THE JOINT AGENCY RESPONSE TO

SUDDEN UNEXPECTED DEATH OF CHILDREN IN DERBY CITY AND DERBYSHIRE

May 2021

Contents

Version Control

Policy to be read in conjunction with the Derby and Derbyshire Safeguarding Children Procedures.
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Version	Updated by	Signed off by	Date	Review Date
1.	CDOP Task and Finish group	DSCB Policy and Procedures Group	Nov 2015	Nov 2018
2.	Guggari Prasad, Paediatrician, Chesterfield Royal Hospital, Theresa Critchlow, Named Nurse Safeguarding Children , Chesterfield Royal Hospital and Dr E Starkey, Paediatrician, Derby Hospitals NHS Foundation Trust	DSCB Policy and Procedures Group	May 2016	March 2018
3.	CDOP Task and Finish Group/DDSCP Officer	DDSCP Policy and Procedures group	November 2019	November 2020
4.	Consultant Paediatrician and Designated Doctor for Child Death for Derby and Derbyshire/ Detective Inspector Derbyshire Police	DDSCP Policy and Procedures Group	February 2021	February 2023

Abbreviations:

SUDI- Sudden Unexpected Death in Infancy
SUDC- Sudden Unexpected Death in Childhood
ED- Emergency Department
EMAS- East Midlands Ambulance Service
CDR partners- Child Death Review Partners
CDOP- Child Death Overview Panel
SOCO- Scene of Crimes Officer
HTA licence- Human Tissue Authority licence
FME- Forensic Medical Examiner
GP- General Practitioner
NCMD- National Child Mortality Database
CDRM – Child death review meeting
SIO-Senior Investigating Officer, this is senior member of the police force.

1. Introduction

This joint agency guidance is intended for hospital emergency departments, paediatric teams, rapid response paediatricians, the east midlands ambulance service (EMAS), social care managers and police to support the response and investigation of sudden unexpected death in children up to 18 years of age for the whole of Derbyshire including Derby City.

1.1 Guideline Scope

An ***unexpected death*** is defined by Kennedy 2016, 'This encompasses all cases in which there is death (or collapse leading to death) of a child, which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent'.

This may include children:

- Found dead in a community setting.
- Brought in dead to the emergency department (ED).
- Who die in the ED following an unsuccessful resuscitation.
- Brought in to the ED in a state of cardio-respiratory arrest but where resuscitation is successful for a period of time before subsequent death. It is important in this case that, following a sudden and unanticipated collapse, if the child is expected to die in the following days, the joint agency response is initiated at the ***point of presentation*** and NOT the moment of death. A 'scene of collapse' visit may be performed and appropriate clinical investigations should also be performed. However these situations will require careful, sensitive and compassionate planning (see section 11, special circumstances).

The joint agency response should be triggered if a child's death:

- Is or could be due to external causes.
- Is sudden and there is no immediately apparent cause (including SUDI/SUDC).
- Where initial circumstances raise any suspicions that the death may not have been natural.
- Occurs in custody or a death whilst detained by the state including under the mental health act.
- In the case of a stillbirth where no healthcare professional was in attendance (see section 11, special situations).

The approach may vary in between these cases. A number of children will die from trauma, for example road traffic accidents or house fires. In the majority of cases a full joint response as documented in this guideline will not be appropriate as systems are in place to investigate the circumstances of the death led by other agencies such as the Police. For others a full joint agency response will be beneficial.

If a child who is normally resident outside this area dies in Derby or Derbyshire, it is anticipated that the immediate response will follow these guidelines until the case is formally handed back over to the relevant Coroner. Likewise if a Derby or Derbyshire child dies in another geographical area, the procedures under *that* Coroner's jurisdiction will be followed until the case is handed back to the Derbyshire Coroner when these processes will be commenced.

This guideline is for use in children up to, *but not including*, their 18th Birthday. It may be that an older teenager is brought into an adult emergency department where the same guideline must be followed.

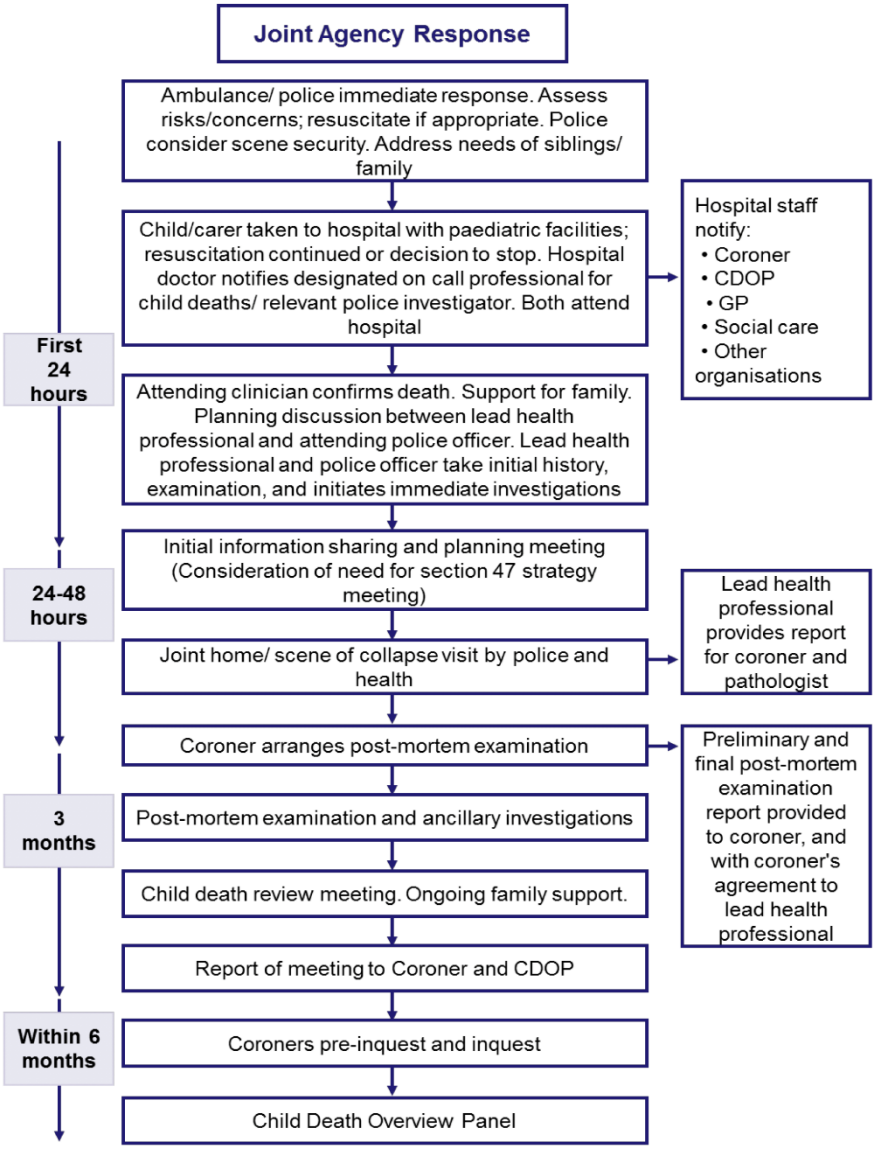
The joint investigative procedures are often referred to as the 'rapid response'.

1.2 Guideline Aims

The aims of these processes are to:

- Assist HM Coroner in ascertaining a cause of death where possible.
- Identify any potentially contributory or modifiable factors.
- Ensure support for families.
- Assure families that their child's death has been fully investigated.
- Ensure that future children are protected and satisfy any wider public interest concerns.

1.3 Flowchart for the Joint Agency Response



(Chart from Page 23, Figure 4, Child Death Review: Statutory and Operational Guidance, Oct 2018)

2. Initial Assessment and Management

2.1 Admission to hospital and confirmation of death

Following the community based death or significant collapse of a child:

- The first professional on the scene, whether ambulance personnel, police or GP should initiate or continue resuscitation attempts. Special note must be made of the position of the child, clothing worn and the circumstances of how the child was found. Those remaining at the scene must be asked not to disturb or move items around where the child was found until the police have viewed the scene. Any comments made by parents, background history, possible substance misuse and the living conditions should be noted and reported to the receiving medical and nursing staff in the hospital.
- It is important that no assumptions or opinions are made initially with regards to the assumed cause or time of death.
- The police should be notified as soon as possible (they are usually informed by the ambulance service) and a senior investigating officer (SIO) from the Police will attend the hospital.
- Resuscitation attempts will follow national protocols.
- If resuscitation attempts are unsuccessful then death must be confirmed by a doctor.
- If the child has presented in cardio-respiratory arrest and resuscitation restores cardio-pulmonary output initially, but it is anticipated that the child will die in the following days, the same process for investigation will need to be followed. The timing and sequence should be discussed between the police and the rapid response paediatrician on call after discussion with the medical team caring for the child. (See section 11.2).
- On rare occasions, the child's death may be verified in the community in cases of unequivocal death. The ambulance staff will have contacted the police who may arrange for the death to be verified at the scene by a police surgeon or other suitably qualified professional. The body must **NOT** be touched until the police have arrived and given permission.
- The east midlands ambulance service should then transport the body to hospital once the police have given permission for the body to be moved. The child should normally be taken to an emergency department rather than a mortuary. The east midlands ambulance service must contact the hospital emergency department prior to departure from the community setting to ensure that appropriate planning can occur. The senior investigating officer will discuss with the coroner's office as to where body should be transported to if not taking them to the emergency department.
- In the rare event that the body is to be taken directly to the mortuary, the person bringing the body must inform the mortuary directly (or via switchboard if out of hours) at either the University Hospital of Derby & Burton or Chesterfield Royal Hospital to advise them of the estimated time of arrival so that mortuary staff are available to receive the body. The person bringing the body is responsible for completing and attaching a printed label with as much information as possible.

3. Immediate Decision Making and Notifications

- A decision needs to be made regarding whether the death fulfils the criteria for a joint agency response. This is made by the on call Consultant Paediatrician or Emergency Department Consultant, the attending Police officer and the Coroner.
- The joint agency response should be triggered if a child's death:
    - Is or could be due to external causes.
    - Is sudden and there is no immediately apparent cause (including SUDI/SUDC).
    - Where initial circumstances raise any suspicions that the death may not have been natural.
    - Occurs in custody or a death whilst detained by the state including under the mental health act.
    - In the case of a stillbirth where no healthcare professional was in attendance (see section 11, special situations).
- By law, all sudden and unexpected deaths must be reported to the Coroner as soon as possible (even out of hours). This is usually done by the attending senior investigating officer.
- In Derbyshire and Derby City all deaths, including expected deaths, are also discussed with the Coroner but usually in daytime hours.
- If a decision is made to commence a joint agency response then the following individuals need to be immediately informed:
    - Derbyshire and Derby City Social Care (or out of hours) in accordance with the DDSCP Making a Referral to Social Care Procedure.
    - Police if not already aware.
    - Consultant Paediatrician on call if not already aware.
    - SUDC Paediatrician if in hours (0900-1700), or the next working day if out of hours.

3.1 Notification of death

- Other agencies and individuals should be informed by the ED or Paediatric nursing staff:
    - The child's General Practitioner
    - Child Health Information System - to cancel any appointments. Remember there may be more than one hospital involved
    - Liaison health visitor
    - Child Health department (who will inform the child's health visitor, school nurse, and the safeguarding children service)
    - Derbyshire or Derby City Children's Social Care
    - Child's named Consultant if relevant.
    - Child's other health professionals if relevant, e.g. community nursing team, midwives etc.
    - CDR partners via the CDOP administrator through the completion of a notification form (previously called Form A). This can be done via, https://www.ecdop.co.uk/Derbyshire/Live/Login
    - MMBRACE-UK notification of a mother and baby through the local MMBRACE Lead reporter for the Trust (if relevant).

4. Investigation and Information gathering

Once death is confirmed and it is agreed the joint agency response is required the following processes occur:

4.1 Compassionate and dignified care of the deceased child.
4.2 Communication with and support for families.
4.3 Medical History.
4.4 Medical Examination.
4.5 Medical Investigations.
4.6 Photographic evidence
4.7 Memory Creation.
4.8 Lead health professional.
4.9 Arrangement of Post Mortem Examination.
4.10 Arrangement of the joint agency home visit.

4.1 Compassionate and dignified care of the deceased child.

- Always handle the child with respect as though s/he were alive.
- Use the child's name.

4.2 Communication with and support for families.

- The fact that the child has died should be gently broken to the parents by a senior member of the team.
- Know the name, age and sex of the child. Use the name at all times.
- Make sure you make notes of any comments and discussions with the parents.
- Check who is present and what their relationship is to the child.
- Make sure there is another relative or friend to support the parent and if possible ensure both parents are present
- Find a quiet room and give your bleep to another doctor. Ensure a nurse is with you.
- Answer questions and give whatever explanations are available.
- Avoid speculating on the cause of death; explain that it will not be possible to give them a diagnosis until all the investigations have been carried out.
- Explain to the parents that all cases of sudden unexpected death must be referred to the coroner for investigation, which will include police involvement and post mortem examination as a matter of routine for all unexpected deaths and must include a multi-agency investigation.
- Explain to the parents what will happen next, and where their child will be taken and when they will be able to see him/her again. Most post mortem examinations in Derbyshire are undertaken at Sheffield Children's Hospital. Families are always welcome to visit the child in Sheffield, either before or after the examination, by appointment.
  The telephone number to arrange to visit the child at Sheffield Children's Hospital is: 0114 2717246 or 0114 2267809. Ask to speak to the Mortuary Manager. They can be

contacted between 0800 to 1600 Monday to Friday, (although visits can be arranged following discussion for the weekend).

- Take into account any religious and cultural beliefs that may have an impact on procedures and handle discussion of these with sensitivity, but with due regard to the importance of these procedures. Offer a spiritual adviser if parents would like.
- Explain that it is routine for the police and paediatrician to visit the home as soon as possible whenever there has been an unexpected death and that they will want to speak with the family.
- Ask the parents where they are going once they leave the ED, document the address and contact number, who will be with them and how they will get there safely (they may need hospital transport).
- Ensure that parents have names and contact numbers for the lead health professional, police liaison and the hospital bereavement office.

4.3 Medical History

- History taking is an ongoing process rather than a one-off event. Remember that you are dealing with people who are in the first stage of grief. They may be shocked, numb, withdrawn, or hysterical. Any gaps can be covered in later meetings with the family.
- The history should be taken by the senior paediatrician on call or possibly the ED team if 17 years of age (a brief history may already have been taken by the resuscitation team).
- Where possible this should be conducted with the police investigator to avoid the need for repeated questioning.
- Always consider the need for communication support, e.g. interpreters for families where English is not the first language, or signers for deaf individuals. Please remember it is not appropriate to use friends or family members to support the communication process, particularly if there are any concerns about child abuse.
- Take a full paediatric history in the same detail as would be the case for a child presenting with any serious illness.
    - The history should include pregnancy, birth, neonatal period, feeding history, immunisations, drug history, development, family/social history,
    - Detailed history of last few days (and in particular the last 24 hours), including precise timings of events, when the child was last seen alive, actions and circumstances of parents when the child was found.
- Record all details accurately (your records may become a legal document in any future investigation) and according to record keeping standards.
- Record the name of the person(s) giving the history.
- Record any discrepancies between accounts given by different people.
- Review the child's personal health record 'red book' if available.
- ED staff will check whether or not the child is known to children's social care and/or is subject to a child protection plan through the relevant contact system.

4.4 Medical Examination.

- A joint medical examination with a Consultant Paediatrician and Forensic Medical Examiner (FME) is now NOT required for paediatric deaths.
- The medical examination will occur in the presence of the senior investigating officer and will be performed by an experienced paediatrician which usually means the consultant paediatrician on call.
- A 16 or 17 year old may have their examination performed by a senior member of the Emergency Department team. However if the young person has a significant past medical history (e.g. life limiting condition, serious congenital, acquired or inherited abnormality, serious chronic metabolic disorder) or examination findings to suggest any underlying genetic or metabolic abnormality then they should be examined by a Senior Paediatrician. If the Emergency department staff have any concerns then they should discuss with the on call Paediatric Consultant.
- Sometimes the Police will not have routinely been called to an older teenage unexpected death but it is vital that they are informed at the earliest opportunity and present for the examination.
- All information from the examination should be documented in the patient's Medical Record and a copy passed to the Senior Investigating Officer to give to the Coroner. The Rapid Response Paediatrician should also receive a copy.
- Keep all clothing in labelled bags and keep with the child initially. Retain any nappy in a separate bag.
- Note particularly:
    - Physical state of child
    - Post death changes such as dependant lividity, position and rigidity
    - General hygiene
    - Weight, length & head circumference with appropriate centiles
    - Ear temperature and time recorded
    - Rashes
    - Bruises, petechiae and other marks (plot on body map – remember to look in hidden areas such as gums, lips, neck, ears, scalp, fundi, genitalia and anus)
    - State of the frenulum
    - Fundoscopy to document any visible retinal haemorrhages
    - Evidence of bleeding

- Everything should be recorded on the body map.
- Note sites of invasive resuscitation procedures on the body map.
- ETT tubes may be removed once the position has been confirmed by a senior doctor who is familiar with the intubation of children and young people. It is important that details of why the tube is correctly or incorrectly sited are recorded as well as the length secured, size and type of ETT used (cuffed/uncuffed). Details may include positives such as the tube is seen passing below the cords, and important negatives such as the tube was not in the oesophagus on laryngoscopy etc.

- Cannulas and central lines etc should be left in situ but the ends can be capped off and all covered in an occlusive dressing and made neat for families. Catheters can be capped with a spigot.

Further information and guidance on the examination can be found in appendix 4 of 'Sudden Unexpected death in infancy and childhood: Multiagency guidelines for care and investigation. Baroness Helena Kennedy. 2nd Edition, November 2016'.

4.5 Medical Investigations

- After death has been pronounced, the coroner has jurisdiction over the body. The coroner has given prior permission for investigative samples as stated in this protocol and mementoes (e.g. footprint, hairlock) to be taken.
- The paediatric pathologists in Sheffield, who undertake the coroner's post mortems on children who die in Derby and Derbyshire, have protocols in place for taking appropriate samples and most samples are satisfactory if taken at post mortem.
- However due to degradation over time the following samples should be taken in all cases of unexpected death:
    - A peripheral blood culture. Two attempts only at femoral blood sampling should be attempted. Cardiac sampling should not be undertaken (affects post mortem findings). If unsuccessful after 2 attempts then this should be abandoned.
    - Nasopharyngeal aspirate – for mc+s and virological studies
    - Swabs for mc+s from any relevant skin lesions (if applicable)
    - If specimens are taken, record the time they are taken, site from which taken, person taking specimen, time of informing the lab and who informed, time specimen arrived in lab and who received it, is carefully recorded.
    - Ensure that the pathologist is aware of all specimens taken, and their results, preferably by telephone conversation or faxed report.

- It has been agreed locally with HM Senior Coroner and with senior pathologists that further samples including urine, CSF and skin biopsies, often stated as Kennedy samples, do NOT need to be taken as can more accurately be taken at post-mortem by the pathologist.
- Samples can only be taken from the deceased in a Human Tissue Authority (HTA) licenced area of the hospital. This is usually the Emergency Department or Mortuary but Hospital Trusts should check their own licencing agreements.
  Please see **Appendix 1**

4.6 Photographic Evidence.

- The Police will decide after the examination whether these are required and if so will arrange for the Scene of Crimes Officer (SOCO) to complete.

4.7 Memory Creation.

- The coroner has given prior permission for mementoes to be taken as stated in this guidance.

- Arrange for appropriate photographs to be taken and, if the parent's wish it, for other mementoes to be kept, such as a lock of hair or prints of hands and feet. If this is not done at this time, the pathologist can arrange for it to be done in the mortuary in Sheffield.
- It is entirely natural for a parent/carer to want to hold or touch the dead child. Providing this is done with a supportive professional present, it should be allowed in most cases, as it is highly unlikely that forensic evidence will be lost. Where possible, the senior investigating officer should be consulted before a parent/carer is allowed to hold the child - and certainly if the death is considered suspicious.
- Families must be directly supervised by a member of staff at all times however when with their deceased child. This can be done in a discrete and sensitive manner.

4.8 Lead Health Professional

- This is the person within health who coordinates the health response to the death ensuring that all health responses are implemented.
- This is usually the on call Paediatric Consultant until the responsibility is handed over to the SUDC Paediatrician on the next working day.
- When the responsibility for lead health professional is transferred from one professional to another, there must be a clear handover of responsibilities and the other lead professionals in other agencies (Police, Social Care & Coroner) should be notified.

4.9 Arrangement of Post Mortem Examination

- The coroner will make a decision as to which pathologist will do the post mortem. At present paediatric post mortems are usually carried out at Sheffield Children's Hospital. All original medical notes will go with the child's body to the pathologist and will be retained at least until all elements of the post mortem examination are completed. It is therefore recommended that a photocopied set of notes is kept in the hospital.
- It is important that the pathologist receives the child's body as it was received in ED. The child should be wrapped, but not washed or dressed before being given to the parents (if appropriate). The pathology department at Sheffield Children's Hospital will clean and re-dress the child after the post mortem. The family may send the child's own clothes and toy or other item to stay with him/her.

4.10 Arrangement of joint agency home visit

- The rapid response paediatrician is contacted and a rapid response home visit is arranged. This will usually occur within 24 hours but may occur within 48 hours in exceptional circumstances.
- The visit is usually occurs within daylight hours, i.e. between 9 – 6pm.
- The police will contact the on call rapid response paediatrician to arrange the joint home visit. They will be contacted via the switchboard for:

- North cases – 24/7 contact, Chesterfield Royal Hospital NHS Foundation Trust (Tel: 01246 277271)
- South cases – In normal working hours contact Safeguarding Unit on 01332 623730, however out of hours contact Derbyshire Healthcare NHS Foundation Trust on 01332 623700.

5. Initial Multiagency Information Sharing and Planning Meeting

- An initial information sharing and planning meeting should occur before the family leave the emergency department.
- This is for information sharing and planning for the ongoing multiagency joint investigation.
- It is ideally conducted in person in the emergency department but can utilise telephone conference call facilities if required, this meeting should be led by the lead health professional.
- It should involve:
  - The on call consultant paediatrician or emergency department consultant
  - The on call senior investigating officer
  - The on call manager for social care
  - If in hours (ie. 9 – 5pm and available), the SUDC Paediatrician
  - Any other relevant professional who knew the patient (if available and in hours). Examples might include the patient's named consultant, community or specialist nurse.
  - The circumstances of death.
  - Information from the ambulance service.
  - Findings from the initial history and examination.
  - Any safeguarding concerns or prior police involvement.

    In some circumstances it may become apparent that there is a requirement for a section 47 strategy discussion and that all of the required information and professionals are already available within this initial information sharing meeting. In these circumstances, and with social care agreement, the professional group may decide that this meeting will be conducted under the S47 strategy discussion procedures.

- The following should then be considered:
  - Any immediate health actions? e.g. prophylaxis for family members
  - Any immediate safeguarding actions? e.g. safety of other siblings?
  - Any immediate Police actions? e.g. commence criminal investigation? Forensic samples required?
  - Who will provide ongoing bereavement support for family?
  - Is there anyone else that needs to be contacted?
  - Are there any outstanding investigations?
  - Are notifications completed?
  - Arrangements for the post-mortem.
  - Arrangements for the joint home visit.
  - Consideration of the need for a Section 47 Strategy Meeting?
  - Should a Trust serious incident review be commenced? This can be commenced at a later date also.
  - Who will be the 'key worker' for the child's family to support them through the process?

- Arrangements for information sharing with schools/educational settings if relevant.

- Document the strategy discussion in the medical records.
- Identify who will be supporting the family and how.
- If there are criminal investigations, the rapid response investigations must proceed under the direct guidance of the police at each stage.
- The immediate decision making proforma will then be completed. **See Appendix 2.** Please note that some sections will be completed over subsequent days by the SUDC paediatrician but the emergency team should complete as much as they are able to at this time.
- Photocopies of the medical records documenting the strategy discussion meeting and the immediate decision making proforma should be sent to the Coroner (via the senior investigating officer) and to the rapid response paediatrician (via the CDOP coordinator).

5.1 Factors which may raise early concern

Any information identified by professionals in the course of their involvement that could give rise to concern or provide important information to the investigation must be shared immediately with the police and children's social care. Such factors (not in order of priority) include:

- Previous child deaths in the same family
- Previous child protection concerns in the same family
- Previous unexplained illnesses or injuries
- Inappropriate delays in seeking help
- Inconsistent explanations
- Evidence of drug/alcohol abuse
- Evidence of domestic abuse within the family
- Evidence of parental mental health problems
- Unexplained injuries or bleeding
- Neglect concerns

5.2 Siblings

If there are safeguarding concerns, the multiagency S47 strategy discussion should consider whether siblings should be examined and/or admitted and make appropriate arrangements.

6. Family support

- The police may appoint a family liaison officer to support the family.
- The Coroner's office will provide a contact for the family.
- There should be a local key worker identified within the Trust who can be a point of contact for the family and liaise with them as proceedings progress.
- The family should have the contact details of the lead health professional.
- Leaflets should be given families. **'When a child dies- A guide for parents and carers'** should be given to ALL bereaved families. **'Help is at hand'** is a leaflet to be given to families where their child appears to have died from self harm/suicide.

7. The Post Mortem Examination & Report

- The coroner's office will ensure that the parents are aware if the body is to be moved.
- The SIO or a representative and the crime scene investigator may be asked to attend the post mortem, depending on the circumstances and whether their presence is required.
- The interim post-mortem findings will be shared with the lead health professional by the Coroner or SIO. The only exception may be if there are concerns about a potential criminal prosecution or in cases of clinical negligence. In these exceptional circumstances a three way discussion will occur between Police, Coroner and the lead health professional and a decision will be made as to whether all, some or none of the findings can be shared.
- Communicating the interim findings of the post mortem to the family will be arranged by the pathologist, with the permission of the coroner.

8. The Joint Agency Home Visit

- This will usually occur within 24 hours but may occur within 48 hours in exceptional circumstances and after liaison with the family.
- The scene of collapse or death should be seen.
- It will be conducted by the on call SUDC paediatrician and the Senior Investigating officer from the child abuse unit of Derbyshire Police.
- If parents are too distressed to return to the home the visit may include history taking at another location and then a scene of death visit.
- If a child dies in a community setting, e.g. road traffic accident, it would not be appropriate to perform a scene of death visit.
- A report will be compiled for the Coroner and Pathologist following the joint home visit. A copy should also be sent to the CDOP Coordinator.

9. Further Multiagency Meetings

- The Initial Multiagency Information Sharing and Planning Meeting will have determined whether a section 47 strategy discussion is required. If this is required then the meeting should take place within 24 hours of the decision to do so and will be led by children's social care in accordance with DDSCP procedures.
- If a decision has been made within the Initial Multiagency Information Sharing and Planning Meeting that a S47 strategy meeting is NOT required, but a further multi-agency meeting would be beneficial, then this meeting should be led by the lead health professional and involve all of the relevant partner agencies involved (e.g. lead health professional, named clinician, health visitor, midwife, school health etc)
- If not attending in person liaison should occur between the safeguarding nurse attending the S47 strategy meeting and the lead health professional, both before and after the meeting to share information.
- Minutes of the meetings should be taken and shared with the Coroner, CDOP coordinator and lead health professional.
- The provisional results of the post mortem examination should be shared with the lead health professional as soon as available. The lead health professional reviews the

case with the emerging findings. They will liaise further with Police and Social care if required.

- Throughout the process if agencies develop concerns then these should be shared with all members as appropriate.

10. Arrangement of the child death review meeting

- The SUDI/C paediatrician will receive the final written post mortem report via the coroner's office as soon as this is available.
- The final child death review meeting will then be arranged.
- This should take place before the inquest so as to inform the Coroner's proceedings.

10.1 The child death review meeting (CDRM)

- The CDRM is a multi-professional meeting where all matters relating to an individual child's death are discussed by the professionals *directly involved* in the care of that child during their life and during the investigation after their death.
- The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved. The review meeting should be flexible and proportionate. It should also be focussed on local learning.
- In every case the Analysis form should be completed at the CDRM and sent to the CDOP coordinator.
- Relevant professionals should be invited but this will vary according to the case. Invited professionals could include:

    - Hospital or community staff involved during the child's life.
    - Pathologist.
    - Patient safety team if a serious incident investigation has occurred.
    - Coroner's officer.
    - Senior investigating officer.
    - Lead health professional.
    - Social care.
    - Education.
    - Others including ambulance service, health visitor, midwife, GP, representatives from voluntary organisations.
    - If certain professionals are unable to attend, they may be invited to submit a Reporting Form (previously called Form B) instead.

10.2 Aims of the child death review meeting

- In all cases the aims of the CDRM are:

    - To review the back ground history, treatment and outcomes of investigations to determine, as far as possible, the likely cause of death.

  - To ascertain any contributory or modifiable factors across domains specific to the child, the social and physical environment and the service delivery.
  - To describe any learning arising from the death and, where appropriate, to identify any actions that should be taken by any of the organisations involved to improve the safety or welfare of children or the child death review process.
  - To review the support provided to the family and to ensure that the family are provided with the outcomes into the multiagency investigation into their child's death in plain understandable English.
  - To ensure that the Coroner and CDOP are informed of the outcomes of all investigations into the child's death.

- Notes of the meeting and the Analysis form completed at the meeting will be sent to the Coroner and the CDOP coordinator.
- The lead health professional or key worker will offer to meet with the parents to discuss the findings and outcome from the meeting.

11. Special Situations

11.1 Unwitnessed stillbirths

- A joint agency response should be triggered in the case of a stillbirth where no healthcare professional was in attendance.
- The coroner must be notified and will usually arrange for a post-mortem to be performed.
- The investigation is usually led by the Police.
- It would usually not be appropriate for a home visit with a paediatrician to be undertaken in this circumstance unless there were specific concerns for example, safeguarding.
- A strategy discussion should occur between the Police, Social Care and Health to decide the scope of the joint agency response.
- A stillbirth is when a baby over 24 completed weeks gestation is born without signs of life. If any sign of life is shown (heartbeat, movement or breathing) then this is a life birth.
- The Derbyshire coroner would like to be informed of cases from and including 22 weeks gestation.
- If the baby is not born alive then the case does not need a review or discussion at CDOP. If the baby is born alive then it does.

11.2 Collapse of a child in the community

- This usually refers to a child being unwell enough that cardiopulmonary resuscitation is required.
- For example, a child brought in to the ED in a state of cardio-respiratory arrest but where resuscitation is successful for a period of time before subsequent death.
- It is important that following a sudden and unanticipated collapse, if the child is ***expected to die in the following days***, the joint agency response is initiated at the ***point of presentation*** and NOT the moment of death.

- The Police may not have been contacted in this situation. It is important that the sergeant on call for the child abuse unit of Derbyshire police is contacted as soon as possible.
- A 'scene of collapse' visit may be performed and appropriate clinical investigations should also be performed.
- Due to the fact that the child is still alive and potentially being cared for at a different geographical location, these situations will require careful, sensitive and compassionate planning.
- Liaison with the centre looking after the child is essential.

11.3 Adapted Approach to the Joint Agency Response

- This usually occurs when a child dies from external trauma, for example fires, road traffic accidents or drowning.
- In the majority of cases a full joint agency response as documented in this guideline will not be appropriate as systems are in place to investigate the circumstances of the death led by other agencies such as the Police. It is usual, for example, that a home visit with a paediatrician is not performed.
- For others a full joint agency response will be beneficial.
- A strategy discussion should occur between the Police, Social Care and Health to decide the scope of the joint agency response.
- Situations where a home visit is most likely not required would include a road traffic accident, or drowning in a community setting.
- Situations where a scene of death visit with police and a paediatrician may be beneficial include, drowning in a domestic dwelling and a fire in a domestic dwelling.

11.4 When inflicted injury is suspected and a criminal investigation is required.

If there is 'any suspicion' that the death of a child or infant has been inflicted by another person then the Police and HM Coroner must be immediately informed and the joint agency response guideline procedures halted until a discussion has occurred between health, HM Coroner and police.

When Derbyshire Police are informed that there is a suspicious inflicted death of a child or baby then the following should occur.

- A senior detective, either the on call Detective Sergeant from the Child Investigation Unit or the duty Detective Inspector, from Derbyshire Police will be assigned to attend the hospital as soon as possible and liaise between HM Coroner, the SIO (senior investigating officer) from the major crime unit and the lead health professional (either ED Consultant or Consultant paediatrician). They will have a discussion and agree the following:

    - Share information so far available.
    - Agree on whether to proceed with a criminal forensic investigation.
    - Agree whether there are any medical lines of investigation required.

- Agree on procedures such as:
  - Whether the Paediatrician can examine the child / baby and take samples as per guideline. If a criminal investigation is proceeding, then this will usually NOT be allowed as a specialist Home Office paediatric forensic post-mortem will be organised.
  - Whether a joint agency response will be initiated including paediatrician attending the home and speaking to family. If a criminal investigation is proceeding this will usually NOT take place, this should be discussed between HM Coroner, SIO and the lead paediatrician.
  - Whether parents / carers can hold the baby / child. If a criminal investigation is proceeding this will usually NOT be allowed prior to post-mortem even if supervised, this should be discussed between the SIO, HM Coroner and the lead paediatrician.
  - Agree on whether there is any evidence from the emergency department that needs to be retrieved by police, e.g clothing, documentation.
  - Agree whether mementoes can be taken, e.g. hand and footprints. If a criminal investigation is proceeding this will usually NOT be allowed. This should be discussed between HM Coroner, SIO and the lead paediatrician.
  - Ensure that there has been a multiagency discussion with children's social care and consideration given to any safeguarding considerations for other children / siblings. A multi-agency strategy discussion should take place as soon as possible involving all statutory partners.
  - Agree who will signpost for bereavement support and what follow up can occur. This may include standard support from GP, follow up with health (e.g. consultant follow up) if agreed, signposting to bereavement services including Derbyshire bereavement hub, whether a family liaison officer will be assigned.

It is often the case that a uniformed officer from the Police is first to attend the emergency department. It is important that the on call Detective Sergeant from the child investigation unit is always informed immediately and they or the duty Detective Inspector will attend the emergency department as soon as possible.

It is likely in criminal cases that evolving information, for example post-mortem reports, may not be shared with health until after any criminal court cases have occurred. HM Coroner will make this decision and will share the post-mortem if felt to be appropriate, for example, it may be disclosed if care proceedings occurring for other children. If any medical issues are found at post-mortem it is the responsibility of the Police and HM Coroner to liaise with the relevant professional as appropriate. It may well be that in such cases the standard CDRM (child death review meeting) does not occur. In such cases the criminal investigation and subsequent inquest can be used as a review of the child prior to CDOP review and a CDRM does not need to occur.

HM coroner has legal authority over the body and investigation, and it is vital that they are involved in all initial decision making. HM Coroner will be involved throughout but where there is a criminal investigation the Police will then investigate the criminal investigation. A coronial inquest is opened and postponed. The HM Coroner may choose to run the Coronial investigation concurrently to the criminal investigation or they may choose to run this after the criminal investigation is concluded. There may then be a coronial inquest depending on the coronial decision.

11.5 Expected Paediatric deaths

Expected paediatric deaths, e.g. those with life limiting conditions who may choose to die at home/hospice, in the vast majority do NOT need a joint agency response.

This is because in the majority the death is expected as part of their condition and, even though they may die in the community, it would be inappropriate to enact the joint agency guidelines.

The speed and pattern of death can vary greatly in children with life limiting conditions with some having a rapid final phase.

However, there are occasions when a child with a life limiting condition may die suddenly and unexpectedly. These deaths must be referred to HM Coroner.

The Sudden Unexpected death in infancy and childhood: Multiagency guidelines for care and investigation, November 2016 2nd edition p.13 – 14: The child with life-limiting or life-threatening condition who dies suddenly and unexpectedly gives some guidance.

If a child with a recognised life-limiting of life-threatening condition dies suddenly or following a brief illness, a SUDI investigation might not be required.

The lead health professional must liaise with the coroner.

In any event, if the death was not expected, the lead health professional should have a discussion with the other members of the joint agency response team, and the clinical team who knew the child and family, and reach an opinion on whether a SUDI investigation should be initiated.

The designated lead health professional must then consult with the coroner who will make the final decision.

11.6 When a child or baby dies in a hospital setting after admission.

The JAR guideline is written to investigate sudden and unexpected death in childhood and infancy. It gives guidance that an unexpected death is defined as the death of a child or infant that was not anticipated as a significant possibility 24 hours before the death. In general, it relates to children where there is a community based collapse and the child is either found dead in a community setting or dies shortly after arrival to the Emergency Department.

There are certain paediatric medical conditions however where the onset of the condition and progress to death can be rapid and naturally occur in a time frame of less than 24 hours. Examples include sepsis, bronchiolitis and congenital heart disease.

In such cases a JAR may not be appropriate if a medical cause of death is clear from the child's presentation or the results of initial investigations. However, these cases must be discussed with the Coroner. The Coroner will not only take into account whether there is a clear medical cause of death, but also whether there are any issues with neglect, or issues with diagnosis or clinical management.

Conversely a child may be admitted to hospital with one condition, whether to a paediatric ward or neonatal unit, but then die suddenly and unexpectedly. In such cases it may be appropriate to still initiate a modified JAR response and the case must be referred to HM Coroner.

The following is proposed:

If a baby / child dies within 24 hours of admission to hospital, there must be a telephone discussion with the on call Coroner and the specific question of whether a JAR response should be initiated should be discussed.

The coroner may decide one of the following:

- No JAR is required as there is a clear medical natural cause of death.
- A modified JAR is required – this may include no home visit if the child died in hospital.
- A full JAR response is required.
- Alongside the question over whether a JAR response is indicated, the Coroner will also decide whether a Coronial investigation is required.

This discussion with HM Coroner should occur on the day of death so that the response can be immediately initiated if required. An on call Coroner is always available. The discussion may involve the other members of the JAR multi-professional team if appropriate. All members of the JAR team should be informed of the baby's death and the Coronial decision around the JAR response.

The coroner must be notified, and a discussion held about a JAR response, if:

- A baby dies suddenly and unexpectedly on a NICU or paediatric ward even if this is more than 24 hours after admission.
- If there are concerns raised by health professionals that abuse or neglect may have contributed to the death, for example, delayed presentation. Under these circumstances both Police and Social Care should also be notified immediately.

HM Coroner also requires that deaths within 24 hours of admission to the neonatal unit following birth should also be notified.

At present it is local policy that all deaths are notified to HM Coroner but if not fulfilling the criteria for sudden and unexpected death this can be done using the electronic notification form rather than a telephone call.

Appendix 1: Kennedy Samples *(Sudden Unexpected death in infancy and childhood: Multiagency guidelines for care and investigation. Baroness Helena Kennedy. 2nd Edition, November 2016)*

Samples to be taken immediately after sudden unexpected deaths

- After death has been pronounced, the coroner has jurisdiction over the body. The coroner has given prior permission for investigative samples as stated in this protocol and mementoes (e.g. footprint, hairlock) to be taken.
- The paediatric pathologists in Sheffield, who undertake the coroner's post mortems on children who die in Derby and Derbyshire, have protocols in place for taking appropriate samples and most samples are satisfactory if taken at post mortem.
- However due to degradation over time the following samples should be taken in all cases of unexpected death:
    - A peripheral blood culture. Two attempts only at femoral blood sampling should be attempted. Cardiac sampling should not be undertaken (affects post mortem findings). If unsuccessful after 2 attempts then this should be abandoned.
    - Nasopharyngeal aspirate – for mc+s and virological studies
    - Swabs for mc+s from any relevant skin lesions (if applicable)
    - If specimens are taken, record the time they are taken, site from which taken, person taking specimen, time of informing the lab and who informed, time specimen arrived in lab and who received it, is carefully recorded.
    - Ensure that the pathologist is aware of all specimens taken, and their results, preferably by telephone conversation or faxed report.
- It has been agreed locally with HM Senior Coroner and with senior pathologists that further samples including urine, CSF and skin biopsies, often stated as Kennedy samples, do NOT need to be taken as can more accurately be taken at post-mortem by the pathologist.
- Samples can only be taken from the deceased in a Human Tissue Authority (HTA) licenced area of the hospital. This is usually the Emergency Department or Mortuary but Hospital Trusts should check their own licencing agreements.
- Skeletal survey will be done as part of post mortem.
- The consultant in charge of the case must ensure that the results of all samples taken during the current episode are communicated promptly to the pathologist.

Sample Table – (samples to be taken immediately after unexpected deaths.)
It is important that the postmortem is not affected. Therefore only 2 attempts may be performed and documented in the medical records. It is best that they are performed by someone senior and experienced. Cardiac sampling should not be performed. Femoral sampling should be attempted and all attempts documented in the medical records and on the body map. If unsuccessful then this should be documented in the medical records. Samples taken successfully should be documented in the medical records.

Sample	Sent to	Test	Tick if done
Blood cultures	Microbiology	Culture and sensitivity	☐
Nasopharyngeal aspirate	Virology	Viral cultures, immune-fluorescence	☐
Nasopharyngeal aspirate	Microbiology	Culture and sensitivity	☐
Swabs from any identifiable lesions	Microbiology	Culture and sensitivity	☐

Appendix 2: Immediate Decision Making Proforma

Child's name	
Address	
NHS Number	
Hospital Number	

No	Decision	Circle as appropriate	Action	Action completed? Date completed
1	Does the death meet the criteria for a joint agency response? i.e. Was the death unexpected?	Yes / No	If Yes Contact SUDIC paediatrician if in hours. Contact on call social worker. Contact Police. Arrange multiagency strategy discussion meeting.	
2	Can a MCCD be issued, after discussion with Coroner?	Yes / No	Date completed. Document cause of death as stated on MCCD	
3	Has a care or service delivery issue occurred? Any Parental concerns about care?	Yes / No Yes / No	If yes, contact Senior Matron and patient safety team	
3a	In relation to 3: Are there any immediate actions required to ensure the safety of other patients?	Yes / No / NA	If yes, document actions taken here	
3b	In relation to 3: Has a datix form been completed with specific concerns?	Yes / No / NA	If yes, document datix number here	
3c	In relation to 3, Has a duty of candour letter been completed and sent?	Yes / No / NA		
4	Family Support • Do the family have the contact details of their key worker? • Do the family have the contact details of their Lead Health Professional? • Have the family received information about the types of investigations occurring? • Who is responsible for ongoing bereavement support?	Yes / No / NA Yes / No / NA Yes / No / NA Yes / No / NA	Details here Details here Details here Details here	

5.	Has the Lead Health professional been identified? *Joint investigation –usually SUDC paediatrician. Other cases usually Named or On call Consultant*	Yes / No	Details here	
6.	Any other immediate actions required? e.g. Medical – prophylaxis? Safeguarding – other siblings?	Yes / No	Details here	
7.	Immediate Notifications completed	Yes / No	Date and Time	
8.	Type of investigation ongoing: Joint Agency Investigation, e.g. unexpected deaths Coronial Investigation, e.g. Coronial decision, parental concerns about care Police Investigation, e.g. RTA, suffocation Serious Incident Investigation, e.g. Care or service delivery concerns Routine Mortality Review	 Yes / No Yes / No Yes / No Yes / No Yes / No	Contact Details of Lead professional	

Name of person completing the form	
Job Title	
Date and time	

Appendix 3: References

HM Government. Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children. July 2018.
HM Government. Child Death Review, Statutory and Operational Guidance (England), October 2018.
Sudden Unexpected death in infancy and childhood: Multiagency guidelines for care and investigation. Baroness Helena Kennedy. 2nd Edition, November 2016
Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children
Revised guidance for registered medical practitioners on the Notification of Deaths Regulations March 2020, Ministry of Justice

Contact numbers:

- Police (24/7) - Tel: 101
- Senior Coroner for Derby and Derbyshire, Dr Robert Hunter, Tel: 01332 613014
- CDOP coordinator, Tel: 01332 623700, extension 31526
- Designated Doctor for Child Death for Derby and Derbyshire, Tel: 01332 623700, extension 31526
- Community Safeguarding Children Unit, Kingsway House, Tel: 01332 623700 ext. 31537
- Sheffield Children's Hospital Pathology Department, Tel: 0114 2717486
- Mortuary Manager (to arrange visits of children), Tel: 0114 2717246, or 0114 2267809.

Distribution:

Health
East Midlands Ambulance Service (EMAS)
Staff at Chesterfield Royal Hospital NHS Foundation Trust and University Hospital of Derby & Burton NHS Foundation Trust:

- All Consultant Paediatricians
- All Consultants in Emergency Medicine
- All Senior Matrons
- All Consultant Obstetricians
- All Senior Midwifery leads
- Named GP (s) for safeguarding
- Named Nurses for safeguarding

Social Care
Senior Manager (s) at Derby City or Derbyshire and Derby and Derbyshire Safeguarding Children Partnership

Police
All Detective Sergeants and Detective Inspectors, North & South PPU Hubs, Derbyshire Constabulary.

Other
HM Senior Coroner, Derby City and Derbyshire