

CHILD DEATH

HOSPITAL/
COMMUNITY

SUDIC

EXPECTED DEATH

Detailed paediatric history / examination and investigations; Complete Pan Cheshire SUDIC documentation; (If suspicious circumstances, joint interview of carers by Health / Police and / or CSC advisable); cf. Immediate Decisions Proforma;

Detailed paediatric history/examination/investigations and documentation; cf. Immediate Decisions Proforma;

2 – 4 hours

Immediate discussion (by telephone or in person) with Police/CSC regarding any suspicious circumstances/safeguarding concerns and proceed as appropriate. Attend to needs of other children and family members; Decide on need for home visit (usually within 24 hours), need for Child Safeguarding Practise Review (CSPR).

Notify relevant professionals including DDCCD/CDOP nurse/CDOP Administrator using Form A; Discuss with Coroner if applicable;

2 – 4 hours

If not already notified, inform Police/Coroner/CSC/DDCCD/CDOP Nurse/CDOP Administrator/GP/HV/ Other Health professionals involved including other health organisations using Form A

Discuss PM with parents/carers; Arrange Bereavement support; Inform re Child Death Review; Give Information leaflet;

Inform parents/carer regarding Coroner's post mortem and child death review process by CDOP; Give info. leaflet; Arrange Bereavement support;

Detailed Medical Report and Form B to be completed by Cons. Paed. and sent to relevant professionals incl. DDCCD, CDOP nurse, CDOP Administrator;

24 – 72 hours

1- 5 working days

Initial RRM/JAR meeting for information sharing/planning and consider need for safeguarding strategy (S47) meeting, chaired by Police and minutes recorded; Decide time/need for CSPR/interim multidisciplinary meeting

Local Child Death Review by Health team to identify gaps and lessons to be learnt. Involve partner agencies as relevant; Relevant minutes to be sent to DDCCD/CDOP nurse/ CDOP Administrator;

1 – 6 months

Detailed medical report and Form B to be completed by Consultant Paediatrician and sent to Coroner/DDCCD/CDOP nurse/CDOP Administrator;

6 – 12 weeks

Local Child Death Review by Health Team (with Coroner's Preliminary PM results, if available); Further Police and CSC investigation; Consider need for CSPR; Ongoing support to parents; Preliminary PM report and proceedings to be shared with parents only if agreed with coroner and if no criminal proceeding underway;

Consultant Paediatrician to discuss results of PM findings / investigation results / care of siblings with parents.

3 - 12 months

Final Multi-disciplinary Child Death Review meeting convened by DDCCD/Consultant Paediatrician with final PM report to share cause of death and plan future care for family. Consider need for CSPR.