Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

CHILD DEATH REVIEW POLICY

This procedural document supersedes:
This procedural document supersedes: PAT/T 62 v2 – Rapid Response to Unexpected Child Deaths and Child Deaths Function Standard Operating Procedure

Did you print this document yourself?
The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Executive Sponsor(s):	Chief Nurse
Author/reviewer: (this version)	Catherine Tokell Lead Nurse for Child Death Review
Date written/revised:	06/09/2021
Approved by:	Policy Approval and Compliance Group
Date of approval:	29 April 2021
Date issued:	28 September 2021
Next review date:	April 2024
Target audience:	Clinical staff, Trust-wide

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 3	28 Sept 2021	• New title • Significant changes please read in full with related hyperlinked documents.	C. Tokell
Version 2	28th April 2017	• Significant changes have been made throughout this document, please read in full.	G Genders
Version 1	25th February 2015	• This is a new procedural document, please read in full.	G Genders

Contents

Page No.

Overview of Basic Child death process

Overview

This chapter briefly describes the whole child death review process. The flow chart below (fig. 1) sets out the main stages of the child death review process. To help readers navigate the guidance, it appears at the start of chapters 2-6 with the relevant stage highlighted.

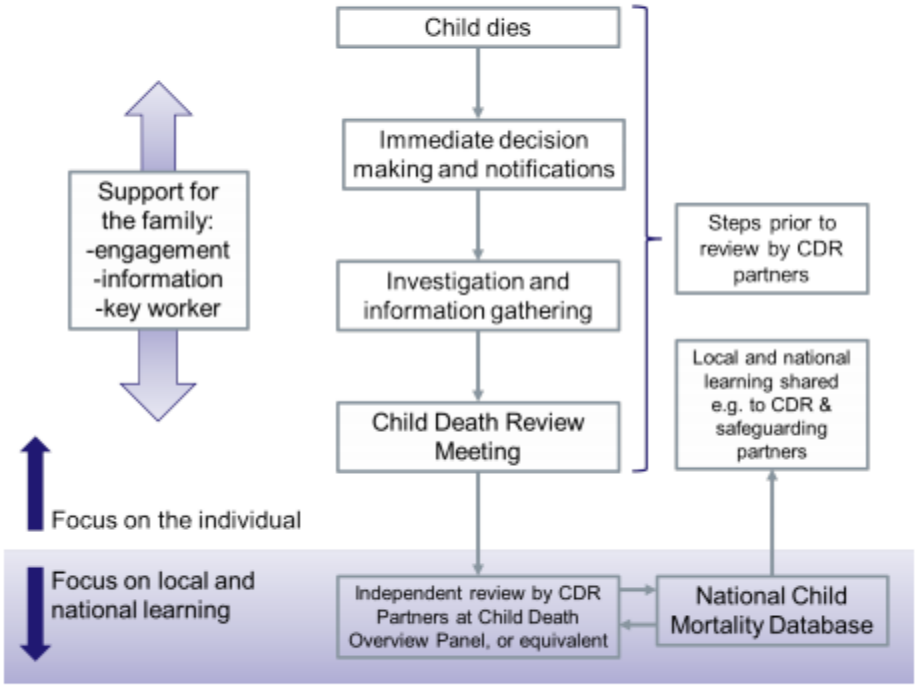

Figure 1 Chart illustrating the full process of a child death review. This includes both the statutory responsibilities of CDR partners to review the deaths of children at an independent multi-agency panel (described here, and throughout, as review at CDOP or equivalent), and the processes that precede or follow this independent review. Further explanation is below.

Joint Agency Response exists in a locality, the role of lead health professional should be taken by the senior attending paediatrician.

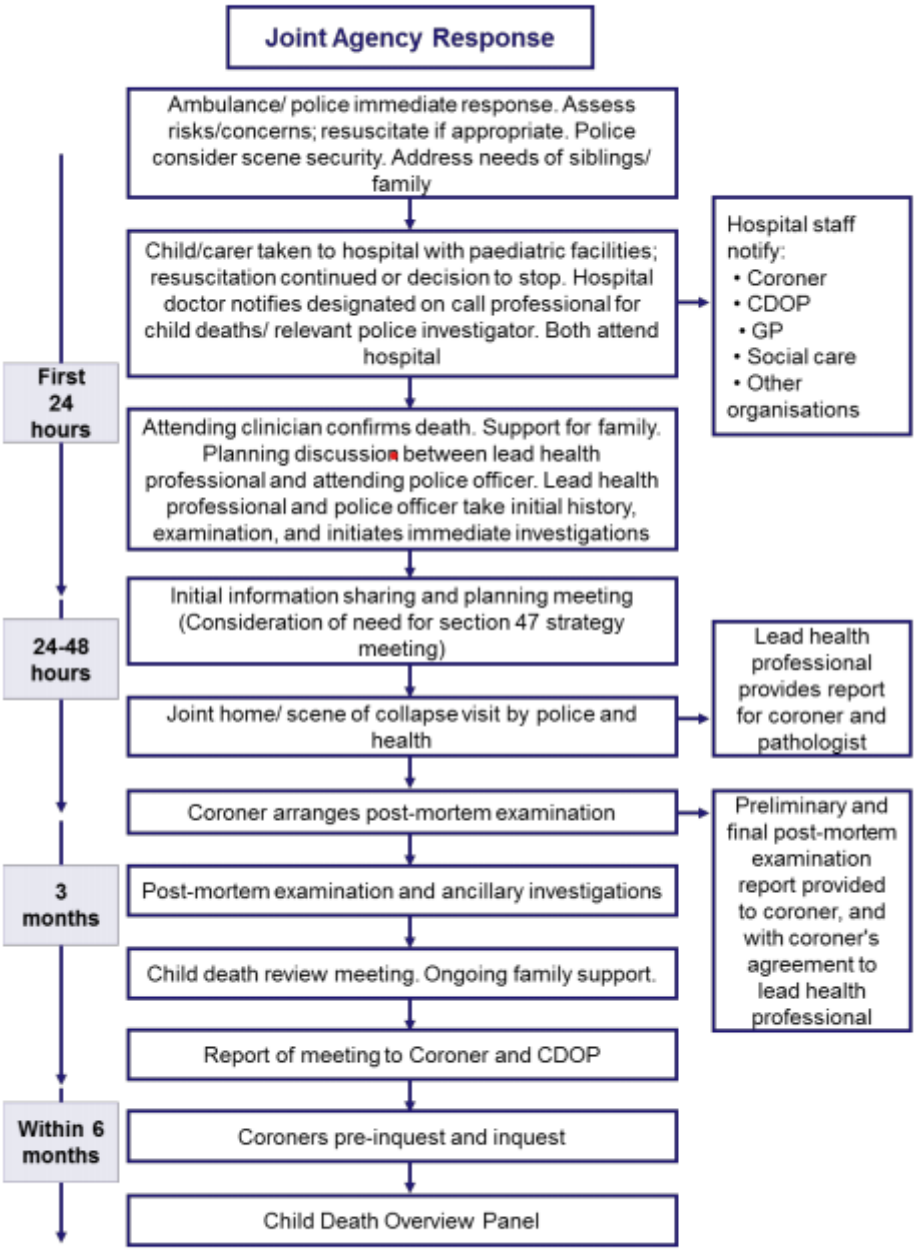

Figure 4: In this flow-chart, CDOP is used to represent the group established by CDR Partners that conducts the final stage of the child death review process.

1 INTRODUCTION

A child is anyone under the age of 18 years of age as defined in the Children Act of 1989. 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. This document uses the term Child Death Review, which is a process which must be undertaken for all children regardless of the cause of death. Families experiencing such a tragedy should be met with empathy and compassion. Families need clear and sensitive communication and an understanding of what happened to their child. 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 (where possible) future child deaths. Doncaster and Nottinghamshire Safeguarding Childrens' Partnership are required to ensure that two interrelated processes are in place within these geographical areas to ensure there is a multidisciplinary approach to review all child deaths.

The Child Death Review Statutory Guidance (2019) sets out key features of what a good child death review process should look like. This process combines best practice with statutory requirements that must be followed. Chapter 5 of Working Together to Safeguard Children (2018) informs of the procedures to be followed when there is a child death. This includes the death of a child (aged 16 – 18) who is being treated on an adult ward or 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.

- Stillbirth: baby born without signs of life after 24 weeks gestation

- Foetal loss: where a pregnancy ends without signs of life before 24 weeks gestation 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.

2 PURPOSE

The purpose of this policy is to provide a local trust response using the Statutory Guidance Review process to manage all child deaths in Doncaster and Bassetlaw, thereby ensuring reviews are standardised as far as possible and complying with statutory obligations.

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

This will enable effective contribution to the National Child Death Overview Panel (CDOP):

- to local and regional thematic learning from reviews
- the identification of specific local learning,
- Leading to the identification of trends that culminate in the identification of modifiable factors that could be altered to prevent future deaths.

Hyper link to the Child Death Review Statutory and Operational Guidance 2018 :
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf

This policy requires that all Trust Staff adhere to the robust reporting mechanism to ensure that the Child Death Team are informed immediately or as soon as is practically possible of all deaths of children under the age of 18 years.

Co-operation with the process and sharing of information as required in a timely manner will enable the Child Death Team/Safeguarding Team to ensure the Statutory CDR process is followed for all families within Doncaster and Bassetlaw and that siblings are considered and protected as required and as a priority.

Ensuring that families are treated with respect and sensitivity that a balance is achieved between meeting medical/forensic requirements and evidence preserving and provision of family support. Thereby ensuring that the families are offered bespoke bereavement support that acknowledges cultural needs and any ongoing legal investigations.

3 DUTIES AND RESPONSIBILITIES

The Trust employ a team of staff to provide a rapid response to a child death, particularly if the death is not expected and occurs within the hospital or at home.

Child death review partners should ensure that a designated doctor for child deaths is appointed to any multi-agency panel (or structure in place to review deaths). The designated doctor for child deaths should be a senior paediatrician who can take a lead role in the review process. Child death review partners should ensure a process is in place whereby the designated doctor for child deaths is notified of each child death and is sent relevant information

KEY Roles:

The Lead professional :
'Designated Doctor for child deaths A senior paediatrician, appointed by the CDR partners, who will take a lead in coordinating responses and health input to the child death review process, across a specified locality or region'.

Medical Examiner *:*
'A medical practitioner appointed as medical examiner whose responsibility is to ensure: that the cause of death is accurately recorded by the attending practitioner'
https://www.rcpath.org/profession/medical-examiners/medical-examiner-officers.html

Lead Nurse for Child Death Review:
'A lead health professional should be appointed, to coordinate the health response to that death. This person may be a doctor or senior nurse, with appropriate training and expertise. This person will ensure that all health responses are implemented, and be responsible for ongoing liaison with the police and other agencies. Where no out-of-hours health rota for a Joint Agency Response exists in a locality, the role of lead health professional should be taken by the senior attending paediatrician'.

Key Worker :
'A person who acts as a single point of contact for the bereaved family, who they can turn to for information on the child death review process, and who can signpost them to sources of support'

All Trust staff must also ensure they adhere to the robust reporting mechanisms outlined within the Doncaster and Nottinghamshire Children Partnership's safeguarding procedures and this policy, supported by the safeguarding team and line manager.

4 PROCEDURE

In the event of a child death, it is the responsibility of DBTH Trust Staff to ensure that the Child Death Review Team are informed immediately or as soon as is practically possible of all deaths of children under the age of 18 years.

Co-operating with the process and sharing of information as required in a timely manner. This will enable the Child Death Team to adhere to the Statutory CDR process for all families within Doncaster and Bassetlaw. By ensuring families are treated with respect and sensitivity a balance is achieved between meeting medical/forensic requirements and evidence preserving and provision of family support. It is important that the Trust endeavours to ensure that family members are offered sensitive equitable but bespoke bereavement support that acknowledges cultural needs any ongoing legal investigations.

When a child dies all Trust staff must:

- During 9-5pm Monday to Friday: Inform the lead for child death as soon as is practically possible.
- During the weekend (between 9-5pm) the on call rota is distributed to switchboards at Doncaster Royal infirmary and Bassetlaw Hospital with contact numbers for those on call. In the event of a child death staff should contact switchboard who will then call the Nurse on call.
- Staff should ensure record keeping follows Trust policy and that all appropriate CDR forms and templates are completed and forwarded to the Child Death Review Team at point of handover, these include eCDOP Notification forms, home visit forms and immedicate decision making proforma. https://www.gov.uk/government/publications/child-death-reviews-forms-for-reporting-child-deaths
- Follow local department standard operation procedures (SOPs) for when a child dies, (e.g.: Peads A&E checklist) including considering the statutory requirements of :

1: Working Together to Safeguard Children when considering siblings.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

2: The Child Death Review Statutory Guidance includes detailed process.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf

4.1 Unexpected Deaths within Community Setting

Children who die unexpectedly within the community must be presented to the local Emergency Department. The Child must be conveyed to hospital by ambulance staff and accompanied by Police. This arrangement applies for all children under 18 years of age. The exception normally relates to situations where it is clear to paramedics and police in attendance, that resuscitation is not appropriate and a forensic examination is required. Additionally, there may be situations where children that have died are conveyed to hospital by family and/or friends (Doncaster Safeguarding Childrens Board and National Safeguarding Childrens Board Safeguarding Procedures).

Upon obtaining the information that a child has died and is to be conveyed to ED, staff must inform the Emergency Department Consultant on-call and Consultant Paediatrician on-call if the child is under 16 years.

A member of hospital staff must be allocated to remain with the parents or carers and support them throughout the process. When in attendance, the family may stay with their

child or within the quiet room according to their wishes. Staff must refer to the child by its name at all times.

Staff must check the child's address and post-code, in order to inform the Nurse on–call for the Child Deaths. This requirement enables the prompt sharing of information and enablement of the process when a child lives out of area.

Where English is not the preferred language of the parents, carers or family, interpreter services should be provided. This requirement must be communicated to members of the Child Death Review team, On-Call Paediatrician or Emergency Department Consultant On-Call as soon as possible on arrival at the hospital. If the child is under 16 years of age, they must be examined by the Consultant Paediatrician. For children over 16 years of age, this may be the Consultant in Emergency Medicine or other relevant adult Consultant. The Paediatrician/Consultant must take a detailed history of events leading up to and following the discovery of the child's death, and follow the procedures outlined within the specific documents for managing sudden deaths within ED (Sudden Unexpected Deaths in Children up to the age of 18 years). For unexpected deaths in children up to the age of 18 years, a medical document outlines the requirements of the initial medical assessment, management and procedures that must be followed in the event of a sudden death of a child. They incorporate guidelines regarding the management of:-

- Resuscitation, hospital care and confirmation of death,
- Examination post death and post death investigations
- Family profile and history
- Medical History
- Recent Events
- Nursing and Medical Checklists.

Ensure that all the original copies are filed in the emergency department record and that copies are made available for the Rapid Response Team. The Rapid Response on-call person is responsible to share the document with the relevant coroner in a timely manner. This process will help to establish the cause of death when appropriate, and help to identify if there are any suspicious circumstances. Any cause for suspicion must be reported immediately to the on-call Detective Police Inspector. In the first instance, this must be discussed with the Police Senior Investigating Officer allocated to the case. Where safeguarding concerns are identified actions must be taken in line with Doncaster or Nottinghamshire Safeguarding Children procedures and staff should ensure that actions are taken to protect any siblings within the family, if appropriate. When the death is confirmed;

The attending paediatrician or physician must inform the parents, having first reviewed all available information.

Staff must contact Children's Social Care within the appropriate geographical area to inform them of the child's death and to establish whether the child was subject to a child protection plan. The outcome of this discussion must be clearly documented within the child's record and shared with the person on-call for the Rapid Response to Unexpected

child death service. Any safeguarding concerns must be acted upon in accordance with Nottinghamshire or Doncaster Safeguarding Children Board procedures as relevant.

Medical and Nursing staff must ensure that parents and families understand the role and process of the Multi-Agency Rapid Response to Unexpected Child Death Team and written information must be given to the parents/carers to support the discussion. Unless sharing of information with family members would jeopardise a police or criminal investigation, parents and carers must always be informed and kept up to date about any new findings.

Prior to transferring a child to the mortuary, the child can be redressed. Any secretions to a child's face should not be washed (the pathologist needs to assess whether any fluids to the face are significant). Cannulas and any tubes - for Bassetlaw should be left in situ. For Doncaster these may be cut but remain in situ. The pathologist requires this in order to check their placement.

When nappies, clothing etc. are removed, they must be stored in individual labelled hospital or evidence bags and stay initially with the child. A discussion with Police is necessary to ascertain whether they will take charge of the belongings or whether they accompany the child when transferred to the mortuary.

When a child dies in Doncaster and is transferred to Sheffield for post mortem, an empty memory box should be provided which will eventually contain hand and footprints, photographs and a lock of hair. Doncaster staff should explain to parents/ carers that the memory box will go with the child to the mortuary and then to Sheffield where the process will be completed. However, it is necessary to gain consent from the parents and the completed consent form will go with the child to Sheffield. ED staff should then ensure the Mortuary attendant is aware that the memory box and consent form will escort the child to Sheffield for post mortem. A copy of the consent form should be filed within the patient's health record. (See section 4.1)

In Bassetlaw only - Staff should obtain consent and provide a memory box. Families should be given a copy of the completed consent form and a copy filed within the child's health record. NB In suspicious circumstances do not remove keepsakes for the family.

Patient identification labels must be attached to both the wrist and ankle of the child. All deceased children must be sent to the mortuary wearing their original inpatient identity band. This must not be removed or replaced. An additional identification band will be added bearing the full name and address of the deceased, age and date of admission (see Patient Identification Policy PAT/PS7 (See Section 4.4).

- Ask the parents if they would like anyone to be informed of the death e.g. partner, grandparents, religious leader.
- Ask parents/carers if they would like you to contact the hospital chaplain or their own religious leaders in order to provide spiritual care. Where appropriate, ask if there are any religious rites that should be adhered to following the death of their child. NB: The Hospital Chaplain is on call 24 hours per day and can be contacted via switchboard.

- Give the parents a copy of the Trust's Bereavement Leaflet (WPR28831). This leaflet provides information for parents regarding what happens after their child has died. Ensure that it is documented within the child's health record that explanatory leaflets have been given to the parents/carers. Encourage parents and carers to see and hold the child (but never leave them unsupervised). This is to ensure a balance between sensitivity towards the family and the need for the Police and Coroners to investigate all unexpected deaths (Doncaster and Nottinghamshire Safeguarding Children Procedures; Baroness H. Kennedy 2016; Association of Chief Police Officers 2014). Before the family leave Hospital.
- Ask the parents/carers where they are going and document in the child's record, their address, and contact telephone number and how they will get there safely. Make sure they are not alone wherever possible and offer hospital transport if required.
- Ensure the parents/ family know they can visit their child to pay last respects at the Hospital Mortuary prior to transfer for a post mortem and this can be arranged by either telephoning the department or ringing the mortuary (Contact details are included within the Trust's bereavement Leaflet -WPR28831).
- Ensure parents are aware of the contact numbers within the Lullaby Trust Leaflet, of local Child Death /Rapid Response professionals whom they can contact for advice/ or with questions after they have gone home.

4.2 Deaths within Hospital Ward Environment

The Paediatrician's Role (or Registrar in the absence of the Consultant) when a death is sudden. The Paediatric Consultant assesses and certifies the child/young person's death. They will inform the parents of the child's death and ensure that a detailed history of events leading up to and following the discovery of the child's death is recorded within the medical child death document. The Senior Paediatrician (Consultant or Registrar) will explain to the family, that the case will be referred to the Coroner. He/she should also explain that the Coroner's role is to determine the cause of death and whether it is likely that a post-mortem examination will take place. NB: If a child lives out of area, it should still be referred to the Coroner covering the geographical area of the child death.

1. The Paediatric Consultant will complete the referral of the child to the Coroner. Additionally, the family should be told the likely venue and timing. In extreme cases where the Consultant is unable to attend the ward, the Registrar may be required to complete the above.

2. The Paediatric Consultant will ensure that all relevant documentation is completed within the child's health record.

3. Where additional investigations are required, the on-call paediatrician should liaise with x-ray and Ophthalmologist on call or others as appropriate.

4. Medical Staff should inform Police immediately (applies 24 hours per day) of all unexpected child deaths. It is the role of the Police to assist the coroner with the investigation of circumstances surrounding all unexpected child deaths. Document actions taken within the child's records.

5. The Family will be introduced to an identified staff member which will be either the Lead Nurse for Child Death Review or the Key Worker within the Child Death Review Team, who will be dedicated to their care until they leave the hospital.

6. Medical staff should complete the relevant parts of the Child Death Checklist (WPR27963) Immediately following the child death, the following actions should be completed by ward staff: 1. Inform the Children and Family Division matron/nurse manager/clinical site manager. 2. Inform Children's Social Care immediately (24 hours per day) that there has been an unexpected child death. This phone call should include:-

A check whether the child was subject to a Child Protection Plan and the outcome of this discussion with social care and any safeguarding concerns or actions taken must be clearly documented within the child's record and shared with the person on-call for the Rapid Response to child death service.

A written multi-agency referral form should be forwarded to Children's Social Care (Bassetlaw Multi Agency Safeguarding Hub or Doncaster Referral and Response Team according to the child's address).

Ward Staff should inform the Child Death Review Team or on-call Nurse via switchboard. In the event that a child dies between the hours 5pm- 9am, Trust staff should ensure the Child Death Review Team team are informed at 9am the next day.

4.3 Care of the Family

Medical and nursing staff should work together to sensitively ensure that parents or carers receive high quality care, support and information during this very traumatic time. Where English is not the first language every attempt should be made to provide a translation/interpreting service including out of hours provision, for example through the Trust Interpretation and Translation Services Policy PAT/PA34 or the "Big Word" language line. Parents/carers should be allowed to stay with their child (with supervision) or remain in a quiet room, according to their wishes and hospital staff should:

Briefly explain the role of the multi-agency response for sudden child deaths and give parents the Lullaby Trust leaflet "A Child Death Review – A guide for parents and carers (2013). Explain to parents sensitively that the child death procedures are routine for all child deaths and aim to find out what has caused their child to die. Inform the parents, that the Police may wish to complete a home visit with or without a Child Death Review Nurse,

additionally that they may choose to attend the ward. This is routine practice and is not an indication that the parents are suspected of being responsible for the death. Additionally, inform parents that they will be informed and kept up to date about any new findings.

Ask the parents if they would like anyone to be informed of the death e.g. partner, grandparents, religious leader.

Ask parents/carers if they would like you to contact the hospital chaplain or their own religious leaders in order to provide spiritual support in an appropriate setting. Ask parents/carers, if there are any religious, spiritual or cultural rites where possible, that should be adhered to following the death of their child. NB: The Hospital Chaplain is on call 24 hours per day and can be contacted via switchboard

Give the parents a copy of the Trusts' Bereavement Leaflet (WPR28831).This leaflet provides information for parents regarding what happens after their child has died. Ensure that it is documented within the child's health record that explanatory leaflets have been given to the parents/carers.

Ask the parents and carers if they wish to see and hold the child (but never leave them unsupervised).

Before the family leave Hospital

- Ask the parents/carers where they are going and document in the child's record, their address, contact telephone number and how they will get there safely. Make sure they are not alone wherever possible and offer hospital transport if required.

- Ensure the parents/ family know they can visit their child to pay last respects at the Hospital Mortuary prior to transfer for a post mortem and this can be arranged by either telephoning the ward or ringing the mortuary (Contact details are included within the Trusts' bereavement Leaflet -WPR28831).

- Ensure parents are aware of the contact numbers within the Lullaby Trust Leaflet, of local Child Death /Rapid Response professionals whom they can contact for advice/ or with questions after they have gone home. See Section 4.4.

4.4 Hospital Led Multi Agency Rapid Response Procedure

In the event of a Sudden Unexpected Death of an Infant/Young Person within Hospital Call being received, medical Staff should inform Police immediately (applies 24 hours per day) of all unexpected child deaths and establish whether the Police will attend the ward. Complete Child Death Information Sharing Proforma to notify local NHS managers and local CDOP of the initial information.

- Share information as appropriate, written or verbally where required (for instance where safeguarding concerns are present).

- Establish contact details of those multi-agency professionals known to the child and family prior to or as a result of the death.

- Commence national dataset Form A Notification of Child Death and form A1, then forward to the CDOP administrators once complete (within 24 hours). A Joint visit with Police/ Designated Paediatrician or Rapid Response Nurse for Unexpected Child Deaths to the family is completed within 12 hours wherever possible.

- The Rapid Response person will ensure a follow-up contact number is provided to parents unless inappropriate (i.e. due to criminal proceedings). The Rapid Response Person completes Form B Local Home Visit document and ensures that a copy is sent to the coroner via the Police Senior Investigating Officer.

- Where safeguarding concerns are present, information sharing and actions will occur immediately in line with NSCB or DSCB procedures.

- An Initial Joint Agency Review (JAR) meeting is organised by the Rapid Response team, to occur within 3 working days, to bring together the Multi-agency Rapid Response Team. The purpose of this meeting is to discuss initial post mortem results, to share all relevant multi-agency information relating to the family and the circumstances of the death, to inform investigations and to ensure plans are in place to support families and professionals involved. The group will consider whether there are any safeguarding concerns and if so, ensure these are addressed in line with DSCB and NSCB procedures. Additionally, the group will consider whether information known should be referred to the local Serious Case Panels for discussion. Minutes of this meeting will be produced and distributed by the Hospital Rapid Response team within 2 weeks to the coroner and relevant others. Timescales for actions will be detailed within the meeting minutes and the chair of the meeting will hold responsibility for ensuring timescales are met and actions monitored.
- Within 2 weeks of the unexpected child death - B forms will be distributed to all professionals that have had contact with the family as a result of or prior to the child's death. The Trust Child Death administrator will be responsible for management of responses and chasing up non- response.

- At 12 weeks post death, the Trust Child Death Administrator will request post mortem reports from the Coroner's offices in Doncaster or Nottinghamshire. Upon receipt of Completed B forms, DSCB Child Death Administrator collates information and sends this to Child Death Rapid Response Team within Doncaster. This role is undertaken by the Trust Rapid Response administrator for Bassetlaw cases. When post mortem reports are received (expected time scale 3- 6 months) - Final Findings meeting to be arranged. Meeting to ensure all circumstances of the case are reviewed and arrangements made to ensure family support. Minutes to be distributed within 2 weeks. The proposed C from is produced and case sent for discussion at the Child Death Overview Panel (expected time scale 6-12 months). Cases presented and discussed at CDOP post inquest.

5 TRAINING/SUPPORT

The standard Learning Needs Analysis (LNA) – The training requirements of staff will be identified through a training needs analysis. Role specific education will be delivered by the service lead.

6 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
To monitor CDR process as identified in the Guidance, thereby allowing assurance to the Trust and to the local children's Safeguarding Partnership that Doncaster and Bassetlaw NHS Teaching Trust are meeting the statutory requirements as laid out in the statutory guidance. **The CDR Statutory Guidance has 7 chapters with requirements:** **Standards Of Chapter 1** **Section 1.1** 'All child deaths are notified to Child Death Team for review using CDR'' In preparation for reporting to the death Overview panel of the Safeguarding Children's partnership	Child Death Review Team	Monthly , with quarterly overview to culminate inclusion in the annual report	To report to Lead Nurse for Trust oversight
Standards of Chapter 2 **Section 2.1** '*All that the deaths are reviewed using CDR process* .' Were a child's death is identified as not having followed process -			To report to Lead Nurse for Trust oversight

to consider : • Trust datix and /or serious incident national reporting guidelines As identified in chapter 3, section 3.4.1 ; and in section 6.6 • subject of training / update sessions To identify in ecdop : the CDR process in : : FORMDS A1 , A, B, , C – a CDRM , with post mortem and or PNMT			
CHAPTER 3: **Section 3.3.1** All deaths are considered: *Does a death meet the Criteria for a JAR?* Outcome of immediate decision to hold a JAR (or not). To identify that there is a recorded rational for decision to hold or not to hold a JAR – in keeping with Guidance – page 22, section 3.3.1	Child death team data base	Monthly figure – with quarterly and annual report.	To report to Lead Nurse for Trust oversight
CHAPTER 4: **Standards of Child death Review Meeting ;** **Section :** **4.1.1** *'CDRM (or equivalent) - to be held* '. To provide an over view of all CDRM, identifying any challenges, blocks and learning.	Child death team and data base	Quarterly report	To report to Lead Nurse for Trust oversight
Chapter 5: **Presentation at Child Death Over View panel (CDOP)** **Standard:** **Section 5.1.1**	Lead Nurse with Designated Dr	Quarterly With feed into annual report, including	To report to Lead Nurse for Trust oversight

*'*Child death review partners must make arrangements for the analysis of information from all deaths reviewed'. 'That All deaths are presented at CDOPs;' • Identify average time scale, the usual journey and experience • Identify blocks and challenges to completion • Identify learning, themes and further points of analysis leading to reporting back to Trust any recommendations and learning Themes of further scrutiny outcomes and recommendations Work with CDOPS and Safeguarding Children's Partnership to cascade learning	CDOP / Child Death Team data base	narrative	
Chapter 6 **Monitoring of key worker – family support** **Standard** **Section 6.3.1** '*The leaflet When a Child Dies – A Guide for Parents and Carers should be given to* ***<u>all</u>*** *bereaved families or carers'* • Identify evidence that leaflet was given to all families. • Identify evidence that support to bereaved families is offered, anon case study vignettes to illustrate work and outcomes. Collate family views and experiences to help inform the future and make changes for the better based on Patient / family expert opinion	Child death team - keyworker report.	Monthly – leading to annual report	To report to Lead Nurse for Trust oversight
Chapter 7 ***Specific circumstances with best practice***	Lead Nurse	Report	To report to Lead

guidelines: **Section : 7.2** How many referrals to LeDeR were completed for children over 4 years old. • Identify number of referrals • Identify and themes, learning and recommendations to be cascaded to Trust	From Team data base	quarterly	Nurse for Trust oversight
Section 7.3 How many deaths of Children in adult health care settings Eg 16 and 17 year olds in adult ITU. • To identify challenges to treat and care for children and young people in appropriate paediatric environment	Lead Nurse from team data base	Report quarterly	To report to Lead Nurse for Trust oversight
Scetion 7.4 Death by Suicide and self harm *'the CDRM should include experts in mental health and key professionals'* • Review recommendations for service development that can directly impact upon outcomes / / reduction in death • Identify best practice in Doncaster and Bassetlaw was a mental health expert present in the JAR and CDRM			To report to Lead Nurse for Trust oversight
Section 7.5 How many referrals to local Child Safeguarding Practice Reviews • Identify referral outcome recommendations and learning points for cascade and training			To report to Lead Nurse for Trust oversight

7 DEFINITIONS

All terminology and definitions are included from page 5 and in the appendices of the CDR

Table of Abbreviations
AHPs – Allied Health Professionals
CCG – Clinical Commissioning Group
CDOP – Child Death Overview Panel
CDR – Child Death Review
CDRM – Child Death Review Meeting DoLS – Deprivation of Liberty Safeguards
ED – Emergency Department
GP – General Practitioner
HSIB – Healthcare Safety Investigation Branch
ICU – Intensive Care Unit
JAR – Joint Agency Response LeDeR – Learning Disabilities Mortality Review
M&M – Mortality and Morbidity meeting
MCCD – Medical Certificate of Cause of Death
MBRRACE-UK – Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MHA – Mental Health Act
NCISH – National Confidential Inquiry into Suicide and Homicide by people with Mental illness
NCMD – National Child Mortality Database NHS – National Health Service NIV – Non-invasive ventilation Ofsted – Office for Standards in Education, Children's Services and Skills
ONS – Office for National Statistics
PICU – Paediatric Intensive Care Unit
PMRT – Perinatal Mortality Review Tool
PPO - Prisons and Probation Ombudsman
RCP – Royal College of Physicians
SIDS – Sudden Infant Death Syndrome
SJR – Structured Judgement Review
SMART – Specific, Measurable, Attainable, Relevant, Time-bound
SUDI – Sudden Unexpected Death in Infancy
SUDC – Sudden Unexpected Death in Childhood
SUDI/C Guidelines – Sudden Death in Infancy/Childhood: multi-agency guidelines for care and investigation

8 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and

assessing the impact of a procedural document any discriminatory factors must be identified.
An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 1)

9 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- CORP/ICT 13 – Police Requests for Information and Evidence
- CORP/RISK 3 – Introducing New Clinical Procedures or Practice
- CORP/RISK 14 – Being Open, Saying Sorry and Duty of Candour Policy
- CORP/RISK 15 –Serious Incident (SI) Policy
- CORP/RISK 16 – Maternity Services Risk Management Strategy
- CORP/REC 6 – Record Keeping Standards
- CORP/COMM 4 – Complaints, Concerns, Comments and Compliments Resolution and Learning
- CORP/COMM 27 – Media and Public Relations Policy
- PAT/PS 10 – Safeguarding Children Policy
- PAT/IC 11 – Pathology Specimens – Collection and Handling of Pathology Specimens
- PAT/T 60 – Care after Death and Bereavement Policy: Operational policy for staff to follow in the event of a patient death
- PAT/PA 28 - Privacy and Dignity Policy
- CORP/EMP 4 – Fair Treatment for All Policy
- CORP/EMP 27 – Equality Analysis Policy

10 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website:
https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

11 REFERENCES

The Child Death Review Statutory and Operational Guidance process relates to, fits with and is complimentary to:

- BETTER BIRTHS Improving outcomes of maternity services in England A Five Year Forward View for maternity care https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf?PDFPATHWAY=PDF
- Children Act of 2004
- Child and Social work Act 2017
- Child Death Review Statutory SOP – Templates and forms https://www.gov.uk/government/publications/child-death-reviews-forms-for-reporting-child-deaths
- Child Death, from 2015, Courts and Judiciary Reports (includes Coroners reports) https://www.judiciary.uk/subject/prevention-of-future-deaths/ https://www.judiciary.uk/subject/child-death/ https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/https-www-judiciary-uk-subject-community-health-care-and-emergency-services-related-death
- Gathering feedback from families following the death of their baby . A resource to support professionals in maternity care. NHS England. June 2017 http://www.londonscn.nhs.uk/wp-content/uploads/2017/06/mat-bereavement-mbem-062017.pdf
- Guidance for all NHS Trusts on working with bereaved families and carers using : Updated NHS England information for parents : 'When a child dies A guide for parents and carers' : https://www.england.nhs.uk/wp-content/uploads/2018/07/parent-leaflet-child-death-review-v2.pdf
- Learning Disabilities Mortality Review (LeDeR) http://www.bristol.ac.uk/sps/leder/notify-a-death/?_ga=2.4265911.589001362.1531124673-1987643447.1528363357 http://www.bristol.ac.uk/sps/leder/
- National Guidance on Learning from Deaths , July 2018 , NHS England and national Quality Board https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-families-v2.pdf
- National Mortality Data Base https://www.ncmd.info/
- NICE Guidelines : End of life care for infants, children and young people https://www.nice.org.uk/guidance/qs160/resources/end-of-life-care-for-infants-children-and-young-people-pdf-75545593722565Working Together to Safeguard Children SUDI/C Guidelines : Sudden unexpected death in infancy and childhood: multi-agency guidelines for care and investigation. https://www.rcpath.org/discover-pathology/news/new-guidelines-for-the-investigation-of-sudden-unexpected-death-in-infancy-launched.html
- NSPCC learning : serious case reviews - case studies and learning. https://learning.nspcc.org.uk/case-reviews/recently-published-case-reviews

- Royal College of Paediatrics and Child health - safeguarding evidence / resources.
  https://www.rcpch.ac.uk/key-topics/child-protection
  https://childprotection.rcpch.ac.uk/
  https://childprotection.rcpch.ac.uk/child-protection-evidence/
- (Working Together 2018
  https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

APPENDIX 1 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Child Death Review Policy – PAT/T 62 v.3	Safeguarding Team	Kate Tokell	Existing	20.04.21

1) Who is responsible for this policy? Name of Division/Directorate: Lead Nurse, Rapid response

2) Describe the purpose of the service / function / policy / project/ strategy? To support Trust staff through the child death process

3) Are there any associated objectives ? **Local safeguarding Board Procedures , National statutory guidance, Service contract**

4) What factors contribute or detract from achieving intended outcomes? – None

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? [any actions to be taken] N/A

7) Are any of the following groups adversely affected by the policy? None are affected

Protected Characteristics	Affected?	Impact
a) Age	X	
b) Disability	X	
c) Gender	X	
d) Gender Reassignment	X	
e) Marriage/Civil Partnership	X	
f) Maternity/Pregnancy	X	
g) Race	X	
h) Religion/Belief	X	
i) Sexual Orientation		

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 x	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: **April 2024**

Checked by: **Elizabeth Boyle** **Date:** **20.04.21**