Surrey Child Death Review Policy

Policy applicable to:

Surrey County Council	✓
NHS Surrey Heartlands CCG	✓
NHS North East Hants and Farnham SCCG	✓
NHS Surrey Heath CCG	✓

Policy number	
Version	2.0
Approved by	Surrey Child Death Review Partnership
Name of originator/ author	Noreen Gurner-Smith, Safeguarding Manager with Lead for Child Death Review Services Nicola Eschbaecher, Named Nurse for Child death reviews
Owner (director)	Amanda Boodhoo, Associate Director for safeguarding
Date of last approval	Not Applicable
Next approval due	September 2022 or more frequently in light of changes to national or local policy and guidance

Version control sheet

Version	Date	Author	Status	Comments / changes since last version
0.1	July 2019	Noreen Gurner-Smith	1st Draft	
0.2	July 2019	Nicola Eschbaecher	2nd Draft	-Comments from NE incorporated -updated equality analysis completed --Update to CDRM -Role of Child Death Health and Well-being Lead added
0.3	August 2019	Noreen Gurner-Smith	3rd Draft	-Update title of Child Well-being Professional and Lead for Learning from Child Deaths -Update SAAF 2019
0.4	September 2019	Noreen Gurner-Smith	4th Draft	Surrey Child Death Review Partnership logo added. Policy applicable to All Surrey County Council staff and Surrey CCG's staff
1.0	September 2019	Noreen Gurner-Smith	Final	
2.0	September 2020	Noreen Gurner-Smith	Final	-Surrey Heartlands CCG added -Update role of Designated Doctor - Surrey Child Death Review Partnership logo added

Equality statement

The Surrey Child Death Review Partnership aim to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We take into account the Human Rights Act 1998 and promote equal opportunities for all. This document has been assessed to ensure that no employee receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Members of staff, volunteers or members of the public may request assistance with this policy if they have particular needs. If the member of staff has language difficulties and difficulty in understanding this policy, the use of an interpreter will be considered.

We embrace the four staff pledges in the NHS Constitution. This policy is consistent with these pledges.

See next page for an Equality Analysis of this policy.

Equality analysis

Equality analysis is a way of considering the effect on different groups protected from discrimination by the Equality Act, such as people of different ages. There are two reasons for this:

- to consider if there are any unintended consequences for some groups
- to consider if the policy will be fully effective for all target groups

Title of Policy: Surrey Child Death Review Policy	**Policy Ref:**
Assessment conducted by (name, role): Noreen Gurner-Smith, Safeguarding Manager with Lead for Child Death Review Services	**Start date for analysis:** July 2019 **Finish date:** September 2019
Give a brief summary of the policy. Explain its aim. This policy sets out the processes to be followed when responding to, investigating, and reviewing the death of any child, from any cause. It runs from the moment of a child's death to the completion of the review by the Child Death Overview Panel (CDOP).	
Who is intended to <u>benefit from</u> this policy? Explain the aim of the policy as applied to this group. All Surrey County Council and Surrey CCG staff, adults, children and young people residing in Surrey.	
1. Evidence considered. *What data or other information have you used to evaluate if this policy is likely to have a positive or an adverse impact upon protected groups when implemented?* Best Practice Guidance for writing procedural documents; Legislation; national and local guidance detailed in Bibliography. Lessons learned from DHR's; SAR's and SCR's.	
2. **Consultation.** *Give details of all consultation and engagement activities used to inform the analysis of impact.* None	
3. Analysis of impact *In the boxes below, identify any issues in the policy where equality characteristics require consideration for either those abiding by the policy or those the policy is aimed to benefit, based upon your research.* *Are there any likely impacts for this group? Will this group be impacted differently by this policy? Are these impacts negative or positive? What actions will be taken to mitigate identified impacts?*	

a) People from different age groups (Age)	No adverse impact. The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths
b) People with disabilities (Disability)	No adverse impact. People with sensory disability need to be able to access information in different ways e.g. via Braille, audio text, large font, black on yellow background etc. The Child death Review Partnership undertakes to provide this policy in the format required on request. This policy aims to improve the experience of bereaved families, as well as professionals after the death of a child.
c) Men and women (Gender or Sex)	No adverse impact. This policy aims to improve the experience of bereaved families, as well as professionals, after the death of a child. There is no evidence that this policy will lead to a differential impact as a result of Gender or Sex.
d) Religious people or those with strongly help philosophical beliefs (Religion or belief)	No adverse impact. This policy aims to improve the experience of bereaved families, as well as professionals, after the death of a child. There is no evidence that this policy will lead to a differential impact as a result of Religion or Belief.
e) People from black and minority ethnic groups (Race)	No adverse impact: This policy aims to improve the experience of bereaved families, as well as professionals, after the death of a child. There is no evidence that this policy will lead to a differential impact as a result of Race.
f) People who have changed gender or who are transitioning to a different gender (Gender reassignment)	No adverse impact: This policy aims to improve the experience of bereaved families, as well as professionals, after the death of a child. There is no evidence that this policy will lead to a differential impact as a result of Gender reassignment.
g) Lesbians, gay men, bisexual people (Sexual orientation)	No adverse impact: This policy aims to improve the experience of bereaved families, as well as professionals, after the death of a child. There is no evidence that this policy will lead to a differential impact as a result of Sexual orientation.

h) Women who are pregnant or on maternity leave (Pregnancy and maternity)	No adverse impact: This policy aims to improve the experience of bereaved families, as well as professionals, after the death of a child. This policy is inclusive of women who are pregnant or on maternity leave.
i) People who are married or in a civil partnership (Marriage and Civil Partnership)	No adverse impact: This policy aims to improve the experience of bereaved families, as well as professionals, after the death of a child. This policy is inclusive to married individuals and people in a same sex relationship.
j) Carers	No adverse impact. This policy aims to improve the experience of bereaved families, as well as professionals, after the death of a child. This policy is inclusive to carers who were involved in caring for a child who dies.
If any negative or positive impacts were identified are they valid, legal and/or justifiable? Please detail.	
4. Monitoring- *How will you review/monitor the impact and effectiveness of your actions?* There is a Safeguarding Adults and Children standing item at each CCG Quality & Clinical Governance Committees meeting that provides regular assurances to the Governing Bodies and Child Death Review Partnership demonstrating how Surrey CCG's are discharging their safeguarding and child death review responsibilities. There is no formal process in place that monitors the impact on protected groups. The safeguarding dashboard is reported on within the Annual and 6 month Interim Board Report.	
5. Sign off	
Lead Officer:	
Date approved:	

Contents

Surrey Child Death Review Partnership Policy

Introduction

1. Background

1.1.1 The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity. Families experiencing such a tragedy should be met with empathy and compassion. They need clear and sensitive communication. They also need to understand what happened to their child and know that people will learn from what happened. The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths.

1.1.2 In 2015, the government commissioned Sir Alan Wood to review the role and functions of Local Safeguarding Children Boards (LSCBs). The Wood Report was published in March 2016, with the government formally responding in May 2016. The Wood Report recommendations were subsequently embedded in statute in April 2017 with the granting of Royal Assent to the Children and Social Work Act 2017.

1.1.3 Under the Children Act 2004, as amended by the Children and Social Work Act 2017, the two child death review partners (local authorities and clinical commissioning groups) must set up child death review arrangements to review all deaths of children normally resident in the local area and, if they consider it appropriate, for any non-resident child who has died in their area.

1.1.4 Child death review partners must make arrangements for the analysis of information from all deaths reviewed. The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified.

1.1.5 If child death review partners find action should be taken by a person or organisation, they must inform them.

1.1.6 In addition, child death review partners:

• must, at such times as they consider appropriate, prepare and publish reports on:

• what they have done as a result of the child death review arrangements in their area, and

• how effective the arrangements have been in practice;

• may request information from a person or organisation for the purposes of enabling or assisting the review and/or analysis process - the person or organisation must comply with the request, and if they do not, the child death review partners may take legal action to seek enforcement.

• may make payments directly towards expenditure incurred in connection with arrangements made for child death reviews or analysis of information about deaths reviewed, or by contributing to a fund out of which payments may be made; and may provide staff, goods, services, accommodation or other resources to any person for purposes connected with the child death review or analysis process.

1.1.7 This policy is intended to be used by Managing Directors / Accountable Officers / Directors of Nursing Quality and Safety, the Child Death Review Team and all staff employed by Surrey County Council and Surrey CCG's to ensure the Surrey Child Death Review partnership meet the statutory requirement to make arrangements to review all child deaths in their area.

2. Legislative Framework / Core Standards

2.1.1 The corporate responsibilities for child death reviews are explicit and are predominantly informed by legislation and national directives. The Child Death Review Partnership is required to fulfil their legal duties under the Children Act 2004, as amended by the Children and Social Work Act 2017.

2.1.2 The following key guidance and legislation informs how the Child Death Review Partnership will discharge their function and duties to set up child death review arrangements to review all deaths of children normally resident in the local area and, if they consider it appropriate, for any non-resident child who has died in their area.

2.1.3 This policy sets out arrangements for undertaking child death reviews in Surrey. It should be read in conjunction with the following:

- Child Death Review Statutory and Operational Guidance (England) 2018
- Children Act 1989 & Children Act 2004
- Children and Social Work Act 2017
- Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers (DfE 2018)
- Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (2019)
- Sudden unexpected death in infancy and childhood: Multi-agency guidelines for care and investigation(2nd edition) 2016
- Surrey Heartlands CCGs Safeguarding Adults and Children Policy (2019)
- Surrey Safeguarding Children Board Procedures (2016)
- Working Together to Safeguard Children (2018)

3. Scope and purpose of this policy

3.1.1 This policy aims to set out the processes to be followed when responding to, investigating, and reviewing the death of any child, from any cause. It runs from the moment of a child's death to the completion of the review by the Child Death Overview Panel (CDOP). This includes the immediate actions that should be taken after a child's death; the local review of a child's death by those who interacted with the child during life, and with the investigation after the child's death; through to the final stage of the child death review process which is the statutory review arranged by child death review partners.

3.1.2 This policy clarifies processes and sets out high-level principles for how the child death review team involved in the child death review process should work together with other partners to meet the two main objectives:

1). to improve the experience of bereaved families, as well as professionals, after the death of a child; and

2). to ensure that information from the child death review process is systematically captured to enable local learning and, through the National Child Mortality Database, to identify learning at the national level, and inform changes in policy and practice.

3.1.3 This policy is applicable to all Surrey County Council and Surrey CCG staff (permanent and temporary) who care for children, or who have a role in the child death review process.

3.1.4 This policy should be read and seen as complimentary to Working Together to Safeguard Children (2018), Sudden unexpected death in infancy and childhood: Multi-agency guidelines for care and investigation(2nd edition) 2016 and the Child Death Review Statutory and Operational Guidance (England) 2018. It does not replace them.

3.1.5 This policy does not cover the Safeguarding policies and procedures as this is covered within the Surrey Heartlands' CCGs Policy 'Safeguarding Adults, Children and Young People Policy'.

4. Definitions

4.1.1 For the purpose of this document, a child is defined in the Children Act as a person under 18 years of age.

4.1.2 For the purpose of this document, stillbirth is a baby born without signs of life after 24 weeks gestation.

4.1.3 For the purpose of this document, late foetal loss is where a pregnancy ends before 24 weeks gestation.

4.1.4 **Child Death Review (CDR)** is the process to be followed when responding to, investigating, and reviewing the death of any child under the age of 18, from any cause. It runs from the moment of a child's death to the completion of the review by the Child Death Overview Panel (CDOP). The process is designed to capture the expertise and thoughts of all individuals who have interacted with the case in order to identify changes that could save the lives of children.

4.1.5 **eCDOP** is a secure, flexible and web-based solution which is accessible 24/7 and enables practitioners to promptly submit child death information thereby allowing Surrey CDR processes to be fully managed efficiently, with effective sharing of multi-agency information.

4.1.6 **Joint Agency Response (JAR)** is a coordinated multi-agency response by the named nurse, police investigator, duty social worker and 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 sudden unexpected death in infancy/childhood (SUDI/C);
- occurs in custody, or where the child was detained under the Mental Health Act;
- where the initial circumstances raise any suspicions that the death may not have been natural; or
- in the case of a stillbirth where no healthcare professional was in attendance.

4.1.7 **Child Death Review Meeting (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 life and their investigation after death.

4.1.8 **Child Death Overview Panel (CDOP)** is a multi-agency panel set up by Child death review (CDR) partners to review the deaths of all children normally resident in their area, and, if appropriate and agreed between CDR partners, the deaths in their area of non-resident children, in order to learn lessons and share any findings for the prevention of future deaths. This review should be informed by a standardised report from the CDRM, and ensures independent, multi-agency scrutiny by senior professionals with no named responsibility for the child's care during life.

5. Roles and Responsibilities

This section explains the roles and responsibilities of the Surrey County Council and NHS Surrey CCG's committees and staff with regard to this Policy.

5.1 The Governing Body and Committees

- To ensure that Surrey Child Death Review Partnership meets its statutory responsibilities as child death review partners to make arrangements to carry out child death reviews These arrangements should result in the establishment of a Child Death Overview Panel (CDOP) to review the deaths of all children normally resident in the relevant local authority area, and if they consider it appropriate the deaths in that area of non-resident children.

5.2 Directors and Managers

- It is the responsibility of the Surrey County Council and Surrey CCG's management teams to ensure that all Surrey County Council staff and all Surrey CCG staff who care for children, or who have a role in the child death review process read and follow this policy.

5.3 Policy Owners / Authors

- The safeguarding manager with the lead for child death review services and the named nurse for child death reviews provide professional leadership and management on behalf of the safeguarding partnership and child death review partnership on all aspects of Surrey CCG's contribution to child death reviews ensuring a co-ordinated and integrated contribution across the health economy.
- It is the responsibility of the safeguarding manager with the lead for child death review services to ensure the policy is kept up-to-date, valid and reflects the latest statutory framework, national guidance and best practice.

5.4 Designated Doctor for Child Death Reviews

- The Designated Doctor should be a senior paediatrician who has the following responsibilities:

  - Work as a member of the Child Death Review Team who are responsible for the child death review process;
  - Provide support to the named nurse in the role as lead health professional
  - Should be notified of each child death and sent relevant information;
  - In conjunction with Named Nurse, advise on the appropriate response to a death in an adult ICU and attend CDRMs;
  - Advise the CDOP regarding necessary experts required to inform ordinary and themed panels;
  - Advise the CDOP in the identification of modifiable contributory factors;
  - In conjunction with Named Nurse, liaise as appropriate with regional clinical networks to ensure that themed panels are properly coordinated;
  - Assist the CDOP in the development and implementation of appropriate preventative strategies to reduce child deaths;
  - Contribute to the annual report summarising the activities of the CDOP;

5.5 Named Nurse for Child Death Reviews

- The named nurse's key responsibility will be on behalf of the Surrey child death review partnership to implement, co-ordinate and manage all child death reviews in accordance with government legislation and local safeguarding partnership policies with the following responsibilities:

  - Will be responsible for triaging all child deaths, allocating cases to the child death review nurses while maintaining oversight and progression of all child deaths;
  - Will undertake the role of lead health professional who is appointed to coordinate the health response to a child death that meets the criteria for a joint agency response;
  - Will take responsibility for ensuring that all health responses are implemented;
  - Will be responsible for ongoing liaison with the police and other agencies;
  - Be a reliable and readily accessible point of contact for the family after the death;
  - Help co-ordinate meetings between the family and professionals as required;
  - Represent the 'voice' of the parents at professional meetings, ensure that their questions are effectively addressed, and to provide feedback to the family afterwards;
  - Carry out a follow up visit/visits to the family to support and feedback answers to their questions; and
  - Support and signpost the family and surviving siblings to other professionals for bereavement support.

5.6 Child Death Review Nurse

- The child death review nurse will work as a key member of the Surrey Wide CCG Safeguarding Team to support the Surrey CCGs and Surrey child death review partnership in meeting their statutory duties as detailed in Child Death Review Statutory and Operational Guidance: England (HM 2018) and will involve the following responsibilities:

  - As appropriate, will undertake the role of lead health professional who is appointed to coordinate the health response to an expected child death;
  - Will take responsibility for ensuring that all health responses are implemented;
  - Will be responsible for ongoing liaison with the other health professionals involved with the family;
  - Will attend appropriate CDRM in acute and community settings to represent the 'voice' of the parents at professional meetings, ensure that their questions are effectively addressed, and to provide feedback to the family afterwards;
  - Will ensure outputs from CDRMs (draft Analysis Forms) are shared with CDOP panel;
  - Be a reliable and readily accessible point of contact for the family after the death;
  - Help co-ordinate meetings between the family and professionals as required;
  - Carry out a follow up visit/visits to the family to support and feedback answers to their questions;
  - Support and signpost the family and surviving siblings to other professionals for bereavement support.

5.7 Child Well-being Professional and Lead for Learning from Child Deaths

- To provide public health expertise and leadership on behalf of the safeguarding partnership and child death review partnership on all aspects of the CCG's contribution to child death reviews with the following responsibilities:

  - Provide expertise and support across the CCGs, liaising with other health organisations to deliver the Child Death Review Partnership's public health responsibilities;
  - Identify and forecast risks to health and provide evidence of how they can be prevented or dealt with efficiently and effectively to avoid preventable differences and variations in people's experiences of services, life chances and outcomes in relation to child death;
  - Ensure an evidence based approach to learning and supporting the interface with the serious safeguarding practice review process and ensure learning is disseminated across the health economy and partnership;
  - Provide a specialist public health approach to address the public health challenges of the Child Death Review Partnership with particular emphasis on reducing inequalities of health;
  - Lead others across projects to improve/protect health and wellbeing including change, developments and service delivery of the child death review process; and
  - Provide public health/health promotion advice and information to health and other professionals, including voluntary and independent sector organisations to support education of patients and the wider public, including an active role in the development of practice based commissioning to reduce health and healthcare inequalities.

5.8 Child Death Review Co-ordinator

- The responsibilities of the co-ordinator role include but are not exclusive to the following:

- Ensure the effective management of the notification, data collection and storage systems;
- Ensure the effective running of ordinary and themed panel meetings;
- Be the designated person to whom the child death notification and other data on each child death should be sent;
- Allocate a unique identifier number to a deceased child following receipt of the Notification Form;
- Seek to establish which agencies have been involved with the child or family either prior to or at the time of death and gain receipt of relevant information (Reporting Form);
- Arrange the CDRM in cases that meet the criteria for a JAR and in expected deaths;
- Liaise with the Chair of the Child Death Review Meetings to receive the meeting's summary notes (draft Analysis Form); and
- Record the CDOP's conclusions (final Analysis Form) and submit data to the National Child Mortality Database.

5.9 All Staff

- This policy is applicable to all Surrey County Council staff and all Surrey CCG staff (permanent and temporary) who care for children, or who have a role in the child death review process. All staff should read and follow this guidance so that they can respond to each child death appropriately.

- All Surrey County Council staff and Surrey CCG staff have a responsibility to notify Surrey CDOP of the death of any child of which they become aware, to share information for the purposes of reviewing the child's death, and to participate in local review arrangements when they have been involved with the child or family.

6. Procedure: Child Death Review Statutory and Operational Guidance 2018

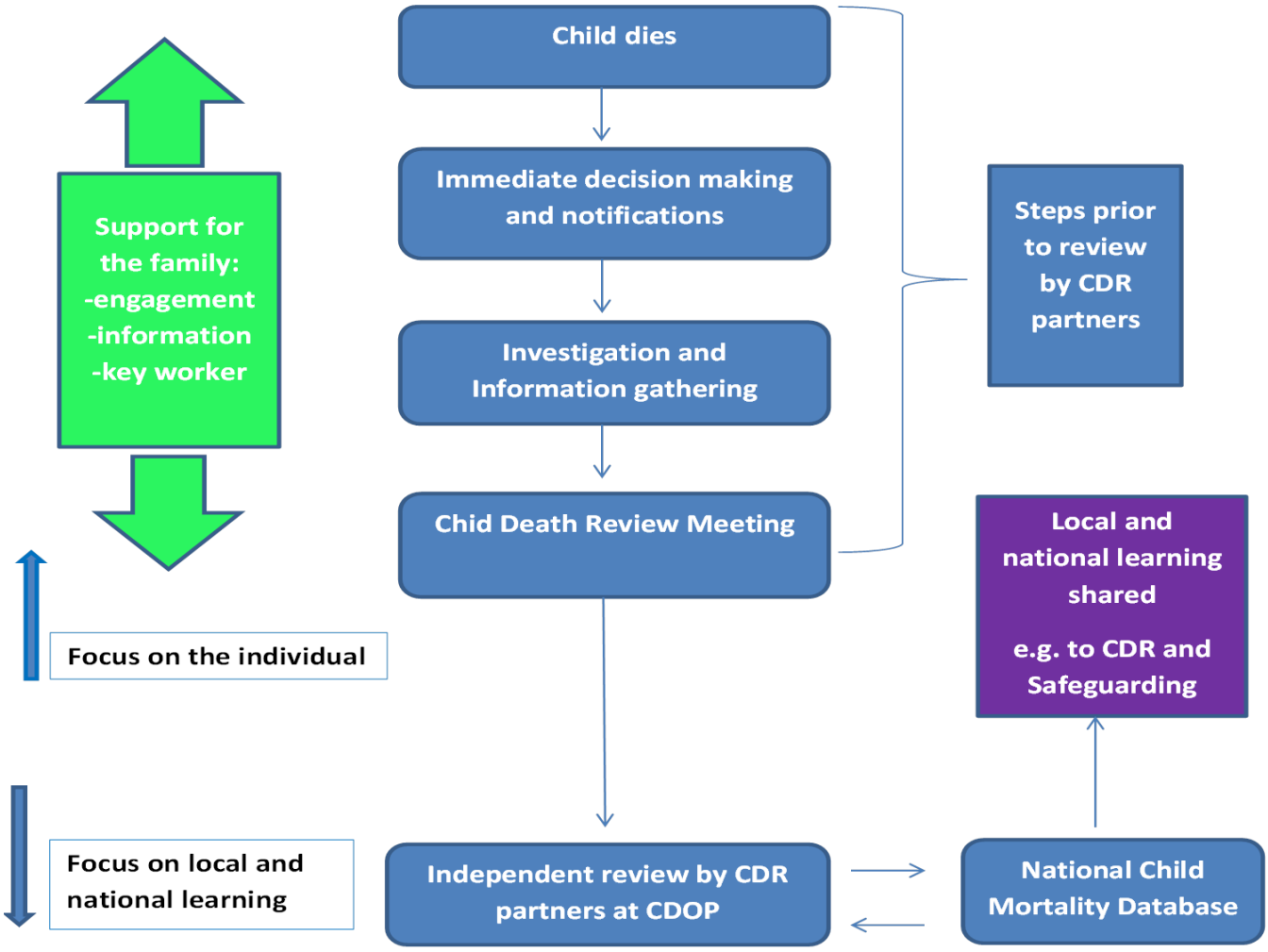
6.1.1 A child death review must be carried out for all children regardless of the cause of death.

6.1.2 This includes the death of any live-born baby where a death certificate has been issued. In the event that the birth is not attended by a healthcare professional, child death review partners may carry out initial enquiries to determine whether or not the baby was born alive. If these enquiries determine that the baby was born alive the death must be reviewed.

For the avoidance of doubt, it does not include stillbirths, late foetal loss, or terminations of pregnancy (of any gestation) carried out within the law.

• Cases where there is a live birth after a planned termination of pregnancy carried out within the law are not subject to a child death review.

6.1.3 The flow chart below sets out the main stages of the child death review process.



6.1.4 Following a child's death, immediate actions need to be taken such as notification of death, or deciding whether other investigations are warranted. In practice, the majority of such discussions will happen in a clinical setting, but may require input from other agencies in certain cases.

6.1.5 Within 1-2 hours if possible, senior professionals with responsibility for the child at the end of his/her life should:

1. Identify the available facts about the circumstances of the child's death;
2. Determine whether the death meets the criteria for a Joint Agency Response (JAR), and if so contact the on-call representatives for the police, health and children's social care so as to initiate the joint agency response;
3. Determine whether an MCCD can be issued, if not, consider whether the death should be referred to the coroner;
4. Determine whether an issue relating to health care or service delivery has occurred or is suspected and therefore whether the death should be referred to the coroner and/or a serious incident investigation;
5. Identify how best to support the family; and
6. Determine whether any actions are necessary to ensure the health and safety of others, including family or community members, healthcare patients and staff.

6.1.6 In all deaths, these discussions should be recorded in medical notes and the outcome of these discussions should also be fed back to the family.

6.1.7 Notification of the child death should be made via Surrey eCDOP Notification Form A and a number of notifications should also be made: e.g. to the child's GP, other professionals and to the Child Health Information System.

6.1.8 After immediate decisions have been taken and notifications made, a number of investigations may then follow. They will vary depending on the circumstances of the case, and may run in parallel. The learning from investigations will inform the CDRM and independent review by CDR partners at CDOP.

6.1.9 Alongside this, essential information needs to be gathered for all child deaths. This includes demographic data, and information relating to the circumstances of death and background medical history. This information should be reported to Surrey CDOP via the Reporting Form, or, for deaths of babies in neonatal units via the Perinatal Mortality Review Tool.

7. Joint Agency Response (JAR)

7.1.1 The *"Sudden and Unexpected Death in Infancy and Childhood: multiagency guidelines for care and investigation (2016)"* gives comprehensive advice and expectations of all agencies involved in a JAR, and should be applied in full by all agencies. This Policy should be seen as complementary to the SUDI/C Guidelines and does not replace them.

7.1.2 All deceased children that meet the criteria for a JAR should be transferred to the nearest appropriate Emergency Department (ED) to enable the JAR to be triggered.

7.1.3 A JAR 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 (incl. Sudden Unexpected Death in Infancy/Childhood: SUDI/C);

• occurs in custody, or where the child was detained under the Mental Health Act;

• where the initial circumstances raise any suspicions that the death may not have been natural; or

• in the case of a stillbirth where no healthcare professional was in attendance

7.1.4 In any of these circumstances, the named nurse for child death reviews, police investigator, and duty social worker should be contacted immediately so as to initiate the JAR. Once alerted, the named nurse and police investigator will attend ED.

7.1.5 A JAR should also be triggered if such children are brought to hospital near death, are successfully resuscitated, but are expected to die in the following days.

7.1.6 In such circumstances the JAR should be considered at the point of presentation and not at the moment of death, since this enables an accurate history of events to be taken and, if necessary, a 'scene of collapse' visit to occur.

7.1.7 Appropriate clinical investigations should also be performed in these cases, as set out in Table 1 of the SUDI/C Guidelines / Memorandum of understanding (MOU) between HM Senior Coroner for Surrey and Surrey CDOP.**(appendix 1)**

7.1.8 Effective cross-agency working is key to the investigation of such deaths and to supporting the family, and requires all professionals to keep each other informed, to share relevant information between themselves, and to work collaboratively.

7.1.9 The named nurse for child death reviews will fulfil the role of lead health professional. The named nurse will ensure that all health responses are implemented, and be responsible for on-going liaison with the police and other agencies.

7.1.10 Where no out-of-hours health rota for a JAR exists in a locality, the role of lead health professional should be taken by the senior attending paediatrician. This responsibility of Lead professional is handed over by the paediatrician to the named nurse at the earliest opportunity when back on duty.

7.1.11 Surrey children's services should also be contacted and asked to check their records relating to the child, immediate family members, other members of the household and others with whom the child has lived. The JAR flow chart sets out the sequence of events that should unfold in a JAR. **(appendix 2)**

7.1.12 Certain factors in the history or examination of the child may give rise to concerns about the circumstances of death. If such factors are identified, they should be documented and shared with the coroner and professionals in other key agencies. All injuries should be recorded and the lead police investigator should arrange a photographic record.

7.1.13 An initial information-sharing and planning meeting should take place between the lead health professional/named nurse; lead police investigator and social care before the family leave the emergency department. This should include consideration of outstanding investigations, notification of agencies, arrangements for the post-mortem examination, and plans for a visit to the home or scene of collapse by the lead police investigator and the named nurse.

7.1.14 In circumstances where a child has died, and abuse or neglect is known or suspected, professionals at the initial information-sharing and planning meeting should notify the safeguarding partners whose responsibility it is to determine whether the case meets criteria for a child safeguarding practice review.

7.1.15 The lead health professional/ named nurse should ensure that all relevant professionals and organisations are informed of the infant's death, including the coroner, the GP and health visitor or midwife, the child health computer system and Surrey CDOP via eCDOP.

7.1.16 There are some types of deaths which fall under the jurisdiction of a specific arm of the police force e.g. Road Traffic Collision Unit or British Transport Police. In such situations the named nurse should ensure that there is a co-ordinated approach with other elements of the JAR, and any report arising from their investigation informs the wider child death review process.

7.1.17 The aims of the JAR response are to:

- establish, as far as is possible, the cause or causes of the infant's death
- identify any potential contributory or modifiable factors
- provide ongoing support to the family
- ensure that all statutory obligations are met
- learn lessons in order to reduce the risks of future infant deaths.

8. Assessment of the environment and circumstances of the death (Joint home/scene visit)

8.1.1 As soon as possible after the infant's death, the named nurse and police investigator should visit the family at home or at the site of the infant's collapse or death.

8.1.2 The purpose of this visit is to obtain further, more detailed information about the circumstances and environment in which the infant died, and to provide the family with information and support.

8.1.3 This visit should normally take place within daylight hours. If there is likely to be a delay in arranging the joint visit, the police investigator should consider whether the police should carry out an initial visit to review the environment, ascertain whether there are any forensic requirements and appropriately record what is found. Unless there are clear forensic reasons to do so, the environment within which the infant died should be left undisturbed so that it can be fully assessed jointly by the police and named nurse, in the presence of the family.

8.1.4 The named nurse with the police investigator should inform the family of the nature and purpose of this home visit. Time should be allowed for the family to go at their own pace, respecting that they may find it difficult to talk through the events or go into the room where the infant has died. Allowance should be made for others, such as grandparents or family friends, to be present to support the parents.

8.1.5 The named nurse with the police investigator should review the key elements of the history, allowing the family to elaborate on any particular aspects and to clarify any points that were unclear or missing from the initial history.

8.1.6 Particular note should be made of any observations made by the family in the days before the infant's death. They may have taken photographs or video clips on a mobile phone that could shed light on the infant's state before death.

8.1.7 When the family is ready, the police investigator and named nurse should review the environment where the infant died. It can be very helpful at this stage for appropriate family members to be present to describe in detail the final events, how the infant was put to sleep and how they were found.

8.1.8 Consideration should be given to reconstruction of the sleeping environment, for example, with the use of a doll or prop. There is no strong evidence that this provides a more accurate understanding of the mode or circumstances of death, but it may prove helpful, particularly if the account is not clear, or if there are indications of possible overlaying or asphyxiation. Care should be taken not to further distress the family if a reconstruction is required.

8.1.9 The police lead investigator should consider whether to request crime scene investigators to take photographs or a video of the scene of the infant's death, and whether any items should be seized for further forensic investigation. Other possible relevant recordings, such as room temperature, are detailed within the police-approved professional practice guidance for investigators. It is rarely necessary to seize bedding or clothing and these rarely add anything to the investigation. However, there may be circumstances when an infant's cot or other sleeping environment needs to be taken for further examination. This should only be taken after the joint visit, so all items can be seen first in situ. Similarly, there may be circumstances where an infant's feeding bottle or other feeds or medications need to be taken for further analysis.

8.1.10 After reviewing the information, the named nurse and police investigator should discuss their findings so far with the family, taking care not to jeopardise any further investigation if there are concerns around possible abuse or neglect. The family should be informed of the further investigations that will need to be carried out, including the post-mortem examination, and how and when they will be informed of the results.

8.1.11 Information may be given to the family at this stage, in general terms, around possible causes of unexpected infant death. It is important, however, to emphasise that it is not possible to give a definitive cause of death until all investigations are complete, and that the ultimate decision on the cause of death rests with the coroner.

8.1.12 The family should be given a *When a Child Dies booklet* for parents, families, and carers to help understand and navigate the child death review process. This document should be offered, in a printed format, to all bereaved families and/or carers. The family should be informed that a named nurse will act as their point of contact for support or advice and also, given contact details for local bereavement support and relevant local or national organisations.

8.1.13 Following the home visit, the named nurse and police investigator should review all information gathered to date.

8.1.14 Following this review, the named nurse should prepare a report of the initial findings, to include details of the history, initial examination of the infant and findings from the home visit, as well as an account of any medical investigations and procedures carried out. This may be done using a standard proforma and added to as the investigation proceeds. **(Appendix 3)**

8.1.15 This report should be made available to the pathologist, the coroner and the police investigator as soon as possible, and preferably prior to the post-mortem examination.

9. The Post-mortem examination (PM)

9.1.1 The aim of the investigation is to establish, as far as is possible, the cause of death. The investigation will concentrate not just on the infant, but will consider the family history, past events and the circumstances. These factors can be helpful in determining why an infant died. All parts of the process should be conducted with sensitivity, discretion and respect for the family and the infant who has died.

9.1.2 The PM will be ordered by the coroner, and should be carried out by a pathologist with up-to-date expertise in paediatric pathology. If significant concerns have been raised about the possibility of neglect or abuse having contributed to the infant's death, a forensic pathologist should accompany the paediatric pathologist and a joint post-mortem examination protocol should be followed.

9.1.3 Families have the right to be represented at the PM by a medical practitioner of their choice, provided they have notified the coroner of their wishes.

9.1.4 The coroner should be immediately informed of the initial results of the PM, which may also, with the coroner's permission, be discussed with the named nurse and lead police investigator as required.

9.1.5 If the initial PM findings suggest evidence of neglect or abuse, the police investigation team and children's social care should immediately be informed and further investigations set in process.

9.1.6 Once the initial PM findings are known, the named nurse and the police investigator should, with the coroner's permission, arrange to meet the family to discuss the initial findings. It is important at that stage to emphasise that the findings are preliminary, that further investigations may be required, and that it is not possible, at that stage, to draw any conclusions about the cause of death.

9.1.7 As part of the explanation about the PM examination given to the family, the named nurse or coroner's officer must explain that, according to the Coroners (Investigation) Regulations 2013, tissue samples will be taken and that, following the coroner's investigation, the family can determine the fate of the tissue according to the Human Tissue Act 2004 guidelines.

10. Expected deaths

10.1.1 The named nurse's key responsibility will be on behalf of the Surrey child death review partnership to implement, co-ordinate and manage all child death reviews. The named nurse will be notified of each child death and sent relevant information.

10.1.2 On receipt of the notification of a child death, the named nurse will triage and allocate the child death to one of the child death review nurses who will undertake the role of lead health professional to coordinate the health response to the child death and ensure that all health responses are implemented.

10.1.3 The child death review nurse will be responsible for ongoing liaison with the health professionals currently involved with the child/family and in consultation, agree the timing of contact/visit to the family.

10.1.4 The child death review nurse will be responsible for ongoing liaison with the medical professionals involved with the child/family to ensure that they attend the planned CDRM and ensure outputs from CDRMs (draft Analysis Forms) are shared with CDOP panel.

10.1.5 The child death review nurse will attend the CDRM in the acute/community settings to represent the 'voice' of the parents at the professional meeting, ensure that their questions are effectively addressed, and to provide feedback to the family afterwards.

10.1.6 The child death review nurse will be a reliable and readily accessible point of contact for the family after the death and will carry out a follow up visit/visits to the family to support and feedback answers to their questions.

10.1.7 The child death review nurse will help co-ordinate meetings between the family and professionals as required.

10.1.8 The child death review nurse will support and signpost the family and surviving siblings to other professionals for bereavement support.

10.1.9 The child death review nurse will manage the child death review for expected deaths with support from the Named Nurse who has overall responsibility for all child deaths.

11. Child Death Review Meeting (CDRM)

11.1.1 Once the results of the PM and other clinical investigations are known, the CDRM is arranged by the CDOP co-ordinator to review emerging findings. The CDRM should ideally take place before the inquest so as to inform the coroner's investigation.

11.1.2 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 life and their investigation after death.

11.1.3 The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved. For example, it could take the form of a final case discussion following a Joint Agency Response; a perinatal mortality review group meeting in the case of a baby who dies in a neonatal unit; a hospital-based mortality meeting following the death of a child in a paediatric intensive care unit; or similar case discussion.

11.1.4 A member of the child death review team will in consultation with the medical team involved co-ordinate, manage and attend all appropriate CDRMs in the acute and community settings. They will represent the 'voice' of the parents at these professional meetings, ensure that their questions are effectively addressed, provide feedback to the family afterwards and also ensure outputs from CDRMs (draft Analysis Forms) are shared with CDOP panel. They will ensure all child death processes are followed across Surrey and ensure that reporting to the National Child Mortality Database is completed. Notes of the meeting should be taken to help with completion of the draft analysis form sent to CDOP.

11.1.5 The CDRM is a meeting for professionals. In order to allow full candour among those attending, and so that any difficult issues relating to the care of the child can be discussed without fear of misunderstanding, parents should not attend this meeting. However, parents should be informed of the meeting by their named nurse/child death review nurse and have an opportunity to contribute information and questions through their named nurse/child death review nurse.

11.1.6 With the exception of hospital based mortality meetings, the CDRM should be chaired by a lead professional for the child death review process.

11.1.7 The meeting should take place once investigations (e.g. any NHS serious incident investigation or post-mortem examination) have concluded, and reports from key agencies and professionals unable to attend the meeting have been received.

11.1.8 The meeting should take place as soon as is practically possible, ideally within three months, although serious incident investigations and the length of time it takes to receive the final post-mortem report will often cause delay.

11.1.9 The CDRM may proceed in the context of a criminal investigation, or prosecution, in consultation with the senior investigating police officer. The meeting cannot take place if the criminal investigation is directed at professionals involved in the care of the child, when prior group discussion might prejudice testimony in court.

11.1.10 At the meeting's conclusion, there should be a clear description of what follow-up meetings have already occurred with the parents, and who is responsible for reporting the meeting's conclusions to the family. This would generally be the named nurse/child death review nurse who is supporting the family. In a coroner's investigation, such liaison should take place in conjunction with the coroner's office, bearing in mind that the conclusion on the cause of death in such cases is the responsibility of the coroner at inquest.

11.1.11 Minutes of the CDRM incorporating analysis of information/factors that may have contributed to death, modifiable factors, identified learning and recommendations will be shared with the Coroner to assist with the Inquest.

11.1.12 In all cases, the aims of the CDRM are:

• to review the background history, treatment, and outcomes of investigations, to determine, as far as is possible, the likely cause of death;

• to ascertain contributory and modifiable factors across domains specific to the child, the social and physical environment, and 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 of any investigation into their child's death; a plain English explanation of why their child died (accepting that sometimes this is not possible even after investigations have been undertaken) and any learning from the review meeting;

• to ensure that CDOP and, where appropriate, the coroner is informed of the outcomes of any investigation into the child's death; and

• to review the support provided to staff involved in the care of the child

12. Child Death Overview Panel (CDOP)

12.1.1 CDOP is a multi-agency panel set up by CDR partners to review the deaths of all children normally resident in their area, and, if appropriate and agreed between CDR partners, the deaths in their area of non-resident children, in order to learn lessons and share any findings for the prevention of future deaths.

12.1.2 CDOPs should conduct an anonymised secondary review of each death where the identifying details of the child and treating professionals are redacted. This review should be informed by a standardised report from the CDRM, and ensures independent, multi-agency scrutiny by senior professionals with no named responsibility for the child's care during life.

12.1.3 The CDOP should be chaired by someone independent of the key providers (NHS, social services, and police) in the area. Panel members should be familiar with their responsibilities and ensure that they read all relevant material in advance of panel meetings. Conflicts of interest should be established at the outset of each meeting and panel members should not lead discussions if they are the named professional with responsibility for the care of the child.

12.1.4 Quoracy should usually demand attendance by lead professionals from health and the local authority. The CDOP should meet on a regular basis, determined by the number and type of deaths to be reviewed across a year.

12.1.5 The functions of CDOP include:

• to collect and collate information about each child death, seeking relevant information from professionals and, where appropriate, family members;

• to analyse the information obtained, including the report from the CDRM, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths;

• to make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children;

• to notify the Child Safeguarding Practice Review Panel and local Safeguarding Partners when it suspects that a child may have been abused or neglected;

• to notify the Medical Examiner (once introduced) and the doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction;

• to provide specified data to the National Child Mortality Database;

• to produce an annual report for CDR partners on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process; and

• to contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.

12.1.6 CDOP, on behalf of CDR partners, may request any professional or organisation to provide relevant information to it, or to any other person or body, for the purposes of enabling or assisting the performance of the child death review partner's functions. Professionals and organisations must comply with such requests.

12.1.7 CDOP should aim to review all children's deaths within six weeks of receiving the report from the CDRM or the result of the coroner's inquest. The exception to this might be when discussion of the case at a themed panel is planned.

12.1.8 Some child deaths may be best reviewed at a themed meeting. A themed meeting is one where CDR partners arrange for a single CDOP, or neighbouring CDOPs, to collectively review child deaths from a particular cause or group of causes. Such arrangements allow appropriate professional experts to be present at the panel to inform discussions, and/or allow easier identification of themes when the number of deaths from a particular cause is small.

12.1.9 Parents should be informed by their named nurse/child death review nurse that the review at CDOP will happen, and the purpose of the meeting should be explained. Particular care and compassion is needed when informing parents about the meeting and its purpose, to avoid adding to parents' distress or giving the impression in error that the parents are being excluded from a meeting about their child. With this in mind, it should be made clear that the meeting discusses many cases, and that all identifiable information relating to an individual child, family or carers, and professionals involved is redacted.

12.1.10 It should also be explained to parents that because of the anonymous nature of the CDOP review, it will not be possible to give them case specific feedback afterwards.

12.1.11 Parents should be assured that any information concerning their child's death which they believe might inform the meeting would be welcome and can be submitted via the named nurse or child death review nurse.

12.1.12 CDOP should assure itself that the information provided to the panel provides evidence that the needs of the family, in terms of follow up and bereavement support, have been met.

12.1.13 CDR partners must at such intervals as they consider appropriate, prepare and publish a report on:

a) what they have done as a result of the arrangements under this section; and

b) how effective the arrangements have been in practice.

12.1.14 In addition to these statutory requirements, CDR partners should aim to ensure that the report is written in plain English, and includes a summary of the key learning arising from the reviews, reports from themed panels, and actions that have been taken to prevent child deaths as a result of this learning.

12.1.15 Surrey CDOP should record the outcome of their discussions on a final Analysis Form, and submit copies of all completed forms associated with the child death review process and the analysis of information about the deaths reviewed (including but not limited to the Notification Form, the Reporting Form, Supplementary Reporting Forms and the Analysis Form) to the National Child Mortality Database.

13. Family engagement and Bereavement support

13.1.1 Every family has the right to have their child's death sensitively reviewed in order to, where possible, identify the cause of death and to ensure that lessons are learnt that may prevent further children's deaths. Professionals have a duty to support and engage with families at all stages in the review process. Parents and carers should be informed about the review process, and given the opportunity to contribute to investigations and meetings, and be informed of their outcomes.

13.1.2 All staff in all agencies and organisations have a duty to support bereaved parents and carers after their child's death and to show kindness and compassion. Where there have been issues with the quality of care provided, healthcare organisations have a duty of candour to explain what has happened, to apologise as appropriate, and to identify what lessons may be learnt to reduce the likelihood of the same incident happening again. This provision should extend beyond the medical sector to any instances of error in the care of the child.

13.1.3 The processes that follow the death of a child are complex, in particular when multiple investigations are required. Recognising this, all bereaved families should be given a single, named point of contact to whom they can turn for information on the child death review process, and who can signpost them to sources of support.

13.1.4 In the case of a child death that triggers a JAR, the single point of contact will be the named nurse. In the case of an expected death, the single point of contact will be the child death review nurse. Families should expect to be able to contact the named nurse/child death review nurse during normal working hours

13.1.5 As single point of contact, the named nurse and child death review nurse will:

• be a reliable and readily accessible point of contact for the family after the death;

• help co-ordinate meetings between the family and professionals as required;

• be able to provide information on the child death review process and the course of any investigations pertaining to the child;

• liaise as required with the coroner's officer and police family liaison officer;

• represent the 'voice' of the parents at professional meetings, ensure that their questions are effectively addressed, and to provide feedback to the family afterwards; and

• maintain appropriate boundaries with families and signpost to expert bereavement support if required.

13.1.6 An appropriate consultant neonatologist or paediatrician should also be identified after every child's death to support the family. This might either be the doctor that the family had most involvement with while the child was alive or the designated professional on-duty at the time of death. The named nurse/ child death review nurse should liaise closely with the appropriate doctor and arrange follow-up meetings at locations and times convenient to the family; and clinical expertise (via other professionals if necessary) to be able to

i) answer questions relating to the medical, nursing or midwifery care of the child;

ii) explain the findings, where relevant, of the post-mortem examination and /or other investigations and

iii) report back the outcome from the CDRM.

13.1.7 At the time of a child's death, other professionals may also provide vital support to the family; these include (but are not limited to) the GP, clinical psychologist, social worker, family support worker, midwife, health visitor or school nurse, palliative care team, chaplaincy and pastoral support team.

13.1.8 In all cases, it is the duty of the named nurse/child death review nurse to ensure that there is clarity regarding each professional's role; that the family does not receive mixed messages; and that communication is clear.

13.1.9 The leaflet *When a Child Dies – A Guide for Parents and Carers* should be given in printed format to all bereaved families or carers.

13.1.10 When their child dies, bereaved parents or carers should:

• have the opportunity to spend time with the child's body in a quiet and private environment;

• have the opportunity to make memories including taking photographs, hand and foot prints and a lock of hair;

• (if the parents or carers wish) expect a member of staff to remain with them, to provide comfort, and to ensure their basic needs are met;

• be given the contact details of their single point of contact and the identity of their medical lead, be informed who will be contacting them and when they will be contacted after they leave the hospital or hospice (and what to do should they have any questions in the meantime);

• know how to make arrangements to view their child's body;

• be given information on death registration and the coronial process (if applicable);

• understand why a post-mortem examination may be indicated and, if so, where it is taking place, and when the results might be expected. In the event of a coroner's case this responsibility falls to the coroner's officer;

• be supported to have an understanding of the child death review process and how they are able to contribute to it;

• be given practical advice in respect to organising the child's funeral;

• have the named nurse/child death review nurse accompany them to meetings to provide practical and emotional support; and

• be able to access expert bereavement support if required. The named nurse/child death review nurse should be able to direct families to the most appropriate support services.

14. Themed panels

14.1.1 Themed CDOP panels should develop in line with local circumstances. The panels below are given as examples:

- Neonatal panel:
- Cardiac panel:
- SUDI/C panel:
- Trauma panel
- Suicide panel:
- Learning disability panel:

14.1.2 It is important to specifically recognise and record if a child or young person has learning disabilities, irrespective of any other diagnoses or syndromes that are recognised. This enables effective monitoring, auditing and evaluation of service provision; resource management and strategic planning; and assurance regarding equitable access to health services.

14.1.3 The Learning Disabilities Mortality Review (LeDeR) programme describes a review process for the deaths of people aged 4 years and over with learning disabilities in England. The LeDeR programme team aims to support local areas to implement the LeDeR review process and to take forward the lessons learned from individual mortality reviews to make improvements to service provision. The LeDeR programme also collates and shares anonymised information from the review so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

14.1.4 It is expected that the child death review process will be the primary review process for children with learning disability and that it will not be necessary for the LeDeR programme to review each case separately. When notified of the death of a child or young person aged 4-17 years who has learning disabilities, or is very likely to have learning disabilities but not yet had a formal assessment for this, the CDOP co-ordinator should report that death to the LeDeR programme at http://www.bristol.ac.uk/sps/leder/notify-a-death/ or telephone 0300 777 4774.

14.1.5 The CDR partners should then ensure that the LeDeR programme is represented at the meeting at which the death is reviewed. In addition, the Local Area Contact for the LeDeR programme and the CDOP chair should discuss the potential input from a LeDeR reviewer to offer expertise about learning disabilities (if appropriate) and to ensure the collection of core data for the LeDeR programme. Any completed notes and/or Analysis Form arising from the discussion should be submitted to the Local Area Contact for the LeDeR programme by the CDR partners.

14.1.6 The designated doctor/named nurse for child deaths should be notified when a child dies in adult ICU. The designated doctor/named nurse can provide a central role in terms of:

• advice regarding the need for a Joint Agency Response;

• identifying whether the child is known to paediatric health professionals who should be represented at the adult mortality and morbidity (M&M) meeting; and attending the adult M&M meeting and completing a standardised Analysis Form for the purposes of Surrey CDOP;

• The Structured Judgement Review approach, or other evidence based structured mortality review tool, should be used to review the quality of clinical care. This, the standardised CDR Analysis Form, and any other notes arising from the adult M&M meeting should be forwarded to Surrey CDOP. The designated doctor/named nurse for child deaths should help co-ordinate this.

14.1.7 Child suicide should be reviewed in the same manner as other child deaths, with the following expectations:

• all deaths related to suspected suicide and self-harm should be referred to the coroner for investigation;

• all deaths related to suspected suicide and self-harm will require a Joint Agency Response;

• the CDRM should include experts in mental health and key professionals involved in the child's life across education, social services and health.

Specific risk factors should be considered, including:

- family factors such as mental illness, alcohol or drug misuse, and domestic violence;
- abuse and neglect;
- bereavement and experience of suicide;
- bullying, including on-line bullying;
- suicide-related internet use, including searching for methods and posting suicidal messages;
- academic pressures, especially related to exams;
- social isolation, especially leading to withdrawal;
- physical health conditions that may have social impact, and their treatment;
- alcohol and illicit drugs;
- mental ill health, self-harm, and suicidal ideation;
- Issues relating to self-identity, including gender identity; or
- exploitation, including child sexual exploitation, radicalisation, and gang-related exploitation.

14.1.8 Suspected child suicides should, where possible, be discussed at a themed specialist CDOP review with attendant mental health specialists.

14.1.9 All deaths of children in inpatient mental health settings will trigger a Joint Agency Response.

14.1.10 The primary responsibility for the investigation of the death of a child in custody lies with the coroner and Prisons and Probation Ombudsman (PPO). NHS providers should inform the CDOP where the child was normally resident of the death of any child in custody. Whilst it is acknowledged that such events will always be investigated by the PPO and the coroner, the CDOP where the death occurs should receive the outcomes of those investigations and conduct a comprehensive review of the case.

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14.1.23	Surrey Safeguarding Children Board Procedures: https://surreyscb.procedures.org.uk/

Appendix 1: MOU between HM Senior Coroner and Surrey CDOP

Sudden Unexpected Death in Infancy and Childhood
MOU between HM Senior Coroner for Surrey and Surrey CDOP

This memorandum of understanding has been made between HM Senior Coroner for Surrey and Surrey CDOP and it applies to the routine taking of samples where the circumstances of the unexpected death of an infant or child do not give rise to any suspicions or concerns that abuse or neglect may have contributed to the death. If there is any suggestion of neglect or abuse, the professionals must contact the Coroner and the police immediately and before any samples are taken.[1] Where there is any doubt about the appropriateness of a course of action, the Coroner should be consulted first via the on-call Coroner's Officer.

Routine suggested samples to be taken immediately after sudden unexpected deaths in infancy and childhood – 'The Kennedy Samples'[2]

Save where there is a criminal investigation, such samples will fall under the jurisdiction of HM Coroner, and hence there must be communication with the coroner's office. Before the infant is certified to have died and/or during the resuscitation period, various samples may have been collected. These samples should be clearly documented, the coroner's officer informed, the samples secured and the results forwarded to the pathologist as soon as possible. The samples listed in the table at 'Appendix A' should be taken in all SUDI cases.

In unexpected deaths in older children, the appropriate clinical samples will be guided by the circumstances of the death and the clinical findings.

1a: Taking the Kennedy Samples

- Samples must be taken with all due care as soon as is reasonably practicable after death.
- In taking samples areas of the body where there appear to be any signs of bruising must be avoided.
- A single attempt at a femoral or cardiac aspiration should be made by a competent practitioner. Repeated attempts should be avoided as they may compromise the integrity of the cardiac anatomy.

1b: Additional samples to be considered after discussion with Consultant Paediatrician

- Skin biopsy for fibroblast culture in all cases of suspected metabolic disease.
- Muscle biopsy if history is suggestive of mitochondrial disorder.
- In suspected carbon monoxide poisoning, blood sample for carboxyhaemoglobin.

[1] In Surrey, a coroner's officer will be on duty at all times. During office hours please call 01483-404530. Out of hours dial 101 and ask for the on-call Coroner's Officer.

[2] 'Sudden unexpected death in infancy and childhood' (2nd edition November 2016) The Baroness Helena Kennedy QC.

1c:

Evidential considerations

- Ensure the coroner has given permission to take samples.
- All samples taken must be documented and labeled to ensure there is an unbroken 'chain of evidence', using an appropriate 'chain of evidence' pro forma.
- This may mean handing samples to a police officer directly, or having the laboratory technician sign upon receiving them in the laboratory.
- Ensure that samples given to the police or coroner's officer are signed for.
- Record the sites from which all samples were taken.

Holding their Child and Mementos for the Family:

If the death is suspicious, the coroner and the police should be informed immediately and in those circumstances access to the child by the parents or loved ones, prior to a post mortem examination, MUST NOT be permitted and tubes and lines MUST NOT be removed.

If the cause of death is unknown or unnatural but not thought to be suspicious then parents or loved ones of the child who wish to hold their child prior to a post mortem examination, may do so provided the following guidance is followed.

1. Those attending or holding the child must always be accompanied and observed by at least one member of medical staff (nurse grade or higher). The name and grade of the member of staff must be noted.

2. There is available an x-ray that clearly shows the tube/s in place:
    a. that was taken no more than 24 hours prior to the child's death, or
    b. that was taken immediately after the child's death.

3. Lines may be removed, but the entry cannulas must remain in place; the entry cannulas themselves MUST NOT be removed. All lines and bags removed and any syringes and medication vials MUST be retained.
4. A hair sample may be taken by a member of the medical staff, whose name and grade must be noted.

5. A hand and / or footprint may be taken by a member of the medical staff, whose name and grade must be noted.

Richard Travers **September 2017**
HM Senior Coroner for the County of Surrey

[1] In Surrey, a coroner's officer will be on duty at all times. During office hours please call 01483-404530. Out of hours dial 101 and ask for the on-call Coroner's Officer.
[1] 'Sudden unexpected death in infancy and childhood' (2nd edition November 2016) The Baroness Helena Kennedy QC.

Appendix A: Kennedy Samples

Sudden Unexpected Death in Infancy and Childhood
MOU between HM Senior Coroner for Surrey and Surrey CDOP

Sample	Send to	Handling	Test
Blood (serum) 1–2 ml	Clinical chemistry	Spin, store serum at –20°C	Toxicology if indicated*
Blood cultures – aerobic and anaerobic 1 ml	Microbiology**	If insufficient blood, aerobic only	Culture and sensitivity
Blood from Guthrie card	Clinical chemistry	Normal (fill in card; do not put into plastic bag)	Inherited metabolic diseases
Blood (lithium heparin) 1–2 ml	Cytogenetics	Normal – keep un-separated	Genetic testing (if indicated)
Cerebrospinal fluid (CSF)	Microbiology***	Normal	Microscopy, culture and sensitivity
Nasopharyngeal aspirate	Virology#	Normal	Nucleic acid amplification techniques**
Nasopharyngeal aspirate	Microbiology	Normal	Culture and sensitivity
Swabs from any identifiable lesions	Microbiology	Normal	Culture and sensitivity
Urine (if available)	Clinical chemistry	Spin, store supernatant at –20°C	Toxicology if indicated, inherited metabolic diseases

Notes:

* Toxicology has a low yield in routine practice, and its use and coverage of substances varies according to coronial practice. Each case should be assessed individually.

** Appropriate interpretation of microbiological and virological results after SUDI remains difficult, with significant variation by group and individual.

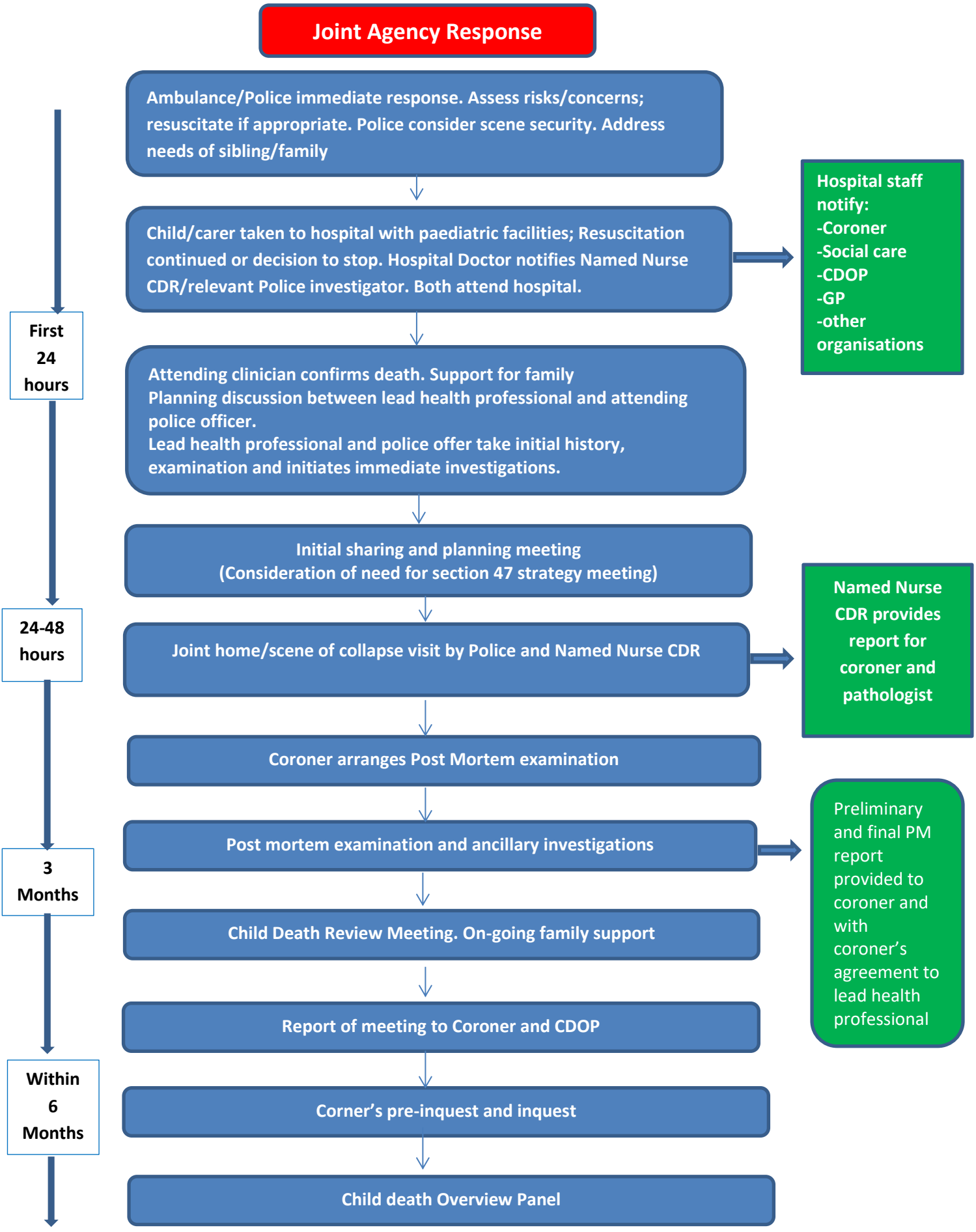
*** If indicated based on clinical history or examination.

Samples must be sent to an appropriate virological laboratory.

[1] In Surrey, a coroner's officer will be on duty at all times. During office hours please call 01483-404530. Out of hours dial 101 and ask for the on-call Coroner's Officer.

[1] 'Sudden unexpected death in infancy and childhood' (2nd edition November 2016) The Baroness Helena Kennedy QC

Appendix 2: Joint Agency Response



Appendix 3: Proforma for History/Physical examination/Scene examination

A: History proforma

1. Identification data

Name of infant: …… **Sex M/F……**

Date of birth: …… **Ethnicity:……**

Address:

Postcode:…… **Date of death:……**

Name of father (+ address if different from infant) **DOB: ……**

Name of mother (+ address if different from infant) **DOB: ……**

Name of partner (if relevant + address) **DOB: ……**

GP name and address: ……

Consultant: ……

SUDI consultant: ……..

Police officer/ senior investigating officer: ……

Social worker: ……

Coroner/coroner's officer: ……....

Other professionals: ……..

……

……

2. Details of transport of infant to hospital

Place of death: ……...

Home address as above / Another location (specify) / DGH (specify)

Time found: …… **Time arrived in A&E: ……**

Resuscitation carried out? Y/N **Where? At scene of death / ambulance / A&E**

By whom: carers / GP / ambulance crew / hospital staff / others (specify)

Confirmation of death:

Date: **Time:** **Location:** **By whom?**

3. History

Taken in A&E by: …… **Taken at home visit by: ……**

History given by: ……..

Relationship to infant: ……..

Events surrounding death:

Note: Who found the infant, where and when; appearance of the infant when found:

……..……..……

Who called emergency services: ……

When infant was last seen alive and by whom: ……...

Details of any resuscitation at home, by ambulance crew and in hospital: ……

……

For accidental/traumatic deaths details of circumstances around the death; witnesses: ……..

……

……

……

Detailed narrative account of last 24–48 hours

To include details of all activities and carers during last 24–48 hours
Any alcohol or drugs consumed by infant or carers
For SUDI, include details of last sleep including where and how put down, where and how found, any changes; details of feeding and care given
Details of when last seen by a doctor or other professional
Further details of previous 2–4 weeks, including infant's health, any changes to routine

Family history

Details of all family and household members including names; dates of birth; health any previous or current illnesses including mental health; any medications;
Occupation
Maternal parity and obstetric history
Parental relationships
Children, including children by previous partners
Household composition
Any previous childhood deaths in the family

Past medical history

Of the infant, to include pregnancy and delivery; perinatal history; feeding; growth and development
Health and any previous or current illnesses; hospital admissions; any medication
Routine checks and immunisations
Systems review
Behavioural and educational history where appropriate

Social history

Type and nature of housing; any major life events
Any travel abroad
Wider family support networks

Any other relevant history

May vary according to the age of the infant, nature of the death

Information retrieved from records

Hospital, GP, health visitor, midwife, NHS Direct, etc. (include family-held records such as the Personal Child Health Record ('Red Book')
Ambulance crew
Social services, databases, case records, child protection register.
Police – intelligence, assist, Police National Computer, domestic violence, etc.

B: Physical examination proforma

To be carried out by consultant paediatrician and police investigator – forensic investigators to be used for photographs where relevant.

Physical examination carried out by: ……..

• Rectal temp (low reading thermometer)……...

Date/time ……. and interval from death ……

• **Full growth measurements** **Centile**

Length: …… ……..

Head circumference: ……. ……..

Weight: …… . …….

• Retinal examination: ……..

• State of nutrition and hygiene: ……..

• Marks, livido, bruises or evidence of injury – to include any medical puncture sites and failed attempts: **(should also be drawn on body chart)**

- NB: Check genitalia and back: ……
- Check mouth: Is the fraenum of lips/tongue intact?……

Further details, observations and comments
• List all drugs given at hospital and any interventions carried out at resuscitation
• Document direct observation of position of endotracheal tube prior to removal
• Document any cannulae, nasogastric tubes and any other medical intervention prior to removal.

Date: _____

Time: _____

Signature(s): _____

C: Scene examination proforma

Infant's name: ……

Date of birth: …….. Date of death: ……..

Address:

Date of scene visit: …….

Persons present: ……

……

Room

Note:

Size, orientation (compass), contents, 'clutter' Ventilation: windows and doors (open or shut)

Heating (including times switched on/off); measure drawer temperature °C

Sleep environment

Note:

Location, position of bed/cot in relation to other objects in room. Was the infant sleeping on a sofa, floor or elsewhere?

Mattress, bedding, objects

Position of infant

When put down; when found

Any evidence of over-wrapping or over-heating? Yes/No

Any restriction to ventilation or breathing? Yes/No

Any risk of smothering? Yes/No

Any potential hazards? Yes/No

Any evidence of neglectful care? Yes/No

Diagram of scene

Note:

North/south orientation; room measurements

Location of doors, windows, heating

Any furniture and objects in the room

Appendix 4 – Procedural Document Checklist for Approval

Title of document being reviewed:		Yes/No/ Unsure	Comments/ Details
A	**Is there a sponsoring director?**		
1.	**Title**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a guideline, policy, protocol or standard?		
2.	**Rationale**		
	Are reasons for development of the document stated?		
3.	**Development Process**		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with stakeholders and users?		
4.	**Content**		
	Is the objective of the document clear?		
	Is the target group clear and unambiguous?		
	Are the intended outcomes described?		
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		
	Are key references cited?		
6.	**Approval**		
	Does the document identify which committee/group will approve it?		
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how the document will be disseminated and implemented amongst the target group? Please provide details.		
8.	**Process for Monitoring Compliance**		
	Have specific, measurable, achievable, realistic and time-specific standards been detailed to monitor compliance with the document? Complete Compliance & Audit Table.		
9.	**Review Date**		
	Is the review date identified?		
10.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for implementing and reviewing the documentation i.e. who is the document owner?		

Title of document being reviewed:		Yes/No/ Unsure	Comments/ Details
Director Approval			
On approval, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name		Date	
Signature			
Committee Approval			
On approval, Chair to sign and date.			
Name		Date	
Signature			

Appendix 5 – Compliance and Audit Table

Criteria	Measurable	Frequency	Reporting to	Action Plan/ Monitoring
Surrey Child death Review Partnership have set up child death review arrangements to review all deaths of children normally resident in the local area and, if they consider it appropriate, for any non-resident child who has died in their area.	Audit of Joint Agency Response and response to expected deaths	Annual	Child death review partnership/Safeguarding partnership/Surrey CCGs	Annual CDOP report and 6 month update to CDR partnership and Safeguarding partnership. Compliance with child death review arrangements will be included in the safeguarding children and adult annual report and 6 month update.