

Section 7 – Child Death Review Processes

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INTRODUCTION

- 7.1 The following procedures are meant to guide practice for all professionals working with children and families and for the members of the LSCB Child Death Review Panel, (CDOP) which incorporates the Durham and Darlington LSCB areas.
- 7.2 The Local Safeguarding Children Boards of Durham and Darlington has a statutory responsibility to review the deaths of all children in the Durham and Darlington areas.
- 7.3 When a child dies in either of the above LSCB areas, there are two interrelated processes for reviewing child deaths (either of which can trigger a serious case review):
 1. Rapid Response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child. This process is augmented by a Local Case Discussion.
 2. An overview of all child deaths up to the age of 18 years (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) undertaken by the Child Death Overview Panel which is a sub-committee of the LSCB.
- 7.4 CDOP is responsible for reviewing the available information on all child deaths, and is accountable to the LSCB Chair. The disclosure of information about a deceased child is to enable the LSCB to carry out its statutory functions relating to child deaths.
- 7.5 The Local Case Discussions and the CDOP examine the circumstances surrounding a child's death and make recommendations where appropriate. The LSCB use the findings from all child deaths, to identify patterns or themes and inform local strategic planning on how best to safeguard and promote the welfare of the children in their area.

DEALING WITH FAMILIES

- 7.6 Families should be treated with sensitivity, discretion and respect at all times, and professionals should approach their enquiries with an open mind.
- 7.7 Chronic illness, disability and life-limiting conditions account for a large proportion of child deaths

INVOLVEMENT OF PARENTS/FAMILY MEMBERS (FOR ALL SUDDEN AND UNEXPECTED CHILD DEATHS)

- 7.8 Parents will be informed by the Rapid Response Nurse that their child's death will be reviewed. A leaflet will be given by the Rapid Response Nurse outlining the Child Death Review process.
- 7.9 Parents and family members will be assured that the objective of the Child Death Review process is to learn lessons in order to improve the health, safety and wellbeing of children and hopefully, to prevent further such child deaths. The process is not about culpability or blame.
- 7.10 Decisions on information sharing (i.e. what information is shared, with whom, and why) must be recorded in each agency's records. It is not appropriate however, for parents or family members to attend the CDOP meeting.
- 7.11 Parents should be informed that all cases will be treated with the utmost confidentiality by the CDOP; information gathered will be stored securely and only anonymised data will be collated at a local, regional or national level.
- 7.12 Whenever necessary, arrangements will be made for the family to have the opportunity to meet with the Designated Paediatrician and/or Rapid Response Nurse to receive feedback about the outcome of the Child Death Review and to have the opportunity to ask questions.
- 7.13 Work to involve parents in the CDOP process is ongoing and any additional guidance will be added to the LSCB website when complete.

DUTY OF REGISTRAR

- 7.14 Registrars must notify the appropriate LSCB about the deaths of children under the age of 18, within seven days from the date the death was registered.

DUTY OF CORONER

- 7.15 The Coroner has a duty to inform the LSCB for the area in which the child died of the fact of an inquest or post mortem. Coroners are also given the powers to share other information with the LSCB for the purposes of reviewing child deaths and carrying out Serious Case Reviews.

DUTY OF ALL AGENCIES INVOLVED WITH THE CHILD

7.16 All agencies involved with the child prior to his or her death are required to complete an agency report form outlining their involvement, and giving details of the child's circumstances. They are required to communicate effectively with other agencies to keep them informed of circumstances and their involvement with the child. Any professional (or member of the public) hearing of a local child death in circumstances that mean it may not yet be known about (for example, a death occurring abroad) can inform the Chair of the LSCB.

ROLE OF DESIGNATED OFFICER

7.17 The Child Death Designated Officer is the person to whom child death notifications are sent. All LSCBs are required to have a designated officer for child deaths. The role of the CDOP co-ordinator is to ensure that all information is received within the correct timescales and that this is available for the CDOP to consider.

ROLE OF CHILD DEATH PAEDIATRICIAN

7.18 A Designated Paediatrician for Child Deaths has been appointed by County Durham and Darlington Foundation NHS Trust. The role of the Designated Paediatrician for Child Deaths is to provide a lead for the management of sudden unexpected deaths of all children. The designated paediatrician will also be responsible for carrying out a Local Case Discussion on each child death so that appropriate lessons can be learned, and will provide medical advice to the CDOP.

ROLE OF RAPID RESPONSE

7.19 Following notification of a sudden death the Rapid Response Nurse will attend the Emergency Department or children's ward, depending on where the child is, to begin supporting the family, to liaise with other agencies and gather detailed information about the child and their family. This will include a detailed history from the child's carers and usually a joint home visit with the police.

7.20 An information sharing meeting may be convened. If there are any concerns about a possible unnatural death, or that abuse or neglect were factors then a strategy meeting will be convened under child protection procedures.

NOTIFICATION OF THE CHILD'S DEATH

- 7.21 Deaths should be notified by the professional confirming the fact of the child's death. For unexpected deaths, this will be at the same time as they inform the Coroner and the Child Death Designated Officer (CDDO). If this is not the area in which the child is normally resident, the designated person should inform their opposite number in the area where the child normally resides.
- 7.22 In these situations, it should be decided on a case-by-case basis which Panel should take responsibility for gathering the necessary information for a Panel's consideration. In some cases this may be done jointly.
- 7.23 Any person notifying the Child Death Designated Officer of the death of a child should provide as much detail as is known to them in relation to the child and family and the circumstances of the death. They should inform the CDDO or the CDOP co-ordinator of any professionals known to be involved with the child or family by completing Form A.
- 7.24 Following notification of the death of a child, the CDOP Co-ordinator should seek to establish which agencies and professionals have been involved with the child or family either prior to or at the time of death. A lead professional should be nominated in each agency to assist with this.
- 7.25 The professionals involved will be required to complete Form B If the death was either an early or a late neonatal death, the standard CMACE (Centre for Maternal and Child Enquiries) Perinatal Death Notification form should continue to be completed as normal and a copy should be sent to both the regional CMACE office and the relevant LSCB Child Death Overview Panel Co-ordinator.

PROFESSIONALS RESPONDING TO INFORMATION REQUESTS

- 7.26 Professionals receiving an agency report form (Form B) should retrieve any relevant case records for the child or other family members to complete any information known to them or their organisation and return the form to the CDOP co-ordinator using a secure means of transfer. This should be completed at the earliest opportunity to allow the CDOP to review the child's death in a timely manner. There will be circumstances where, because of ongoing medical or police investigations information may not be available. It may be appropriate for the lead professional in each agency to collate information from all involved professionals within their agency.

7.27 All professionals have a duty to provide the necessary information to the CDOP co-ordinator, to allow for a meaningful review. Agency reports should be completed and sent to the CDOP co-ordinator within three weeks. Any non-compliance with a request for completion of an agency report form will be followed up and ultimately a letter of non compliance will be sent to the relevant Chief Executive.

CHILDREN WITH LIFE LIMITING/LIFE THREATENING CONDITIONS

7.28 Whilst it is to be expected that children with life-limiting or life-threatening conditions (LL/LT conditions) will die prematurely, it is not always easy to predict when, or in what manner they will die. Professionals responding to the death of a child with a LL/LT condition should ensure that their response to these families is appropriate and supportive, does not cause any unnecessary distress at a time when they are dealing with the tragic but anticipated, natural death of their child, and that their child's expected death can be dignified and peaceful. End of life care plans may be in place and therefore families, where appropriate, should be supported, to choose where their child's body is cared for after death, for example, in a children's hospice. The lives of children with LL/LT conditions are as valued and important as those of any other children, and hence the unexpected, death of a child with LL/LT conditions should be managed as for any other unexpected death so as to determine the cause of death and any contributory factors. This is both out of respect for the child and family, and to fulfil any statutory requirements.

THE CHILD DEATH OVERVIEW PANEL

7.29 The CDOP should undertake an overview of all child deaths up to the age of 18 years (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) in the LSCB areas covered by Darlington and Durham CDOP. This overview will be based on information available from those who were involved in the care of the child, both before and immediately after the death, and other sources including, perhaps, the coroner. The panel will:

- Have a fixed core membership drawn from the key organisations represented on the LSCB (see paragraph 7.27 Working Together 2010) to review these cases, with flexibility to co-opt other relevant professionals as and when appropriate;
- Hold meetings at regular intervals to enable each child's death to be discussed in a timely manner (the length of the discussion may vary depending on the nature of the death in question and the quantity of information available);

- Review the appropriateness of the professionals' responses to each death of a child, their involvement before and at the time of the death, and relevant environmental, social, health and cultural aspects of each death, to ensure a thorough consideration of how such deaths might be prevented in the future;
- Determine whether or not the death was deemed preventable. The decision must be agreed by the CDOP and approved by the Chair of the CDOP. This decision cannot be finalised however until the outcome of other investigations (for example Serious Case Reviews, criminal proceedings, post mortem or Inquests) is known;
- Make recommendations to the LSCB or other relevant bodies as soon as these have been decided in order that prompt action can be taken to prevent such deaths in future where possible; and
- Identify any patterns or trends in the local data and report these to the LSCB either in an annual report, or when trends first become apparent.

7.30 The CDOP has a clear relationship and agreed channels of communication with the local coronial service and the registrar superintendent.

7.31 The LSCB should be informed of all deaths of children normally resident in its geographical area. The chair of the CDOP is responsible for ensuring that this process operates effectively.

PROCESSES FOR A RAPID RESPONSE AND LOCAL REVIEW FROM PROFESSIONALS TO ALL UNEXPECTED DEATHS OF CHILDREN (0–18 YEARS)

7.32 Durham and Darlington **NHS Guidelines for the Management of Unexpected Death in Childhood (SUDC)** provide clear procedures for NHS and PCT staff responding to an unexpected child death in Durham, and should be read as a step by step guide.

7.33 Each death of a child is a tragedy for his or her family, and subsequent enquiries/ investigations should keep an appropriate balance between forensic and medical requirements and the family's need for support. A minority of unexpected deaths are the consequence of abuse or neglect or are found to have abuse or neglect as an associated factor. In all cases, enquiries should seek to understand the reasons for the child's death, address the possible needs of other children in the household, the needs of all family members, and also consider any lessons to be learnt about how best to safeguard and promote children's welfare in the future.

- 7.34 The Designated Paediatrician responsible for unexpected deaths in childhood should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt, the processes for unexpected child deaths should be followed until the available evidence enables a different decision to be made. When a child dies unexpectedly, several investigative processes may be instigated, particularly when abuse or neglect is a factor. This guidance intends that the relevant professionals and organisations work together in a coordinated way, in order to minimise duplication and ensure that the lessons learnt contribute to safeguarding and promoting the welfare of children in the future.
- 7.35 It is intended that those professionals involved (before and/or after the death) with a child who dies unexpectedly should come together to respond to the child's death. The work of the team convened in response to each child's death should be coordinated by the Designated Paediatrician responsible for unexpected deaths in childhood.
- 7.36 The professionals who come together as a team will carry out their normal functions – for example, as a Paediatrician, GP, Nurse, Health Visitor, Midwife, Mental Health professional, Substance Misuse worker, Social Worker, Youth Offending Team worker, Probation or Police Officer in response to the unexpected death of a child in accordance with this guidance. They should also work according to the protocol agreed with the local coronial service. Other professionals known to the family from specialist agencies will be accessed on a case by case basis to support the core team; i.e. hospice support workers, children's community nurses.
- 7.37 The joint responsibilities of these professionals include ongoing support to the family. Any information pertaining to the death arising from the rapid response, including the outcome of a final Local Case Discussion should be passed to the Coroner. The CDOP members may attend an Inquest at the discretion of HM Coroner and ask questions as a 'properly interested person'; there may be issues identified through the inquest that the CDOP would then be able to review to identify any wider public health concerns.

RESPONDING QUICKLY TO THE UNEXPECTED DEATH OF A CHILD

7.38 The role of the Rapid Response Team is to:

- Make immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the coroner;
- Undertake the types of enquiries/investigations that relate to the current responsibilities of their respective organisations when a child dies unexpectedly. This includes liaising with those who have ongoing responsibilities for other family members;
- Collect information in a standard, nationally agreed manner;

- Providing support to the bereaved family, and where appropriate referring on to specialist bereavement services; *and*
- Follow the death through and maintaining contact at regular intervals with family members and other professionals who have ongoing responsibilities for other family members, to ensure they are informed and kept up-to-date with information about the child's death.

7.39 If, during the enquiries, concerns are expressed in relation to the needs of surviving children in the family, discussions should take place with Safeguarding and Specialist Services. It may be decided that it is appropriate to initiate an initial assessment using the Framework for the Assessment of Children in Need and their Families (2000).

7.40 If concerns are raised at any stage about the possibility of surviving children in the household being abused or neglected, the LSCB procedures for safeguarding children. Safeguarding and Specialist Services has lead responsibility for safeguarding and promoting the welfare of children.

7.41 When a child dies unexpectedly and no doctor is able to issue a medical certificate of the cause of death, the child's death must be reported to the Coroner. Agencies and professionals contributing to the process should co-operate with their local Coroner to ensure the Inquest is able to proceed appropriately. The process of the rapid response can greatly assist the Coroner in gathering information to inform the Inquest.

7.42 The type of response to each child's unexpected death will depend to a certain extent on the age of the child, but there are some key elements that underpin all subsequent work. Supplementary information is required for making enquiries into, for example deaths of infants, those deaths in hospital that are the result of trauma, and suicides.

7.43 A multi-professional approach is required to ensure collaboration among all involved, including ambulance staff, Accident and Emergency (A&E) department staff, Coroners' Officers, Police, GPs, Health Visitors, School Nurses, Community Children's Nurses, Midwives, Paediatricians, End Of Life Care staff, Mental Health professionals, Substance Misuse workers, Hospital Bereavement staff, Voluntary Agencies, Coroners, Pathologists, Forensic Medical Examiners, Local Authority Children's Social Care, YOTs, Probation, Schools, Prison staff where a child has died in custody and any others who may find themselves with a contribution to make in individual cases (for example, fire fighters or faith leaders).

OTHER RELATED PROCESSES

Criminal investigations

7.44 The Police are the lead agency for any criminal investigation. The Police must be informed immediately that there is a suspicion of a crime, to ensure that the evidence is properly secured and that any further interviews with family members and other relevant people accord with the requirements of the Police and Criminal Evidence Act 1984.

7.45 Where there is an ongoing criminal investigation, the Senior Investigating Officer and the Crown Prosecution Service must be consulted as to what it is appropriate for the professionals involved in reviewing a child's death to be doing, and what actions to take in order not to prejudice any criminal proceedings. Where a death of a young person occurs in custody, local agencies must co-operate with the Prisons and Probation Ombudsman.

Youth Offending Teams

7.46 The Youth Justice Board for England and Wales (YJB) requires Youth Offending Teams (YOTs) to report and undertake Local Reviews of youth offending practice in cases where a child or young person has either died or attempted suicide whilst under supervision or within three months of the expiry of supervision. Where a child has died, the Local Management Review undertaken by the YOT in relation to the death should feed into the child death processes initiated by the CDOP.

Serious Case Review

7.47 If it is thought, at any time, that the criteria for a Serious Case Review might apply, the chair of the LSCB should be contacted and the Serious Case Review (see Section 8 of these procedures) should be followed. If a Serious Case Review is initiated, the CDOP will not be able to conclude the Child Death Review until after the Serious Case Review Executive Summary has been published. **This should not however prevent lessons from being learnt and from being acted upon.**

IMMEDIATE RESPONSE TO THE UNEXPECTED DEATH OF A CHILD

- 7.48 The professional confirming the fact of death should consult the Designated Paediatrician with responsibility for unexpected deaths in childhood, or the Rapid Response Nurse, who will ensure that relevant professionals (i.e. the Coroner, the Police and Local Authority Children's Social Care) are informed of the death. Contact may be required with more than one Local Authority if the child died away from home for more information about what should happen when a child who is normally resident within a LSCB area dies outside the area, including abroad). Any relevant information identified by Local Authority Children's Social Care should be shared promptly with the Police, Rapid Response Nurse and On-call Paediatrician. The Health Visitor or School Nurse and GP should also be promptly informed as a matter of routine and relevant information should be shared. This is the responsibility of the Rapid Response Nurse.
- 7.49 When a child dies unexpectedly, a Paediatrician (on-call or designated) or Rapid Response Nurse should initiate an immediate information-sharing and planning discussion between the lead agencies (i.e. Health, Police and Local Authority Children's Social Care) to decide what should happen next and who will do what. This may also include The Coroner's Officer and Consultant Paediatrician on call, and any others who are involved (for example, the Community Children's Nurse on call, other members of the Primary Health Care Team or other professionals who have been involved with the child and/ or family prior to or around the time of death). The agreed plan should include a commitment to collaborate closely and communicate as often as necessary, often by telephone. Where the death occurred in a hospital, the plan should also address the actions required by the Trust's Serious Untoward Incidents protocol. Where the death occurred in a custodial setting, the plan should ensure appropriate liaison with the investigator from the Prisons and Probation Ombudsman. All deaths of young people in a custodial setting will be subject to a Serious Case Review.
- 7.50 For all unexpected deaths of children (including those not seen in A&E) urgent contact should be made with any other agencies who know or are involved with the child (including Child and Adolescent Mental Health Services, School or Early Years) to inform them of the child's death and to obtain information on the history of the child, the family and other members of the household. If a young person is under the supervision of a YOT, the YOT should also be approached.
- 7.51 The Police will begin an investigation into the sudden or unexpected death of a child on behalf of the Coroner. They will carry this out in accordance with relevant Association of Chief Police Officers guidelines.
- 7.52 All information collected relating to the circumstances of the death – including a review of all relevant medical, social and educational records – must be included in a report for the Coroner prepared jointly by the Rapid Response Nurse/Designated Paediatrician.

7.53 This report should be delivered to the coroner within 28 days of the death, unless some of the crucial information is not yet available.

RAPID RESPONSE TO A CHILD DEATH IN A NON-HOSPITAL SETTING

7.54 A detailed interview with parents or carers needs to take place as soon as possible. According to the Durham Constabulary Protocol this interview will take place at the Victim Suite at Meadowfield (Durham) or Park Place (Darlington). The interview will be conducted jointly by an experienced Police Officer and the Rapid Response Nurse and will be videoed.

7.55 The interviews will be conducted for each parent separately.

7.56 Following the interview, the Police Officer and Rapid Response Nurse should consider doing a joint home visit or a visit to the child's place of death if not at home.

7.57 The purpose of a joint home visit is to identify all possible factors that may assist to determine why a child has died. Parents' should be offered the opportunity to be present at the home visit as they may remember further details of events leading up to the child's death.

7.58 Returning to the place where their child died will be very difficult for parents but with a health professional to support them it may also be a therapeutic experience. Some parents may not wish to return to the home. The Rapid Response Nurse should be sensitive and support them in their decision.

7.59 It is essential that a professional interpreter is available for the entire interview and home visit if English is not the preferred language. Wherever possible, the family should have the same interpreter in all their contacts with hospital and community staff during the immediate period of bereavement.

- Couples should always be offered the help of a trained interpreter, even where one parent speaks English.
- It is never acceptable to use a child or teenager to interpret when a child dies. The long-term consequences of doing so, both for the young person and the family, can be extremely damaging.

- The use of family members, friends, acquaintances and even complete strangers are sometimes called in to interpret for bereaved parents. This almost always makes a very difficult situation worse. Unless they have had specific training, few people understand the requirements of health interpreting. Few people speak both languages equally well: the interpretation may be incorrect or unclear. Important cross-cultural issues are unlikely to be explained. Interpreting for bereaved families also requires an understanding of counselling and the skills involved.
- The interpreter should be well informed beforehand about the situation and the reason for the visit.

7.60 The information to be gathered at the interview and home visits is included in the history proforma completed by the Rapid Response Nurse.

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

7.62 After discussion with the Police Senior Investigating Officer, Designated Paediatrician for Child Deaths and other agencies it may be appropriate to hold a Rapid Response meeting to facilitate information sharing. It is the role of the Rapid Response Nurse to convene this meeting.

POST-MORTEM RESULTS

7.63 The full post-mortem results will usually be received within 8-12 weeks. The Coroner's Officer will inform parents of the post-mortem results unless there are concerns that death is due to non-accidental injury.

7.64 In all cases, further discussions (usually on the telephone) should take place very shortly after the initial post-mortem results are available. This would be initiated by the Coroner's Officer to disseminate information about the post-mortem results and could involve the Pathologist, Police, Consultant Paediatrician, Children's Services and other relevant health professionals if involved.

7.65 Where the results indicate that there is evidence of abuse or neglect, the Designated Officer and the Designated Paediatrician for Child Deaths must be informed.

LOCAL CASE DISCUSSION

7.66 A Local Child Death Review should be convened by the Designated Paediatrician for Child Deaths when the results of the main post-mortem tests are known. This will enable a discussion of all the issues and may give the best opportunity to identify the possible cause of death and any contributory factors. The meeting should include those professionals who knew the child and family, and those involved in investigating the death (e.g. Rapid Response Nurse, GP, Health Visitor, School Nurse, Consultant Paediatrician, relevant hospital staff, Ambulance Staff, Pathologist, Senior Investigating Police Officers and, where appropriate, Social Workers).

7.67 This meeting would take the form of a critical incident review meeting for professionals and is a requirement of the statutory child death review procedure.

7.68 Prior to the meeting the Agency Report Form (see Appendix 2) will be sent to all professionals involved with the child. This should be returned to the relevant Designated Officer who will then forward the form to the Designated Paediatrician for Child Deaths before the meeting.

7.69 At this meeting all relevant information concerning the circumstances of the death, the child's history and subsequent investigations should be reviewed. As many records as possible, or copies of them, should be collated in the infant's hospital case record by the Designated Paediatrician for Child Deaths before the meeting. Local guidance will be required with respect to the confidentiality issues in relation to third party information such as maternal obstetric records. Depending on the circumstances of the death, the relevant records might be:

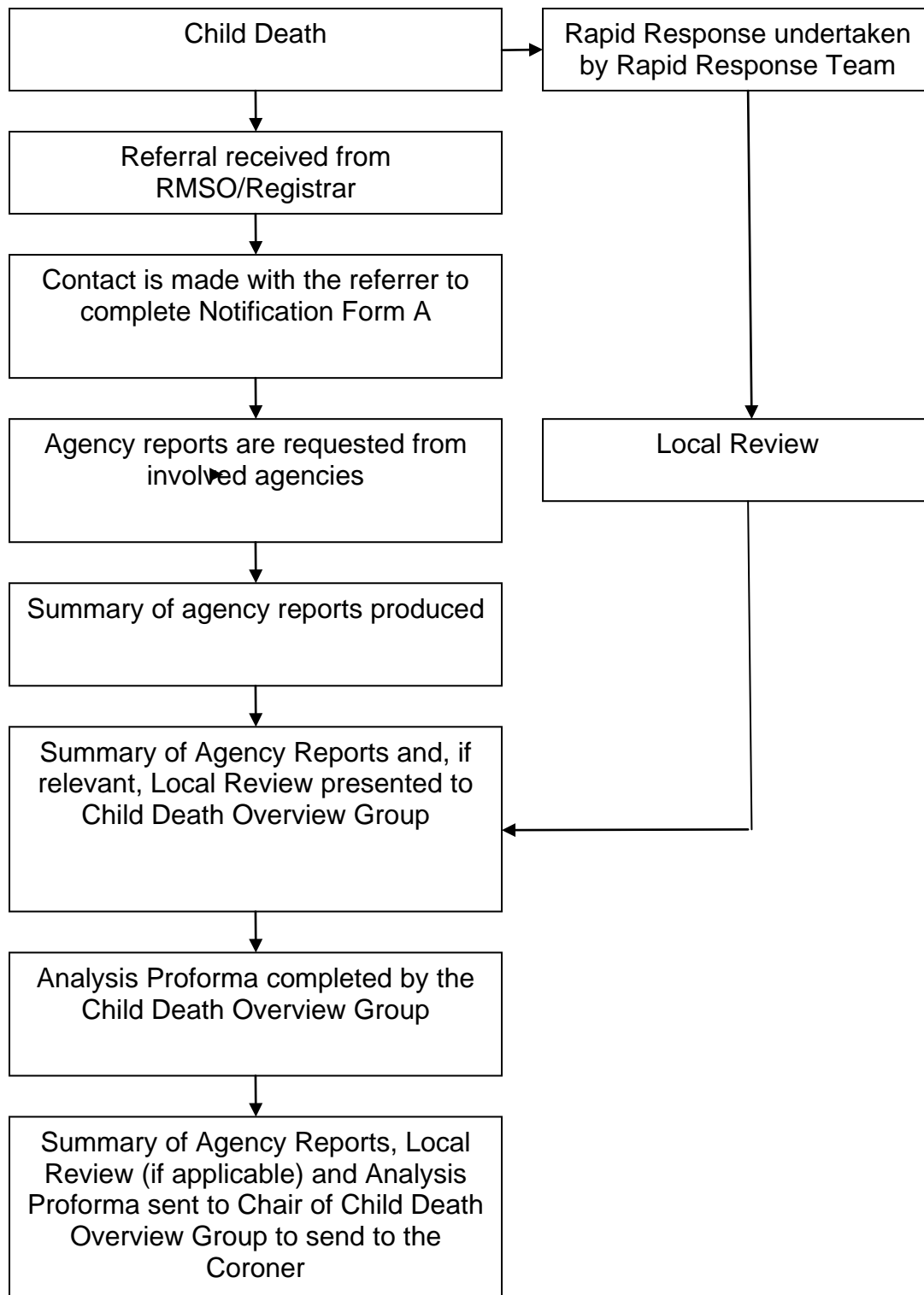
- Information from interviews and scene of death, covering points listed in Kennedy appendix I, Durham Constabulary SUDI Policy etc.
- Ambulance/paramedic records.
- Emergency Department records.
- Other hospital records of the child.
- Hospital records of the mother (especially obstetric notes).
- GP records.
- Health Visitor / School Health / Family Nurse Partnership records.
- Personal child health record book.
- Sure Start records where relevant.
- Any relevant Police records.
- Any relevant Children's Services records.
- Copies of any written statements subsequently made by professionals in any agency or discipline.
- A copy of the autopsy report (see below).

- 7.70 If the pathologist who carried out the autopsy does not feel it would be useful to be present, the results of the autopsy should be conveyed verbally to the paediatrician. A copy of the autopsy report should also be sought from the Coroner, although there may be circumstances in which its release may be regarded as inappropriate.
- 7.71 The main purpose of the meeting is for sharing information to identify the cause of death and/or those factors that may have contributed to the death which includes avoidable factors and then to plan the future care for the family. Potential lessons to be learnt may also be identified by this process.
- 7.72 At the meeting a report will be completed by the Designated Paediatrician for Child Deaths. These will be forwarded to Durham/ Darlington LSCB for consideration at the Child Death Overview Group.
- 7.73 There should be an explicit discussion of the possibility of abuse or neglect either causing or contributing to the death, and if no evidence is identified to suggest maltreatment this should be documented as part of the minutes of the meeting.
- 7.74 Where evidence of abuse or neglect becomes apparent at this meeting, the Designated Officer will be informed. In this case, a Serious Case Review Panel will be convened.
- 7.75 Within 2-3 weeks, with the consent of HM Coroner, the results of the post mortem examination and Local Case Discussion should be discussed with the parents, except in those cases where abuse is suspected and/or the Police are conducting a criminal investigation. Where there are concerns that regarding abuse or neglect, there should be a discussion with Children's Services, the Police and Pathologist, to agree what information should be shared with the parents, when and by whom.
- 7.76 An agreed record of the Local Case Discussion and all reports should be sent to the coroner, to take into consideration in the conduct of the inquest and, in the cause of death, notified to the Registrar of Births and Deaths. The record of the Local Case Discussion and the record of the core data set should also be made available to the relevant local CDOP.
- 7.77 When a child dies away from their normal place of residence, a joint decision will need to be made by the Rapid Response Team in the LSCB area in which the death occurred and the team in the child's normal area of residence as to which team will lead the investigation and in which LSCB area the Local Case Discussion meeting should be held. On occasion separate meetings may be appropriate in both LSCB areas, but good communication between the teams is essential (see paragraphs 7.33–7.34 Working Together 2010). This information can then be analysed and decisions can be made about what actions should be taken by whom to prevent similar deaths in the future.

MEETING WITH THE PARENTS

7.78 In most cases it will be the Designated Paediatrician for Child Deaths who meets with the parents. However, it may be decided that it would be more appropriate for the family to see the original Consultant Paediatrician responsible for the child's care. A member of the Primary Health Care Team should usually attend this meeting. This would be arranged by the Designated Paediatrician for Child Deaths.

FLOWCHART RE: CHILD DEATH REVIEW PROCESS



Throughout the process of investigation, the need to initiate a Serious Case Review must be considered.

DEFINITIONS

7.79 The following terms are used in this document:

- An **unexpected death** is defined as the death of a child, in any setting, that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death.
- Sudden Unexpected Death in Childhood (**SUDIC**): This is the sudden unexpected death of an apparently well child.