to other Police investigation, for example those occurring as a result of road traffic collisions, the rapid response team should form and establish close liaison with the investigating branch of the Police. Based on the information received the rapid response team should agree the appropriate form of their response. It may be the case that it is not appropriate or necessary to continue with a rapid response and police will complete their investigation. If a rapid response does not need to proceed, the team must first assure themselves that the supportive and investigative functions are being sufficiently undertaken via the other processes that are occurring.

4.9 Following the visit to the scene of death, information collected at the scene should be summarised and forwarded to the Child Death Review Officer and Coroners Officer. This process will provide important information for the pathologist and assist in the identification of the reasons for their loss.
5.0 **Process within MEHT**  
(Refer to Appendix A and B)

5.1 On arrival the child should be taken to the appropriate resuscitation area and the emergency paediatric resuscitation procedure should be initiated. The child must immediately be assessed by a senior paediatrician and death confirmed or appropriate resuscitation started; unless it is clear that the child has been dead for a period of time resuscitation should always be initiated. Resuscitation does not necessarily need to be continued until the consultant arrives if cessation of resuscitation attempts is deemed appropriate by the resuscitation team leader.

5.2 A qualified nurse will stay with the family, keeping them informed about what is happening. The identity of the people accompanying the child and their relationship to the child must be clarified by this nurse and recorded.

5.3 As soon as practicable (i.e. as a response to an emergency) after arrival at a hospital the child should be examined by the consultant paediatrician on call (in some cases this might be together with a consultant in emergency medicine, or for some young people over 16 years the consultant in emergency medicine may be more appropriate than a paediatrician) and a detailed and careful history of events leading up to and following the discovery of the child’s collapse/accident should be taken from the parents/carers. Information must include a full medical history, a family history, history of any other child deaths, previous incidents of concern and an account of what happened and who was present. The history should be made available to the police.

5.4 The Consultant Paediatrician should examine the child and document the findings in the medical examination proforma including body maps (refer to Appendix C). Any injury or superficial lesion should be documented on a body chart. The site and route of any intervention in resuscitation needs to be carefully recorded. The object of the examination is to try to ascertain as much as possible about the cause of death and this should be stressed to the parents. The examination will include but is not solely aimed at identifying evidence of Non Accidental Injury/neglect.  
(Refer to Appendix C)

5.5 During the process of resuscitation, various investigations will be initiated, in order to determine the cause of death. If resuscitation is not instituted, then in most cases such investigations should be taken as soon as possible after the arrival of the child.

5.6 Once death has been confirmed by the attending doctor (usually the consultant paediatrician), the Coroner assumes immediate responsibility for the body and the permission of the coroner must be obtained prior to taking samples from it. However, in Essex there is an arrangement with the Coroner that certain samples may be taken immediately after the end of resuscitation. As a result, the samples as detailed within the SOP in Appendix A inset Appendix 2 of this document may be taken without gaining consent on a case by case basis but no further samples for investigation may be taken without the Coroner’s permission.

5.7 After resuscitation remove all intravenous and intra-arterial lines and carefully document all the sites of access after agreement with the Coroner’s Officer. If a cannula has been inserted and has been thought to be the cause of death e.g. pneumothorax, it should not be removed. An endotracheal tube position must be
assessed by direct laryngoscopy immediately after resuscitation by someone other than the clinician who inserted it and then removed it. The child’s clothing should be kept with the body as per the police protocol. Please take advice from Police senior investigating officer (SIO) or coroner.

5.8 When the child is pronounced dead, the consultant clinician should inform the parents, having first reviewed all the available information. They should explain future police and coroner involvement including the Coroner’s authority to order a post mortem examination. Before the family leave the Emergency Department the Consultant Paediatrician on-call should see them together with the police. In certain cases the police may wish to deploy a Family Liaison Officer who has a particular investigative role to perform, the family should be given a copy of the leaflet ‘The review we have to do when a child dies’ produced by the ESCB (Essex Safeguarding Children Board).

5.9 Review of the history and circumstances of the death by the police SIO, consultant paediatrician on-call and, where possible, the designated paediatrician for child deaths should take place. Any child protection concerns for other children in the household must be discussed. If significant concerns emerge, this discussion will become the initial multi-agency strategy discussion under the Child Protection Section 47 Procedures.

5.10 The Consultant clinician who has seen the child should inform the Police, Social Care (if indicated), Coroner’s Office, and the Designated Paediatrician with Responsibility for Deaths in childhood immediately after the Coroner is informed.

5.11 The On-call Paediatrician has responsibility for ensuring a rapid response team is formed to each unexpected death and that the rapid response process is carried out as per the Southend, Essex and Thurrock (SET) procedure. A team must be formed as soon as possible and preferably within 4 hours of the death. He / she will assume responsibility to provide consultant paediatric support in managing this event in line with the multi-agency procedures agreed. The Rapid response nurse will undertake the scene visit as part of the rapid response process along with police.

(Refer to Appendix E)

5.12 The same processes apply to a child who was admitted to a hospital ward and subsequently dies unexpectedly in hospital.

5.13 All deaths (either expected or unexpected) have to be notified to the child death review (CDR) officer through the on line notification form A which can be found on the Trust’s Intranet on the Safeguarding Children page, or via the link: https://www.ecdop.co.uk/Essex/Live/public.

(Refer to Appendix A; inset Appendix 1)

6.0 Multi-agency Procedures/ Documents

6.1 The following documents have been agreed by the LSCB for Essex, Southend and Thurrock and should be followed by all the relevant agencies.

- SET procedures for Responding to Deaths in Childhood

(Refer to Appendix E)
- Protocol for the initial assessment of an infant or child presenting unexpectedly dead or moribund
  (Refer to Appendix F)

6.2 Child Death Review Panels

6.2.1 In Essex a joint process operates across Essex, Southend and Thurrock. For the purpose of this process Essex is divided into five localities with a local child death review panel operating in each

- North East (incorporating Colchester General Hospital);
- West Essex (Princess Alexandra Hospital);
- Mid Essex (Broomfield Hospital);
- South East (Southend Hospital);
- South West (Basildon Hospital).

6.2.2 Child Death review panel has representation from MEHT. The Named Doctor for Safeguarding Children for MEHT is also the designated lead for child deaths in Mid Essex and represents this forum at the Local and Strategic Child Death Review Panel. Full Panel Membership may be obtained by contacting the Child Death Review Officer.

Phone: 01245459426 (CDR Manager) Email: cdr@essex.gov.uk.cjsm.net

6.3 Essex Wide Strategic Child Death Overview Panel

6.3.1 There will be a strategic child death review panel operating across the country as a whole. This panel will be a formal subcommittee of the LSCB’s for Southend, Essex and Thurrock.

6.3.2 The lead agencies involved in the review process for most deaths will be health, the police and in some cases social care. All agencies that have had contact with a child who has died will be asked to share information on the child for the purpose of informing the professional response and work of the review panels. The recommendations made by the local panels will be provided to the Strategic Child Death Overview Panel who will be responsible for endorsing the recommendations and communicating them via the Safeguarding Boards to relevant agencies.

7.0 Cultural Requirements and Religious Observance

7.1 Patients should have access to staff who are sensitive to their spiritual needs. Multidisciplinary teams should have access to suitably qualified, authorised spiritual care givers who can act as a resource for patients and staff. They should also be aware of local community resources for spiritual care.

7.2 The Trust will seek to work with the different religions and cultural groups to document the appropriate procedures each would expect to follow after a death in hospital.

7.3 Check the need for an interpreter or advocate at the earliest opportunity, to facilitate the provision of appropriate support.
7.4 Its important at all times to respond to the cultural and religious needs of the deceased and their families. All staff should refer to the “Faiths and Practice Booklets” held on each ward/department. However the information given is generalised and basic, and must not replace discussion with families, as to their personal requirements.

8.0 The Role of the Coroner

8.1 Once death has been confirmed by the attending doctor (usually the Consultant Paediatrician), the Coroner assumes immediate responsibility for the body and the permission of the coroner must be obtained prior to taking further samples from it. For further guidance see Southend, Essex and Thurrock Protocol child death review procedures. (Refer to Appendix E)

9.0 Staff and Training

9.1 All paediatricians and relevant clinical staff from the key clinical areas will attend training provided by LSCB.

9.2 Specific training is also provided by the LSCB for staff whom are Child Death Review panel members.

10.0 Audit and Monitoring

10.1 The Essex wide strategic Child Death Panel in collaboration with the local Mid Essex Panel will:

- Monitor the appropriateness of the response of professionals to each unexpected death of a child, reviewing the reports produced by the professionals concerned with feedback on their work;
- Monitor the support the assessment services offered to families of children who died;
- Monitor and advise the LSCB on the resources and training required to ensure an effective inter-agency response to child deaths.

11.0 References

The Local Safeguarding Children Boards Regulations 2006 s6 Available at: http://www.legislation.gov.uk/uksi/2006/90/made

(SET) Southend Essex Thurrock Child Protection Procedures 2019
# Standard Operating Procedure

The process for initiating the Child Death Review Rapid Response

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<tr>
<td>Author / Reviewer</td>
<td>Andrea Brewis - Child Death Review Rapid Response Team (Health) Lead Marianne Green – CNST Lead Midwife</td>
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<td>Review date</td>
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Signed ..............................................................................................................
Chair of Trust Policy Group

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<td>APPENDIX 7: PRIVACY IMPACT SCREENING TOOL</td>
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1. QUICK REFERENCE GUIDE

It is the responsibility of the Designated Paediatrician (Child Death Review) or the on-call Consultant Paediatrician to know when and how to initiate the Rapid Response team utilising this standard operating procedure for reference.
2. PURPOSE

It is the responsibility of the Designated Paediatrician (Child Death Review) or the on-call Consultant Paediatrician to know when and how to initiate the Rapid Response team; this document describes the Standard Operating Procedure (SOP) to be followed.

3. SCOPE

All Consultant Paediatricians who are present at or who have been informed of an unexpected child death across Essex, including Southend and Thurrock.

An unexpected death is defined as the death of an infant or child (less than 18 years old) which:

- 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 which led to the death*.

(The second part of this definition is especially relevant when there is a significant time delay between the collapse of the child and their eventual death).*5.12, Working Together to Safeguard Children 2013

Where there is uncertainty about whether the death of a child falls into the category of an unexpected death the rapid response team should convene a multi-agency discussion to consider the available information known at that time, reviewing it against the criteria above.

If doubt still exists following the multi-agency discussion advice from the Designated Paediatrician and the Coroner should be sought. The Designated Paediatrician must make a decision on whether or not a rapid response is required based on their professional judgement, the information available to them at the time and liaison with the Coroner.

If it is decided that the definition is met the process below must be followed in full. If it is agreed that the definition is not met the process for expected deaths must be followed.

The reasons for not proceeding with rapid response must be documented as directed on the Form A: Notification of Child Death Appendix 1.

Deaths identified from the outset as falling outside of the definition of an unexpected death need not be subject to the rapid response procedures and the procedures for expected deaths must be followed. This does not however preclude the ability of professionals involved with the child to organise a discussion of the case similar to that which would be held by the rapid response team.

The purpose of this discussion would be to identify if there were any lessons that could be learnt that might improve the care of other children. Such a discussion may be conducted using the same format as a professionals’ meeting, the output of which could be captured on the Rapid Response Progress Record form.
If the above case discussion (described above) is held this should be administered by the Child Death Review (CDR) Health Administrator for the area and the Rapid Response Progress Record form should be provided to the Local CDRP for consideration at the local review of the child’s death.

The Rapid Response Team (Health) service is available between the hours of
08.30 – 19.00hrs Monday – Friday
10.00 – 14.00hrs on Saturdays and Sundays
Via Long Range Pager Number: 07699723745

4. DEFINITIONS

Unexpected death - the death of an infant or child (less than 16 years old) which:

- 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 which led to the death*.

(The second part of this definition is especially relevant when there is a significant time delay between the collapse of the child and their eventual death)*5.12, Working Together to Safeguard Children 2013

CDR – Child Death review
CDRP – Child Death Review Panel
CDRRR Team – Child Death Review Rapid Response Team
RRT – Rapid Response Team
PAHT – Princess Alexandra Hospital Trust

5. DUTIES

The Child Death Review Rapid Response Team Health Lead has responsibility for:

- dissemination of this SOP
- implementing and monitoring compliance of the SOP by the Designated and Consultant Paediatricians and other members of the CDRRR Team.
- Review and update of the SOP
Designated and Consultant Paediatricians have responsibility for:

- Ensuring they meet the training standard
- Implementing the process described in the SOP

All staff involved in the care and treatment of children have responsibility for:

- being aware of and supporting the implementation of the Rapid Response Initiation process following the unexpected death of a child.

6. PROCESS

Initially

- Once the child has been declared dead the Consultant Paediatrician will contact the Essex Police Control Room on 101.
- The Essex Police control room personnel will take all required details. For this phone call the following details must be to hand:
  - Name and address of the child
  - Date and time of death of the child
  - Contact details for the child’s family
  - Direct contact details for the referring Consultant Paediatrician
- The on call Detective Inspector will then liaise directly with the Consultant Paediatrician and the Rapid Response Team Health personnel (RRT)
- The attending Consultant/ Paediatrician is required to complete form A – Appendix 1
  - This form is then sent to cdr@essex.gov.uk
- The Consultant Paediatrician will take the relevant samples / investigations from the child as directed by HM Coroner – Appendix 2

If the child has died within a working day as detailed above

- A multiagency discussion with the Detective Inspector will take place at the time of the phone call.
- The Detective Inspector will be responsible for contacting the RRT (I-Health) by pager number 07695728745 during their service provision hours.
- From this phone call the CDR team will either attend the relevant hospital or the Paediatrician will inform the family that the RRT will contact them directly within 24 hours.
- The Consultant Paediatrician will give written information to the child’s parents and verbal explanation that the Rapid Response Team will be contacting them directly within 24 hours. Appendix 3
- If the referring Consultant is unable to attend the face to face meeting with the RRT he/she will nominate a named colleague to facilitate liaison.
If the child dies out of hours

- All the initial procedure must be followed and the Detective Inspector will be responsible for contacting the RRT (Health) by pager number 07699726745 during their service provision hours.
- From this phone call the CDR team will either attend the relevant hospital or the Paediatrician will inform the family that the RRT will contact them directly within 24 hours.
- The Consultant Paediatrician will give written information to the child’s parents and verbal explanation that the Rapid Response Team will be contacting them directly within 24 hours. Appendix 3
- If the referring Consultant is unable to attend the face to face meeting with the RRT he/she will nominate a named colleague to facilitate liaison.

7. MANDATORY TRAINING

All members of the CDRRT Team must attend the University of Warwick Advanced Course in the Management of Unexpected Childhood Deaths. This is monitored by the CDRRT Lead.

8. MONITORING COMPLIANCE WITH THIS DOCUMENT

The table below outlines the Trust’s monitoring arrangements for this document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

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</tr>
<tr>
<td>% of families offered bereavement counselling and signposting to other services</td>
<td>100%</td>
<td>CDR RRT Database</td>
<td></td>
</tr>
<tr>
<td>% of families who received bereavement counselling and signposting to other services</td>
<td>100%</td>
<td>CDR RRT Database</td>
<td></td>
</tr>
<tr>
<td>% of families who received a debrief and explanation of the death certificate</td>
<td>100%</td>
<td>CDR RRT Database</td>
<td></td>
</tr>
</tbody>
</table>

9. REFERENCES

Working Together to Safeguard Children (2013) Gov.UK


Regulation 6 of the Local Safeguarding Children Board Regulations 2005
Sidesbotham and Fleming 2008

University of Warwick and outlined in the Kennedy Protocol (www.rcpch.ac.uk)

Centre for Maternal and Child Enquires (CMACE)


10. RELATED TRUST POLICIES

Information Governance Policy
Safeguarding Vulnerable Adults Policy
Safeguarding Children and Young People Policy
Incident Reporting Policy
Risk Management Strategy
Appendix 2: ROUTINE SAMPLES TO BE TAKEN IMMEDIATELY AFTER SUDDEN UNEXPECTED DEATHS IN INFANCY

Blood samples should be taken from a peripheral vein only (e.g. femoral vein). Cardiac puncture should be avoided if possible as this may cause damage to intrathoracic structures and make post-mortem findings difficult to interpret.

A full skeletal survey should also be carried out for all under 2 year olds before the post-mortem examination, in accordance with the guidance in paragraph 11 overleaf.

<table>
<thead>
<tr>
<th>Sample</th>
<th>Send to</th>
<th>Handling</th>
<th>Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood cultures – Aerobic and anaerobic</td>
<td>Microbiology</td>
<td>If insufficient blood, aerobic only</td>
<td>Culture and sensitivity</td>
</tr>
<tr>
<td>from Guthrie card</td>
<td>Clinical Chemistry</td>
<td>Normal (fill in card; do not put into plastic bag)</td>
<td>Inherited metabolic diseases</td>
</tr>
<tr>
<td>Cerebrospinal Fluid (CSF) (a few drops)</td>
<td>Microbiology</td>
<td>Normal</td>
<td>Microscopy, culture and sensitivity</td>
</tr>
<tr>
<td>Nasopharyngeal Aspirate</td>
<td>Virology</td>
<td>Normal</td>
<td>Viral cultures, immuno-fluorescence and DNA amplification techniques*</td>
</tr>
<tr>
<td>Nasopharyngeal Aspirate</td>
<td>Microbiology</td>
<td>Normal</td>
<td>Culture and sensitivity</td>
</tr>
<tr>
<td>Swabs from any identifiable lesions</td>
<td>Microbiology</td>
<td>Normal</td>
<td>Culture and sensitivity</td>
</tr>
<tr>
<td>Urine (if available)</td>
<td>Microbiology</td>
<td>Normal</td>
<td>Culture and sensitivity</td>
</tr>
</tbody>
</table>

* Samples must be sent to an appropriate virological laboratory

The Coroner has also provide permission for the following samples to be taken but these are not considered routine samples but can be taken if it is considered appropriate

<table>
<thead>
<tr>
<th>Sample</th>
<th>Send to</th>
<th>Handling</th>
<th>Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood (serum) 1-2 ml</td>
<td>Clinical Chemistry</td>
<td>Spin, store serum At -20°C</td>
<td>Toxicology</td>
</tr>
<tr>
<td>Blood (Lithium heparin) 1-2 ml</td>
<td>Cytogenetics</td>
<td>Normal – keep unseparated</td>
<td>Chromosomes (if dysmorphic)</td>
</tr>
</tbody>
</table>

Taken from Southend, Essex and Thurrock Protocol for Initial Assessment of an infant or child presenting unexpectedly dead or moribund

Dec 2010 Review due Dec 2012
Paragraph 11:
It is expected that for all children under the age of two a skeletal survey should be undertaken. This should be reported by a radiologist with recent experience and training in paediatric radiology.
Consideration should always be given to undertaking a skeletal survey for children over this age especially where there is evidence to suggest that the death is suspicious. The survey will be undertaken at the place of post mortem unless it is suspected that the child has been subject to a non-accidental injury and there are other children in the household who may be at risk. In these circumstances if waiting for the post mortem will lead to unacceptable delay (more than 24 hours) arrangements should be made, following discussion with the Coroner, to undertake the survey on site.
Appendix 3

Parent Information Pack following the Unexpected Death of A Child

The following information pack will be given to the parents before they leave the hospital, this packs will be available in all paediatric A&E departments, Children’s Wards and NICUs for local distribution. CRDPRT will be responsible for the supplies of the patient information packs.

The pack will contain:

Contact Details for Rapid Response Team (Health)

Child Death Review Information Booklet
Terms of Reference
Child Death Review Local Operational Meetings

Background

To support the delivery of the priorities and desired outcomes of the SET Procedures for Responding to Deaths in Childhood (2014).

The Child Death Review (CDR) Rapid Response Team (RRT) will:
- Respond to all unexpected deaths of children up to the age of 18yrs in conjunction with Designated Doctor for CDR and be part of a multi-agency approach to responding and reviewing the child’s death.
- Monitor, support, influence and establish where possible in conjunction with the Coroner, a cause of death; to identify any contributory modifiable or notable factors
- Review the follow up plans for the family and provide ongoing support to the family, via the Rapid Response Team (RRT) when a child has died.

Purpose of the Operational Meeting

The Operational Meeting will provide a support and advisory function to the RRT working with them to both ensure that the locality focus is reflected and there is a consistent approach across the county therefore supporting the countywide strategy.

1. Responsibilities

The key responsibilities of the Local Operational Meeting are to:

- Share information, operational learning with RRT and partnership agencies / representatives
- Contribute to improving outcomes and performance against the National Indicators relevant to safeguarding
- Monitoring training standards and support the locality delivery of appropriate safeguarding training and advice
- Comply with the SET Safeguarding and Child Protection Procedure (2015) relating to safeguarding
- Ensure that there is effective communication across all partnership agencies / representatives within Essex, Southend & Thurrock to facilitate dissemination of information pertinent to safeguarding.
- Forum for case reflection to identify areas of good practice and clarify areas for improvement.

2. Aim

The primary aim of the Operational meeting is to contribute to the improvement of the CDR process across Southend, Essex and Thurrock thereby influencing successful implementation of the process.
3. **Activities**

To help achieve these, the Operational meeting will:

- Ensure local agencies are aware of each other’s roles and develop good working relationships around the Child Death review process.
- Audit specific requirements and ensure appropriate training on Child Death Review and the Rapid Response Team is delivered locally.
- Support the engagement of all relevant stakeholders

4. **Membership**

Membership will include:

- The area’s Designated Doctor for CDR
- Rapid Response Team member – Health and Police representation
- An *Associate Director Family & Women’s Services Health Group*, as requested by Designated Doctor for CDR
- A Designated nurse or representative from the CCG with responsibility for commissioning services
- Child Death Review Manager
- Relevant professional (Paramedic staff, Bereavement Coordinator, Social Care, Education etc.) by specific invitation

5. **Meeting arrangements**

- Meetings will take place quarterly and be timed to enable effective attendance; meetings will be scheduled following Local CDR Panel meetings in each area and will be added as an agenda item.
- The Designated Doctor for CDR will also have the option to call additional meetings to address specific issues that require group agreement or decision
- At each meeting action plans will be updated.

6. **Review**

These arrangements will be reviewed on an annual basis to ensure that it continues to be fit for purpose.
Appendix B: Emergency Department Flow Chart and checklist

Baby/child found lifeless – ambulance called by 999
Ambulance informs Emergency Department

Emergency Dept. triage nurse receiving call, notes time and notifies:
1. Senior Emergency Dept. resuscitation team – prepares equipment and drugs
2. Paediatric registrar - informs consultant
3. Nurse allocated for parents (experienced, trained)
4. Ward clerk orders child and parent medical records from store, for immediate delivery

Ambulance arrives at Emergency Department

Emergency Department resuscitation room
1. Attempt resuscitation
2. Preliminary history
3. Preliminary examination
4. Obtain laboratory specimens
5. Rectal temperature and time
6. Most senior doctor discusses with team and parents prior to stopping resuscitation

Parents
1. Greet at door
2. Quiet room
3. Offer to view resuscitation accompanied
4. Offer chaplain

Parents
1. Carry baby into room in arms as a baby
2. Refer to baby by name
3. Give baby to parents to hold but supervise at all times

Parents interviewed by paediatrician and police to obtain full history
Consider health and child protection needs of the family

Complete documentation
Complete notification (checklist)

Multi-agency initial case discussion/formation of rapid response team (see appendix 6)

Caring for the family
1. Mementoes and photos
2. Procedural information
3. Bereavement support

Parents return home; arrangements for home visit

Staff debrief
Appendix C

Appendix C: Examination Proforma to be completed by the Lead Consultant in all cases of Unexpected Death of an Infant or Child

The history will be documented on standard medical notes sheets, the examination proforma can be completed by the Paediatrician.

Child’s Name:
Examination by:
Date:
Time:

<table>
<thead>
<tr>
<th>Description</th>
<th>cm</th>
<th>cm</th>
<th>kg</th>
<th>cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>General condition including cleanliness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clothes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hair/Nails</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nappies/Rash</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teeth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height centile</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight centile</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OFC centile</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mouth including frenulae</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thorax</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limbs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NAME OF EXAMINING DOCTOR:

SIGNATURE OF EXAMINING DOCTOR:

<table>
<thead>
<tr>
<th>Time</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NAME OF EXAMINING DOCTOR:

SIGNATURE OF EXAMINING DOCTOR:

Time

Date:
Appendix D

Appendix D: Checklist / care plan after UNEXPECTED DEATHS

The death of any infant, child or young person (0-18 years excluding still births) must be notified to the Local Safeguarding Children Board (Children Act 2004 Section 11) (Complete form A in appendix 1 for both expected and unexpected deaths either email on line to cdr@essex.gov.uk / cdr@essex.gov.uk.cjsm.net or fax to 01245506649

This proforma provides staff with guidance on their roles after such a death and must be used by staff in any area where a death occurs.

<table>
<thead>
<tr>
<th>Child’s Details:</th>
<th>First Name(s):</th>
<th>Surname:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date and Place of Death:</td>
<td>DOB:</td>
<td>Age:</td>
</tr>
<tr>
<td>Date of Admission:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Number:</td>
<td>NHS Number:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post Code:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G.P Name and Address:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother’s Name</th>
<th>Father’s Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>If different to child’s</td>
<td>If different to child’s</td>
</tr>
<tr>
<td>Post Code:</td>
<td>Post Code:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Tel. Numbers:</th>
<th>Contact Tel. Numbers:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Senior Staff taking responsibility for Case and completion/forwarding of this check list:</th>
</tr>
</thead>
<tbody>
<tr>
<td>On call (Lead) Paediatric Consultant……………………………………….. (Print or Stamp Name)</td>
</tr>
<tr>
<td>Senior Nurse/Midwife………………………………………………………..(Print or Stamp Name)</td>
</tr>
<tr>
<td>Adult Consultant (16 years to under 18 years)………………………………….(Print or Stamp Name)</td>
</tr>
</tbody>
</table>

The on-call consultant will always attend the hospital in the case of an unexpected death.
The Senior Nurse is according to the area where the death has occurred.
Senior staff may delegate roles to other staff but have overall responsibility for ensuring all actions are followed.

Name and bleep number of Dr who confirmed death:
Name of nurse caring for child at time of death:

Page 2 relates to additional steps to be taken in any case of cases of unexpected death, (whether or not the circumstances are suspicious). Pages 2-3 are mandatory as part of the Child Death Review Process and need to be carried out in the time frame indicated. Pages 4-5 include care of the child and family and ensuring key staff are contacted.
<table>
<thead>
<tr>
<th>Immediate notification of: (In cases of unexpected death)</th>
<th>By Whom</th>
<th>Contact Details</th>
<th>By When</th>
<th>Completed By:</th>
</tr>
</thead>
</table>
| Essex Coroner (Samples as per appendix can be taken prior to obtaining coroners permission) | On-call Consultant | In office hours: 03330135000  
Out of Hours: Through police  
Contact Essex Police HQ on 101 / 01245491491  
The Coroner’s Office will contact the caller after police information | ASAP | 
| Designated Doctor for Child Death for advice | On-call Consultant | Dr Manas Datta 01245 513260 | ASAP for advice | 
| Police Force Incident Room | On-call consultant or Senior Nurse | 0300 333 4444 (ask for Control Room) or Phone 101  
Chelmsford Child abuse unit: 01245 502110 or Phone 101 ext 420850 | ASAP | 
| Children’s Social Care | On-call Consultant | In office hours:  
Tel: 0345 603 7627  
Out of hours: 0345 606 1212  
Fax: 08456 016 230 | ASAP | 
| Child Death Review Administrator | On-call Consultant | Tel: 01245 459426 (Manager)  
Email: cdr@essex.gov.uk  
Child Death Review Team: 01992566131  
tpa-tr.SET-CDR-RRT@nhs.net  
Long Range Pager: 07623514672 | Same day or next working day | 
| Named Nurse Safeguarding Children (if required) | Senior Nurse | Sue Kent 01702435555 ext. 7276  
Children’s Safeguarding Team Broomfield Hospital: 01245514286 | Same day or next working day |
Appendix E: Response to unexpected deaths following initial case discussion

**Paediatrician, Police, Social Care (if appropriate), Coroner’s Officer, (any other professional as required)**

**Initial Case Discussion**
- Review known information
- Agree future responsibilities
- Decide on and plan visit to place of death (gain permission)

**Paediatrician, Police, (and member of primary health care team)**

**Undertake Visit to scene of death**

**Visit information summarised and provided to:**
- Pathologist (by Police)
- Coroner
- CDR Officer

**Pathologist**

**Post Mortem**

**Initial PM results to rapid response team**
- Pathologist sends report to Coroner
- Coroner releases to CDR Officer
- CDR Officer provides to Police member of rapid response team
- Police member shares information with rapid response team

**Rapid Response team (core and appropriate wider membership)**

**Second case discussion**
- Initial PM results
- Outcome of home visit
- Current dataset; Dataset updated as required

**Final PM results to rapid response team**
- Pathologist sends report to Coroner
- Coroner releases to CDR Officer
- CDR Officer provides to Police member of rapid response team
- Police member shares with rapid response team members

**Rapid Response team (core and appropriate wider membership)**

**Final case discussion**
- Final PM results
- Any further information obtained; finalised dataset produced and agreed; form F completed

**Finalised dataset to CDR Officer; CDR Officer forwards Form F to Coroner**

**Rapid Response Team**

Meets with parents to feed back PM results and outcomes of final case discussion

**CDR Officer**

Produces anonymised summary report on death for local CDR Panel meeting
Appendix F – Response to Unexpected Deaths

**Child Death Review & Rapid Response Policy/08071/4.0**

1. **Child dies / collapses**
   - Call ambulance
   - Attempt resuscitation

2. **Ambulance Service**
   - Control Room contact FIR
   - Attend scene
   - Resuscitation
   - Scene observation / initial history taking
   - Transfer child and family to E.D.

3. **On call paediatrician**
   - Attends child
   - Takes history
   - Resuscitation
   - Child declared dead
   - Staff identified to support family in the Department

4. **Parents informed of child’s death and next steps in process**
   - Further history and information gained
   - Contact details exchanged

5. **Samples and x-rays taken (as per agreed guidance)**
   - Observations of child’s body recorded

6. **Death notification made**

7. **Rapid response team formed (paediatrician and police)**

8. **Police**
   - Identify required social care input
   - Check police databases and obtain information from initial response
   - Identify involvement of FLO and Coroner’s Officer

9. **All involved professionals identified and informed**
   - Requested to complete dataset
   - Invited to case discussions as appropriate
   - Lead professional for family liaison on CDRRR identified
   - Hospital / social care records obtained

10. **Primary Health Care**
    - Initiate bereavement support to family

11. **Paediatrician, Police, (and member of primary health care team)**
    - Undertake Visit to scene of death

---

**Protocol on initial assessment of an infant or child presenting unexpectedly dead or moribund to be followed by hospital staff**

---

**Child protection and serious case review processes initiated if required**
Visit information summarised and provided to:
- Pathologist (by Police)
- Coroner
- CDR Officer

Pathologist

Post Mortem

Initial PM results to rapid response team
- Pathologist sends report to Coroner
- Coroner releases to CDR Officer
- CDR Officer provides to Police member of rapid response team
- Police member shares information with rapid response team

Rapid Response team (core and appropriate wider membership)

Second case discussion
Discussion of:
- Initial PM results
- Outcome of home visit
- Current dataset
Dataset updated as required

Final PM results to rapid response team
- Pathologist sends report to Coroner
- Coroner releases to CDR Officer
- CDR Officer provides to Police member of rapid response team
- Police member shares with rapid response team members

Rapid Response team (core and appropriate wider membership)

Final case discussion
Discussion of:
- Final PM results
- Any further information obtained
Finalised dataset produced and agreed
Form F completed

Finalised dataset to CDR Officer
CDR Officer forwards Form F to Coroner

Rapid Response Team

Meets with parents to feed back PM results and outcomes of final case discussion

CDR Officer

Produces anonymised summary report on death for local CDR Panel meeting
**Appendix G: Preliminary Equality Analysis**

**This assessment relates to:** 08071 Child Death Review and Rapid Response Policy

<table>
<thead>
<tr>
<th>A change in a service to patients</th>
<th>A change to an existing policy</th>
<th>X</th>
<th>A change to the way staff work</th>
</tr>
</thead>
<tbody>
<tr>
<td>A new policy</td>
<td>Something else (please give details)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are you proposing to change?</td>
<td>Full Review</td>
</tr>
<tr>
<td>2. Why are you making this change? (What will the change achieve?)</td>
<td>3 year review</td>
</tr>
<tr>
<td>3. Who benefits from this change and how?</td>
<td>Patients &amp; Clinicians</td>
</tr>
<tr>
<td>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.</td>
<td>No</td>
</tr>
<tr>
<td>5. a) Will you be undertaking any consultation as part of this change? b) If so, with whom?</td>
<td>Yes Refer to pages 1 &amp; 2 consultation</td>
</tr>
</tbody>
</table>

Preliminary analysis completed by:

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manas Datta</td>
<td>Paediatric Consultant</td>
<td>April 2019</td>
</tr>
</tbody>
</table>