Kent CDOP
Unexpected Child Death Procedures

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Summary of Purpose	These procedures describe the multi-agency response to the unexpected death of child within Kent and the subsequent coordinated follow up arrangements for those children who have died and for those who die outside the county.	
Review Date	This document is to be reviewed a minimum of every 2 years after the last review date. Incremental reviews may take place as required.	
Accessibility	This document can be made available in large print, or in electronic format. There are no copies currently available in other languages.	
How this document was created	Version 1	Document created by Dr Charles Unter in April 2008
Equalities Impact Assessment	During the preparation of this policy and when considering the roles & responsibilities of all agencies, organisations and staff involved, care has been taken to promote fairness, equality and diversity in the services delivered regardless of disability, ethnic origin, race, gender, age, religious belief or sexual orientation. These issues have been addressed in the policy by the application of an impact assessment checklist.	

Version	Detail of Change	Date
1.0	Document created	April 2008
2.0	Document Reviewed & Amended in light of Working Together 2010	August 2010
3.0	Document Reviewed & Amended in light of Working Together 2013	May 2013
4.0	Document Reviewed & Amended following implementation of Working Together 2015/eCDOP	July 2016

Contents

1. Legislative background

1.1 This procedure describes the multi-agency 'Rapid Response' process in respect to the unexpected death of a child within Kent and the subsequent coordinated follow up arrangements for those children resident in Kent who have died either within or outside the county/country. Children not normally resident in Kent, including looked after children accommodated in Kent, are the responsibility of their placing local authority. The Local Safeguarding Children Board (LSCB) of the resident local authority is responsible for following up the death in accordance with their local CDOP procedures.

2. Legislative background

2.1 The LSCB functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under Section 14(2) of the Children Act 2004. The LSCB is responsible for:

- **Collecting and analysing information about each death, with a view to identifying:**
  - any case giving rise to the need for a review mentioned in Regulation 5(1)(e)
  - any matters of concern affecting the safety and welfare of children in the area of the Authority;
  - any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area

- **Putting in place procedures for ensuring that there is a coordinated response by the Authority, their Board partners and other relevant persons to an unexpected death.**

2.2 This guidance is based on the statutory guidance in Chapter 5, Working Together to Safeguard Children 2015, published in March 2015 by the Department of Education.

3. Scope

3.1 These procedures must be followed in the event of an unexpected death of any child or young person from birth up to the age of 18 years, including babies of any gestation where signs of life are noted, but excludes both those babies who are stillborn and planned terminations of pregnancy carried out within the law. Signs of

life will be assumed present unless deemed absent by a doctor or midwife present at the birth.

3.2 Each death of a child will be initially identified as expected or unexpected from the Form A notification and confirmed by the Designated Doctor on review of the case information.

3.3 Working Together 2015 classifies an unexpected death as *'the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death.'*

3.4 In situations when multi-agency partners are unclear whether the death of a child is expected or unexpected, advice should be sought from the Designated Doctor for child death (or nominated substitute when she/he is unavailable). The unexpected child death procedures should be followed until there is sufficient evidence for a decision to be made.

3.5 This procedure applies to all child deaths in Kent.

4. Overall Principals

4.1 Each child death is a tragedy for his or her family (including any siblings), and subsequent enquiries/investigations should keep an appropriate balance between forensic and medical requirements and the family's need for support.

4.2 A minority of unexpected deaths are the consequence of abuse or neglect or are found to have abuse or neglect as an associated factor.

4.3 In all cases, enquires should seek to understand the reasons for the child's death, address the possible needs or other children in the household, the needs of all family members, and also consider any lessons to be learnt about how best to safeguard and promote children's welfare in the future.

4.4 Families should be treated with sensitivity, discretion and respect at all times, recognising any cultural and religious needs, and professionals should approach their enquiries with an open mind.

4.5 It is important that there is a coordinated multi-agency approach involving partners working together and sharing information.

4.6 Preservation of evidence and good record keeping is essential.

4.7 There should be congruence with the specific requirements of the local coroner.

4.8 A timely response and the need to conclude any enquiries or investigations expeditiously is important so that the funeral is not delayed unnecessarily.

4.9 Police officers in attendance must be sensitive to the potential distress caused by uniforms, marked police cars, personal radios and mobile phones. The duty Detective Inspector (DI) from the Public Protection Unit (PPU) should lead the police response (on call DI out of hours).

4.10 Chronic illness, disability and life limiting conditions account for a large proportion of child deaths. Whilst it is to be expected that children with life-limiting (LL) or life threating (LT) conditions will die prematurely young, it is not always easy to predict when, or in what matter they will die.

4.11 The lives of children with LL/LT conditions are as valued and important as those of any other children, and hence the unexpected death of a child with LL/LT conditions should be managed as for any other unexpected so as to determine the cause of death and any contributory factors. This is out of respect for the child and family, and to fulfil any statutory requirements.

4.12 Professional's responding to the unexpected death of a child with a LL/LT condition should ensure that their response to these families is appropriate and supportive and does not cause any unnecessary distress.

5. General advice for all staff of all agencies

5.1 Child death can be a difficult time for staff and though the time spent with the family may be brief, it could influence how relatives deal with the bereavement for a long time afterwards. The following points should be remembered:

- The family will begin the first stages of grief and may be shocked, numb, withdrawn or highly emotional. If any practitioner is concerned about the emotional welfare of a family member the appropriate advice should be taken immediately and a referral made.

- It is essential to complete a verbatim and detailed initial account of events, including timings. Information should be as specific and detailed as possible and documentation should be signed and dated.

- It is normal for a parent to want physical contact with her/his dead child and this should be allowed, albeit observed, if the Child Abuse Investigation Unit Detective Inspector (PPU DI) / Senior Investigator Officer agrees, which would usually be the case except in exceptional circumstances to preserve evidence.

- The child should be handled as if she/he was still alive and her/his name used at all times. The need to allow time for parents to ask questions, including where their child will be taken and when they are able to see her/him again.
- Parents/Carers should be advised of an appropriate point of contact and given any supporting information i.e. leaflets.

- There is a possibility that there will be a delay in the funeral if a post mortem examination is required by the coroner to ascertain the clinical cause of death, and that an inquest will probably be needed to establish the other matters required by law.

- There is a need for all staff to ensure they keep written records of all information obtained and any actions taken as well as any referral and subsequent contact with families and professionals.

6. Roles and responsibilities when responding to an unexpected death of a child

6.1 When a child dies unexpectedly, several investigative processes may be instigated, particularly when abuse or neglect is a factor. The following procedure aims to ensure that those professionals/organisation involved work together in a coordinated way in order to minimise duplication and ensure that the lessons learnt contribute to safeguarding and promoting the welfare of children in the future:

- All professionals involved with a child who dies unexpectedly (before and/or after the death) must collaboratively respond to the child's death. The local Designated Paediatrician for Unexpected Deaths in Childhood (or the nominated substitute when she/he is unavailable) should coordinate the work of the team convened in response to a child's death.

- An Immediate response form should be complete on eCDOP, available at https://www.ges-online.com/Kent/eCDOP/Live/Public

- A Form A notification should then also be completed, available at https://www.qes-online.com/Kent/eCDOP/Live/Public

- Each member of the team will carry out their usual roles and responsibilities, for example, as a Paediatrician, GP, Specialist Nurse, Health Visitor, Midwife, Teacher, Mental Health Professional, Substance Misuse Worker, Social Worker, Youth Offending Team Worker, Probation or Police Officer. Other professionals know to the family from specialist agencies should be accessed on a case-by-case basis to support the core team, i.e. Hospice Support Workers, Children's Community Nurses.

- A joint home visit at an early stage by the Designated Doctor and Senior Investigating Officer (DI) is encouraged and can provide valuable information from family as well as offering sensitive support in a conducive environment.

6.2 The joint responsibilities of these professionals include:

- Responding quickly to the unexpected death of a child, including necessary enquiries.

- Undertaking necessary enquiries/investigations that relate to the current responsibilities of their respective organisations including any services provided to the child and family.

- Liaising with those who have ongoing responsibilities for other family members.

- Collecting information in a standard, nationally agreed manner.

- Providing support to be bereaved family, and where appropriate referring on to bereavement services.

- Maintaining regular post bereavement contact at regular intervals with family members and other professionals who have ongoing responsibilities for other family members, to ensure they are informed and kept up-to-date with information about the child's death.

7. Responding to the unexpected death of a child

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

7.2 Once the death of a child has been referred to the Coroner and she/he has accepted it, the Coroner has jurisdiction over the body and all that pertains to it.

7.3 A multi-professional approach is required to ensure collaboration among all involve, which may include Ambulance staff, A&E department staff, Coroner's Officers, Police, GPs, Health Visitors, School Nurses, Community Children's Nurses, Midwives, Paediatricians, Palliative or end of life Care Staff, Mental Health Professionals, Substance Misuse Workers, Hospital Bereavement Staff, Voluntary Agencies, Coroners, Pathologists, Forensic Medical Examiners, Children's Social Services, YOTs, Probation, Schools, Prison staff (where a child has died in custody) and any others who may find themselves with a contribution to make in individual cases (for example, Fireman or Faith leaders etc.).

7.4 Each agency will have detailed policy/guidance on their role in investigating the death of children. Such guidance will conform to the requirements of these procedures.

7.5 At any stage of the response consideration should be given to the appropriateness or not of recommending a Serious Case Review (SCR). For guidance please see: http://www.kscb.org.uk/procedures/serious-case-reviews/case-review-process

8. Initial Action

8.1 The provision of medical assistance to the child is the first priory and an ambulance must be requested, unless already in attendance, and the Police advised.

9. Emergency services and General Practitioners

9.1 The Ambulance Service (or GP if first professional on the scene) should not assume death and thus should try to resuscitate immediately (unless clearly inappropriate).

Resuscitation, once commenced, should be continued according to the *UK Resuscitation Guidelines (2015)* until an experienced doctor (usually the Consultant Paediatrician on call) has made a decision that it is appropriate to stop further efforts. (https://www.resus.org.uk/resuscitation-guidelines/)

9.2 Although all children who have died unexpectedly will be taken to hospital in accordance with South Coast Ambulance's (SECAmbs) protocol, there will be cases where the immediate involvement and authorisation by the Police will be necessary before this takes place i.e. severe trauma, inability to extract body.

9.3 If the child has not been removed by the Ambulance Service the Police will arrange for a forensic medical examiner (FME), Custody Nurse, GP or Paramedic to confirm the fact of death at the scene.

9.4 If no medical certificate of 'cause of death' can be issued, following consultation with the Police (PPU or on call Detective Inspector) the Coroner will be informed.

9.5 The attending professionals should provide relevant information and history, including any suspicions and concerns, to the receiving A&E hospital, Doctor via Ambulance Control and directly to the Police Communication Centre.

9.6 In the rare event that a deceased child is taken directly to the mortuary the Police Senior Investigation Officer must immediately inform the on call Paediatrician/A&E consultant/ Designated Doctor or Specialist Nurse for Child Death.

9.7 The attending professional should record the position of the child, clothing worn and circumstances of how the child was found, living conditions and any comments made by parents/carers or other witnesses.

10. Hospital Staff – General

10.1 On arrival at hospital the accident and emergency (A&E) staff must inform the duty consultant Paediatrician and Consultant in emergency medicine (for children 16-18 years old) immediately of the arrival of the child and family and:

- Attempt resuscitation (unless clearly inappropriate) according to the *UK Resuscitation Guidance (2015)* (https://www.resus.org.uk/resuscitation-guidelines/) until the consultant has decided to stop further efforts.

- Establish and record the identify of those present and their relationship to the child.

- Allocate member of staff to support parents/carers and keep them informed at all times.

- Check the police have been notified (via the Force Contact and Control Centre on 01622 690690) if the child is dead on arrival or subsequently dies.

- Contact the Central Referral Unit (CRU) on **03000 41 41 41** (out of hours **03000 41 91 91**) and advise of the child's death. A request should be made to establish whether the child or any family members or any other person living at the premises is or has been known to Specialist Children's Services (SCS). If the child or others is or has been mentioned as known, the CRU will make further enquiries with the Central Duty Team (CDT). If the child does not reside in Kent then enquiries with the resident local authority will be required. If any concerns arise as a result of this information, a referral should be made to Kent SCS. If the child is brought into A&E outside office hours then contact will need to be made with the CRU Out of Hours Service or the relevant local authority if the child does not reside in Kent to establish whether any relevant information is held. It is possible that some local information may not be known until the next working day.

- Inform the Hospital Trust's named Safeguarding Nurse of the child's death.

- Inform the Designated Paediatrician for Unexpected Child Death or Specialist Named Nurse for Child Death at the earliest opporunity.

- Anyone who contributes to the written records must legibly sign, date, time and record her/his designation/role.

11. Consultant Paediatrician

11.1 As soon as practicable (i.e. as a response to an emergency) after arrival at a hospital, the baby or child should be examined by the Consultant Paediatrician on call. For young people over 16 years of age, the Consultant in Emergency Medicine would perform this joint examination with the Police.

11.2 In accordance with Working Together to Safeguard Children 2015 requirements, the examination and record should include:

- Any injuries, rashes and observation about the child's physical condition. The examination findings including any post mortem changes and core body temperature should be documented on a body chart.

- Site and route of any intervention in resuscitation as well as a full account of any resuscitation and any medical investigations or interventions carried out.

- A detailed and careful history of events leading up to and following the discovery of the child's collapse.

- A full medical and family history, including siblings, history of other child deaths and medical concerns.

- The Police should be informed immediately of any injuries or concerns observed and the examination should be halted so as to minimise any potential loss of evidence.

11.3 When the child is pronounced dead the Consultant on call will:

- Request and review all hospital records of the child and siblings, and arrange for them to be photocopied for the Police. Consent should be gained early from the family for the examination of their medical records.

- Inform the parents of the death and the known medical facts. This should be in the privacy of an interview room, but in the presence of the member of staff allocated to support the family. A record of what is said should be made. Refer to Senior Police Investigating Officer is any suspicions arise.

- Speak directly to the Coroner's office/officer unless the Police have already made initial contact.

- Undertake a formal examination of the child wherever possible in conjunction with the Police Senior Investigating Officer or his/her nominated officer.

- Explain to parents that the Coroner must be informed to decide if a post mortem will be necessary to try to discover the cause of death. Provide verbal and written information on the post mortem process to parents, noting also the parents' rights to be represented at the post mortem by a medical practitioner of their choice, provided they have notified the Coroner *(Coroners' Rules 1984)* and it does not unduly delay the post mortem. Explain that the post mortem may involve taking particular tissue blocks and slides to ascertain the cause of

death. Consent from those with parental responsibility for the child is required for tissue to be retained beyond the period required by the Coroner (for example, for use in research or for possible future review). *See Human Tissue Authority website for further information.* http://www.hta.gov.uk/_db/_documents/Model_communication_pathway_final.pdf

- Explain to parents that the Police will be involved and SCS records will be checked as a matter of routine and a home visit may be made.

- Contact the Police if not already done and make arrangements for the officer designated to lead the investigation to be introduced to the parents, usually whilst they are at the hospital.

- Promptly inform the Health Visitor or School Nurse and GP to enable relevant information to be shared.

- Ensure personal mementos, clothing or bedding are not removed prior to consultation with Coroner and Police. There should be clear audit trail evidencing who has taken property, when and where it can be found. Unless there are clear reasons not to, mementos such as photographs, lock of hair, or hand and footprints should be offered to the family. If the parents/carers ask for the child be dressed with certain clothing this should be discussed with the Police Senior Investigating Officer and Coroner.

- Provided clearance has been obtained from the Senior Investigation Police Officer, allow parents to see and hold their child, with discreet supervision, both in the hospital and mortuary. The parents should be allowed to spend as much time as they wish with the child and any examination of the child or further investigations should, where possible, be carried out in a manner that causes least disruption to the family.

- Provide information and support, including, for example, leaflets published by the Lullaby Trust. Support should be offered to the family, including where available, a bereavement counsellor, hospital chaplain or other faith leader. The hospital staff should offer to contact any relatives or friends to support the parents at this time.

- Consider a full skeletal survey in consultation with the Coroner's pathologist. Ideally this should be undertaken prior to the post mortem as it may significantly alter required investigations.

- The comments of parents/carers should be noted in detail. Parents/carers must not be left unsupervised with the child's body – staff should maintain a discreet presence.

12. Immediate decision making discussion and early multi-agency response meetings when responding to an unexpected death of a child

12.1 The emphasis is on supporting families and determining the cause of death. Some deaths are unexplained and will require a greater depth of investigation within the response process. Most unexpected deaths will be non-suspicious and the rapid response process with take place, which includes a multi-agency early response meeting. There may be safeguarding concerns that arise during the immediate multi-agency response process which will require a child protection (section 47) investigation to take precedence.

12.2 Following an unexpected death, an immediate decision making discussion will take place in person or by conference call involving the lead professional from Police, Specialist Children's Services (SCS), and Health. This is to review the available information and decide whether an early response meeting be convened by the Designated Doctor for Unexpected Child Death or whether a strategy discussion should be held under a Section 47 investigation which will be convened and led by SCS. The decision will be formally recorded by each multi-agency partner in eCDOP on the Immediate Response Form so that the decision making is clear and understood.

12.3 The issues that should be included in the immediate multi-agency decision making discussion/meeting are as follows:

- Confirmation death is unexpected
- eCDOP Immediate Response Form/ Form A notification to be completed
- Liaison with other agencies i.e. School, Nursery, GP etc.
- Safeguarding issues
- Scene visit
- Bereavement support for family
- Liaison with Coroner

- Liaison with Pathologist

12.4 If an Early Response Meeting (ERM) is agreed, it is led by Health and supported by the Police. The Multi-Agency Early Response Meeting must include SCS attendance as well as Early Help if the child is known to that service. Should any safeguarding concerns arise in connection with the death or in respect of surviving siblings, child protection procedures will be considered, escalated and implemented. This can be at any point in the process. When this happens, a strategy discussion will be convened by the Specialist Children's Services and they will lead this process. If there are relevant concerns that meet Section 47 during an ERM, the meeting will be suspended, the Chair will be changed and the meeting will be led by SCS. Attendance of the Designated Doctor/ Specialist Nurse at any strategy meeting is necessary. If a child protection investigation is undertaken, the Designated Doctor or Specialist Nurse will liaise closely with SCS to ensure a coordinated approach to information sharing an bereavement support for the family. The Police will be the lead agency for any criminal investigation and investigate the death on behalf of the Coroner.

12.5 Chairs of meetings should clearly explain the nature of the meeting being held so that clarity of process is established and recorded.

12.6 The cultural, religious and equality needs of the children and their families should always be taken into consideration.

12.7 In preparation for an ERM, urgent contact should be made with any other agencies who know or are involved with the child, to inform them of the child's death and to obtain information on the history of the child, the family and other members of the household and to invite the professionals to the ERM. This meeting/discussion may also include the Coroner's Officer and Consultant Paediatrician on call, and any others who are involved (for example, the Community Children's Nurse on call, other members of the Primary Health Care Team or other professionals who have been involved with the child and/or family prior to, or around the time of death). The agreed plan should include a commitment to collaborate closely and communicate as often as necessary often by telephone.

12.8 A referral to SCS should be made if concerns arise at any stage, whether or not the child and/or family are known to the statutory agencies.

12.9 The Police will begin an investigation into the unexpected death of a child on behalf of the Coroner. They will carry this out in accordance with the relevant Association of Chief Police Officer's guidance.

12.10 In certain circumstances a Serious Incident Requiring Investigation (SIRI) will be raised. If the death occurred in a hospital this should be internally reported in accordance with the Hospital Trust's Serious Incidents Policy. If the death occurred outside a hospital the Specialist Nurse will consider if a SIRI is to be notified. The Designated Doctor for Unexpected Child Death will contact and explain to the family the child death review process unless any other professional has agreed to undertake this task e.g. Police in cases of road traffic accidents. It is the responsibility of the Specialist Nurse for Child Deaths to follow up and ensure that this has taken place and on occasion will discharge this responsibility by contacting the family. Families may have difficulty in understanding the process so all professional should take the opporunity to reiterate the process to them when meeting/talking with families. When told about the process families should be asked if they wish to be informed of the outcome of the review.

12.11 When a child dies away from their normal place of residence, a joint decision will need to be made between the team in the LSCB area in which the death occurred and the team in the child's normal area of residence as to which one will lead the investigation and in which LSCB area the case review meeting should be held. Good communication between teams is essential. This information can then be analysed and decisions can be made about what actions should be taken by whom to prevent similar deaths in the future.

12.12 Where the death occurred in a custodial setting, appropriate liaison with the investigator from the Prisons and Probation Ombudsman should occur. If the death occurred in Police custody or after Police contact, liaison with the Independent Police Complaints Commission should take place.

12.13 If a young person is under the supervision of a YOT, the YOT should also be approached.

12.14 The same processed apply to a child who is admitted to a hospital ward and subsequently dies unexpectedly in hospital.

12.15 If the child who has died is subject to a child protection plan then a Section 47 investigation will take place irrespective of the circumstances of the death (e.g. road traffics collision).

13. Visit to place of collapse or death

13.1 The Police may attend and secure of the death immediately and before any discussion with the parents. The Police should ensure that the immediate scene of the child's collapse and/or death is left understand until the scene is closed. This must be balanced with the practicalities of keeping the scene open and the needs of the family. A Detective Inspector nay close the scene if it has been examined and is declared non suspicious, and the likelihood of a joint visit is not imminent. In these cases a discussion between the Police and Designated Doctor or deputy should take place. The Detective Inspector will record the rational for closing the scene. Consideration should be given to video recording the scene other graphical representation, especially is a joint visit with health may be delayed.

13.2 When a child dies unexpectedly the Senior Investigating Police Officer and Senior Healthcare Professional should make a decision about whether a joint visit to the place where the child died should be undertaken. This should almost always take place for infants who die unexpectedly. As well as deciding if the visit should take place, it should be decided how soon (within 24-48 hours) and who should attend. It is likely to be a Senior Investigating Police Officer and a Healthcare Professional experienced in responding to unexpected child deaths (this will most commonly be a Paediatrician or Specialist Nurse) who will visit, talk with the parents and evaluate the environment where the child died. Usually they should make this visit together, but may visit separately and then confer.

13.3 The Coroner's office should be informed of the visit and further information provided to parents about Coroner's procedures, as necessary.

13.4 It must be explained to parents that the joint visit is a routine part of the investigation to help identify and understand the factors that may have contributed to the death and to contribute information for the Pathologist, prior to the post mortem examination. It is also designed to provide sensitive support for the family in a familiar environment.

13.5 A record of the visit should be made in accordance with single agencies procedures.

13.6 After this visit, the Senior Investigating Police Officer and/or visiting Healthcare Professional, should review whether there is any additional information that could raise concerns about the possibility of abuse or neglect having contributed

to the child's death. If any concerns about the possibility of abuse or neglect have been newly identified, SCS should be informed and will call a formal strategy meeting under the child protection procedures. Section 47 enquiries should be initiated on any surviving siblings and the Police should institute a 'crime scene investigation' if not already initiated.

14. Coroner

14.1 If a doctor is not able to issues a medical certificate of the cause of the death, the lead professional or investigator must report the child's death to the Coroner in accordance with a protocol agreed with the local coronial service. The Coroner must investigate violent or unnatural death, or death of no known cause, and all deaths where a person is in custody at the time of death. The Coroner will then have jurisdiction over the child's body at all time. Unless the death is natural a public inquest will be held.

14.2 The Coroner will order a post mortem examination to be carried out as soon as possible by the most appropriate Pathologist available (this may be a Paediatric Pathologist, Forensic Pathologist or both) who will perform the examination according to the guidelines and protocols laid down by the Royal College of Pathologists. The designated Paediatrician will collate and share information about the circumstances of the child's death with the Pathologist in order to inform this process.

14.3 If the death is unnatural or the cause of death cannot be confirmed. The coroner will hold an inquest. Professionals and organisations who are involved in the child death review process must cooperate with the Coroner and provide her/him with a joint report about the circumstances of the child's death. This report should include a review of all medical, local authority social care and educational records on the child. The report should be delivered to the Coroner within 28 days of the death unless crucial information is not yet available.

15. Case discussion following the preliminary results of the post mortem examination becoming available

15.1 Although the results of the post mortem belong to the Coroner, it should be possible for the Paediatrician, Pathologist, and the lead Police Investigator to discuss the findings as soon as possible, and the Coroner should be informed

immediately of the initial results. If these results suggest evidence of abuse or neglect as a possible cause of death the Paediatrician should inform the Police and SCS immediately. He or she should also inform the LSCB Chair so that they can consider whether the criteria are met for initiating an SCR.

15.2 In all cases, the Designated Paediatrician for Unexpected Child Deaths of the Paediatrician acting as his/her deputy should convene a further multi-agency discussion (usually on the telephone) shortly after the initial post mortem results are available. This discussion should take place 5 to 7 days after the death and should involve the Pathologist, police, Children's Social Services, and the Paediatrician, plus any other relevant professionals from Health and Education. This is to review any further information that has come to light, how to share this information with parents and to raise additional concerns about safeguarding issues. Any additional information should be included in the report to the Coroner not in 14.3.

16. Late Case Discussion following the final results of the post mortem examination becoming available

16.1 A late case discussion meeting should be held as soon as the final post mortem result is available. The type of professionals involved in this meeting depends on the age of the child and the circumstances of the death.

16.2 The designated Paediatrician with responsibility for unexpected deaths in childhood (or agreed deputy) should convene and Chair this meeting. the main purpose of the case discussion is to share information to identify the cause of death and/or those factors that may have contributed to the death, and then to plan future care for the family. This process will enable any learning to be identified and will also inform the inquest.

16.3 There should be an explicit discussion of the possibility of abuse or neglect either causing or contributing to the death. If no evidence is identified to suggest maltreatment, this should be documented as part of the minutes of the meeting.

16.4 At the late case discussion, it should be agreed how and by whom detailed information about the cause of the child's death will be shared with the parents. In addition it will be agreed who will offer the parents ongoing support. The results of the post mortem examination, with the consent of the Coroner, should be discussed with the parents at the earliest opportunity, except in those cases

where abuse or neglect is suspected and/or the police are conducting a criminal investigation. In the latter situation, the Paediatrician should discuss with SCS and the police what information should be shared with the parents and when.

16.5 An agreed record of the late discussion meeting and all reports should be sent to the Coroner, to take into consideration in the conduct of the inquest and, in the cause of death, notified to the Register of Births and Deaths. The record of the late case discussion should also be made available to Kent's CDOP.

17. Involvement of parents and family members (for all child deaths)

17.1 It is vitally important that professionals inform and involve parents and other family members in the rapid response processes. Parents and family members should also be informed that their child's death will be reviewed, and will often have significant information and questions to contribute to the review process. Parents and family members should be assured that the objective of the child death review process is to learn lessons in order to improve the health, safety and wellbeing of children and contribution to the prevention of further such child.

17.2 The Designated Doctor for child deaths will contact and explain to the family the child death review process unless any other professionals has agreed to undertake this task e.g. Police in cases of road traffic collisions. It is the responsibility of the Specialist Nurse for Child Deaths to follow up and ensure that this has taken place and on occasions will discharge that responsibility by carrying out a personal visit to the family. Families may difficulty in understanding the process so all professionals should take this opporunity when meeting/talking with families to reiterate the process to them. When the family are told about the process they should be asked if they wish to be informed of the outcome of the review.

17.3 The responsibility for informing the family about the child death review process must be decided at the early case discussion or Section 47 strategy meeting.

17.4 It is not appropriate for parents to attend the CDOP meetings as this is a meeting for professionals to discuss not only the individual case but also wider public health issues. Parents should however be encouraged to contribute any comments or questions they might have to the review of their child's death. Parents should be informed that information gathered will be stored securely and only anonymised data will be collated at a regional or national level. Parents

should also be made aware that the CDOP will make recommendation and report on the lesion learned to the KSCB.

17.5 A meeting with parents and/or GP by the Designated Doctor and/or Specialist Nurse, to explain and discuss the post mortem findings, should take place once the information is available. This will precede or follow the late case discussion.

17.6 The KSCB produces an annual report which is a public document, but it will not contain any personal information that could identify an individual child or their family.

18. Expected Child Deaths

18.1 Children dying at home or in a hospice or other setting who have been undergoing end of life care will not usually be considered to have died unexpectedly, and the unexpected death pathway to such deaths is rarely required and therefore they should not usually be moved to a hospital A&E department. Parents whose children die at home in such circumstances may wish their child to remain at home, or to be taken to a hospice cool room.

18.2 When a child's death is not regarded as 'unexpected', the team looking after the child may choose to organise a discussion of the case, since it is likely that important lessons can be learn that might improve the care of other children. Such a discussion may be conducted using the same format as a professional's meeting. Information from these discussions would provide the CDOP with evidence of good local practice and allow a wider engagement of professionals with the child death review process. The Designated Doctor for child death should liaise with the Child's Paediatrician to encourage this practice.

18.3 The child's Paediatrician should advise the family of the child death review process and supply them with a copy of the DCSF leaflet, unless any other professional has agreed to undertake this task e.g. Community Nurse. It is the responsibility of the Specialist Nurse for Child Deaths to follow up and ensure that this has taken place and on occasions will discharge that responsibility by contacting the family. Families may have difficulty in understanding the process so all professionals should take this opporunity when meeting/talking with families to reiterate the process to them. When the family is told about the process they should be asked if they wish to be informed of the outcome of the review.

19. Notification and Information Gathering of Child Death to KSCB

19.1 Any professional who is made aware of a child's death should electronically complete a Form A as soon as practicable and, at least within **24 hours**, on the Kent eCDOP link at: https://www.qes-online.com/Kent/eCDOP/Live/Public

19.2 Each multi-agency partner will be required to submit information (Form B) regarding their involvement with the child and family as part of the statutory guidance outlined in Chapter 5 of the Working Together to Safeguard Children 2015. This will be requested electronically via the Kent eCDOP database.

19.3 The Coroner's office should be informed of the visit and further information provided to parents about Coroner's procedures, as necessary.

19.4 It must be explained to parents that the joint visit is a routine part of the investigation to help identify and understand the factors that may have contributed to the death and to contribute information for the Pathologist, prior to the post mortem examination. It is also designed to provide sensitive support for the family in a familiar environment.

19.5 A record of the visit should be made in accordance with single agencies procedures.

20. Record Keeping

20.1 All actions taken regarding the investigation of the death of a child must be recorded on the child's file or in accordance with the agency's policy. Those actions may include:

- Examination of scene
- Examination of the child
- Record of items seized
- Record of samples taken
- History of events including interviews with parents and other significant witnessed
- Result of agency checks
- Liaison with other agencies

- Record of support provided to the family including any referrals to other agencies

20.2 All meetings held in accordance with the rapid response process or the Section 47 investigation must be minuted and formally shared with the appropriate agencies including the Coroner. These minutes will form part of the eCDOP database and be available to the CDOP members as part of the Child Death Review Process (see Appendix C for Agenda).

20.3 Records of child death investigations and reviews should be retained in accordance with agencies own policies and procedures.

20.4 The CDOP database records will retain case information for 10 years after the death.