

Timeline

Child Death Review Protocol / Joint Agency Response

Child death: <18 years old
In all cases of unexpected death, these children should be taken to ED unless clearly inappropriate

- Health professional present at time of death:**
1. ASAP Lead Clinician to inform the **Police: Tel: 101**, the **Coroner** in all cases of unexpected death: **Tel: 01483-637300 (office hours), Out of hours Tel 101 and ask for the on-call Coroner's officer** and **Social Care via MASH: Tel: 0300-470 9100 (office hours), Out of hours contact emergency duty team Tel: 01483 - 517898**
 2. Initial information-sharing and planning discussion held between Lead Clinician, Police and Social Care (to include information from the Ambulance crew ; Discussion to be documented in Child's records)
 3. If Safeguarding concerns are identified, an initial multi-agency strategy discussion/meeting to be convened by Children's Social Care.
 4. Police to arrange joint home/scene visit with Specialist Nurse for Child Death Reviews: **Tel: 07824-350491**
 5. Inform **Child Death Review Coordinator Tel: 01372-833319** asap
 6. Complete **Child Death Review Notification Form A**: email to CDOP Co-ordinator within 24 hours. Email: cdop@surreycc.gcsx.gov.uk
 7. Complete Child Death SI if the case meets the SI criteria and follow Hospital Policy
 8. Notify GP and Post death checklist completed.
- If safeguarding concerns are identified, Health professional to follow Surrey Safeguarding Children Board procedures and Hospital Safeguarding Children Procedures.**

1 Working Day

Child Death Coordinator
 Cascades information to relevant members of Child Death Review Team including **Designated Doctor and Specialist Nurse for Child Death reviews**

- Details of death are entered on Child Death Review Database
- Notification of child death and Form B for completion circulated to appropriate Professionals

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 Response**.
Home / site visit arranged with Police

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

Case does NOT meet Unexpected Death definition
Submitted for review at overview panel

Local Child Death Review Arrangements

- Relevant providers and professionals are informed that the CDR process has been triggered
- Providers check records and identify staff involved
- Relevant professionals will be requested by invitation to attend the post death review meeting

3 working days – 3 months & 1st Post Mortem Report

Post Child Death Review Meeting

- Information is shared & case discussed with key professionals
- Family support and/or other plans for family/surviving children / staff are agreed.
- Consideration of need for referral for SCR discussed
- Any missing information and any further investigation required is identified

Case does not require further investigation
Submitted for review at overview panel

Final Post Mortem Report

Final Post Death Review Discussion/ 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

