surrey safeguarding CHILDREN BOARD

NHS
Surrey Wide CCG Safeguarding Children Team

Child Death Review Protocol

Timeline

Child dies 0 – 18yrs in a healthcare setting (all deaths including expected & unexpected deaths)

In cases of unexpected death, these children should be taken to ED unless clearly inappropriate

- In hospital: SCBU / A&E / Ward / ITU/Theatre
- At home
- In community establishment: school / hospice/ care-home/WIC/MIU/other venue
- Road Traffic Incident or other accident
- Other: Including murder / suicide

Health professional present at time of death:

- Lead Clinician to inform the **Coroner** in all cases of unexpected death: **Tel: 101 (ask for the on call Coroner's officer).**
- Lead clinician to Inform the **Police** in all cases of unexpected death: **Tel: 101**
- Post death checklist completed.
- Lead Clinician to inform **Child Death Coordinator : Tel: 01372 – 833319**
- Completes **Child Death Review Notification Form A** and forwards to Child Death Coordinator via email:**cdop@surreycc.gcsx.gov.uk**
- Completes Child Death SUI if the case meets the SUI criteria and follows Trust Procedure.

If child protection concerns are present, health professional to follow Surrey Safeguarding Children Board & Local trust Child Protection procedures

1 Working Day

Child Death Coordinator

- Cascades information to relevant members of Child Death Review Team including **Child Death Review Doctor, Paul Wright and Specialist Nurse, Noreen Gurner**
- Details of death are entered on Child Death Review DataBase

Child Death Review Doctor and / or Specialist Nurse

Decide on the child death review response required & make appropriate arrangements

Case meets unexpected death criteria and requires **an Immediate Rapid Response.**
Home / site visit arranged

Case meets unexpected death criteria for a **Planned Rapid Response.**

Visit arranged with parents / carer

Case does NOT meet Unexpected Death definition

Submitted for review at overview panel

Local Child Death Review Arrangements

- Relevant NHS service providers are informed that the CDR process has been triggered
- NHS Providers check records and identify staff involved
- NHS staff may be requested by invitation to attend the initial post death planning meeting

3 working days – 8 weeks & 1st Post Mortem report

Initial Rapid Response Meeting / or Initial Discussion

- Initial information is shared & case discussed with key professionals including NHS staff
- Family support and / or other plans for family / surviving children / staff are agreed, including NHS follow up actions
- Agency Report **Form B** completed with relevant data

Case does not require further investigation

Submitted for review at overview panel

Final PM

Post Death Review Meeting

- Information is shared and considered by professional network
- Further planning undertaken if necessary
- Further meetings arranged if appropriate
- Agency Report **Form B** updated with additional relevant data

3-12 months

Overview Panel

- Case reviewed.
- Data set completed for initial local analysis
- Reported to Surrey Safeguarding Children Board
- Lessons identified, recommendations circulated as per agreed route

Data submitted for regional analysis

All NHS staff to engage and participate

Child Death Review Team Only

June 2016