NHS Shropshire Telford and Wrekin Child Death Service Policy

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Version 2	10.04.25	Minor amendment

The formally approved version of this document is that held on the NHS Shropshire, Telford and Wrekin Integrated Care Board (ICB)

Website: https://www.shropshiretelfordandwrekin.nhs.uk/

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1 Introduction

Background

1. 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. Families experiencing such a tragedy should be met with empathy and compassion. They need clear and sensitive communication. They also need to understand what happened to their child and know that people will learn from what happened. 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 future child deaths.

2. Under the Children Act 2004, the child death review partners (Local Authorities and Integrated Care Boards (ICB's)) must set up child death review arrangements to review all deaths of children normally resident in the local area and, if they consider it appropriate, for any non-resident child who has died in their area.

3. Child death review partners should make arrangements for child death reviews as they see fit in order to meet the statutory requirements under the Children Act 2004. This will enable effective thematic learning from reviews, i.e., a local review may be able to identify specific learning but trends analysis at a national level may identify modifiable factors that could be altered to prevent future deaths.

4. In addition, child death review partners:

    - must, at such times as they consider appropriate, prepare, and publish reports on:
    - what they have done as a result of the child death review arrangements in their area,
    - how effective the arrangements have been in practice.

This policy is intended to be used by NHS Shropshire Telford and Wrekin ICB who lead the Child Death Service to ensure the Shropshire Telford and Wrekin Child Death Overview Panel (STW CDOP) meet the statutory requirement to make arrangements to review all child deaths in their area.

This policy sets out arrangements for undertaking child death reviews in Shropshire Telford and Wrekin (STW). It should be read in conjunction with the following:

- Child Death Review Statutory and Operational Guidance (England)
- Children Act 1989

- Children Act 2004
- New guidelines for the investigation of sudden unexpected death in infancy launched
- Working together to safeguard children - GOV.UK
- STW Child Death Service Standard Operating Procedure
- STW Child Death Service Pathway for SUDIC Scene/Home Visits
- STW Child Death Service Bereavement Support for Families
- STW Child Mortality Workshop

2 Scope and Purpose of Policy

This policy aims to set out the processes to be followed when responding to, investigating, and reviewing the death of any child, from any cause. It runs from the moment of a child's death to the completion of the review by the Shropshire Telford and Wrekin Child Death Overview Panel (STW CDOP). This includes the immediate actions that should be taken after a child's death; the local review of a child's death by those who interacted with the child during life, and the investigation after the child's death; through to the final stage of the child death review process which is the statutory review arranged by STW CDOP.

This policy clarifies processes and sets out principles for how the STW CDOP involved in the child death review process should work together with other partners to meet the two main objectives set out below:

- to improve the experience of bereaved families, as well as professionals, after the death of a child; and to ensure that information from the child death review process is systematically captured to enable local learning and,
- through the National Child Mortality Database (NCMD), to identify learning at the national level, and inform changes in policy and practice.

All other professionals who care for children, or who have a role in the child death review process, should read and follow this policy so that they can respond to each child death appropriately. This includes people working within:

- health services (across all sectors: acute, maternity, mental health, primary care and community)
- children's social care services
- police, including British Transport Police, and Royal Military Police
- coronial services
- education
- public health

3 Table of Abbreviations

AHPs	Allied Health Professionals
CDOP	Child Death Overview Panel
CDR	Child Death Review
CDRM	Child Death Review Meeting
DoLS	Deprivation of Liberty Safeguards
e-CDOP	Electronic Child Death Overview Panel
ED	Emergency Department
GP	General Practitioner
HSIB	Healthcare Safety Investigation Branch
ICB	Integrated Care Board
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
NHS STW ICB	NHS Shropshire Telford and Wrekin ICB
PICU	Paediatric Intensive Care Unit
PMRT	Perinatal Mortality Review Tool
SIDS	Sudden Infant Death Syndrome
STW CDOP	Shropshire Telford and Wrekin Child Death Overview Panel
STW	Shropshire Telford and Wrekin
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

4 Terminology

Terminology around child death review can be confusing, and local usage varies. The term “child death review process” refers to the entirety of the process described in this guidance. Professionals have a duty to support and engage with this process. Throughout this document, the following definitions are used:

Child

The child death review process covers children; a child is defined in the Act as a person under 18 years of age. A child death review must be carried out for all children regardless of the cause of death. This includes the death of any live-born baby where a death certificate has been issued. If 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
- Late 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.

Child Death Review Partners

“Child death review partners” (“CDR partners”) are defined in section 16Q of the Children Act 2004 and means, in relation to a local authority area in England, the local authority and any ICB for an area any part of which falls within the local authority area. CDR partners for two or more local authority areas in England may agree that their areas should be treated as a single area. The responsibilities of CDR partners regarding the child death review process are set out in sections 16M-Q of the Children Act 2004. CDR partners must also have regard to this guidance and Chapter 6 of Working Together. (Sections 16M-Q of the Children Act 2004 have been inserted by sections 24-28 of the Children and Social Work Act 2017.)

Child Death Review Meeting

The stage of the review process that precedes the independent multi-agency panel arranged by CDR partners. This meeting should be a multi-professional meeting where all matters relating to an individual child’s death are discussed. The Child Death Review Meeting (CDRM) should be attended by professionals who were directly involved in the care of the child during his or her life, and any professionals involved in the investigation into his or her death. The nature of this meeting will vary according to the circumstances of the child’s death and the practitioners involved and should not be limited to medical staff. For example, the CDRM could take the form of a final case discussion following a Joint Agency

Response, a perinatal mortality review group meeting in the case of a baby who dies up to 28 days old or in a neonatal unit having never left hospital, or a hospital-based mortality meeting following the death of a child on a paediatric intensive care unit. These meetings could, as a way of standardising practice nationally, be known as a Child Death Review Meeting. Outputs from CDRMs (draft Analysis Forms) should be shared with the group set up by CDR partners to conduct reviews, described in this guidance as a Child Death Overview Panel.

Child Death Overview Panel

A multi-agency panel set up by CDR partners to review the deaths of all children normally resident in their area, and, if appropriate and agreed between CDR partners, the deaths in their area of non-resident children, in order to learn lessons and share any findings for the prevention of future deaths. This stage of the review process is described as a Child Death Overview Panel (CDOP) throughout this guidance. The CDOP should be informed by a standardised report from the CDRM, and ensures independent, multi-agency scrutiny by senior professionals with no named responsibility for the child's care during life. In practice, CDOPs will conduct the independent multi-agency scrutiny on behalf of the local CDR partners responsible for ensuring that the review of deaths of all children normally resident in that area takes place.

Forms: Notification, Reporting, Analysis

Three standard forms should be used in the child death review process:

- Notification Form (previously "Form A") for initial notification of a death to CDR partners. Reporting Form (previously "Form B") for gathering information from agencies or professionals who have information relevant to the case.
- Reporting forms should be completed by the relevant responsible officer and shared with the relevant CDOP. For certain child deaths, a supplementary Reporting Form should also be completed as required; and
- Analysis Form (previously "Form C") initially drafted at the CDRM and completed at CDOP for evaluating information and identifying lessons to be learned. The Analysis Form is the final output of the child death review process. This information is shared with the National Child Mortality Database (NCMD) who collect and analyse data for all children who die in England before their 18th birthday. The purpose of the NCMD is to save and improve children's lives in the future by learning lessons regarding child deaths and identify preventable factors. The NCMD uses this data to inform policies and actions to reduce child death.

Joint Agency Response

A coordinated multi-agency response (on-call health professional, police Senior Investigating Officer (SIO), duty social worker), should be triggered if a child's death:

- is or could be due to external causes.
- is sudden and there is no immediately apparent cause (including SUDI/C).
- occurs in custody, or where the child was detained under the Mental Health Act.
- where the initial circumstances raise any suspicions that the death may not have been natural.
- or in the case of a stillbirth where no healthcare professional was in attendance.

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. This person will usually be a healthcare professional.

Lead health professional

When a Joint Agency Response is triggered, 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.

Medical Certificate of Cause of Death (MCCD)

An official certificate that enables the deceased’s family to register the death, provides a permanent legal record of the fact of death, and enables the family to arrange the funeral. It provides information on the relative contributions of different diseases to mortality.

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 (doctor) on the MCCD; that timely and appropriate referral to the coroner has occurred where appropriate; engage with the bereaved to understand any concerns; and to ensure that possible clinical governance concerns have been highlighted.

National Child Mortality Database

The National Child Mortality Database (NCMD) is a repository of data relating to all children’s deaths in England. It enables more detailed analysis and interpretation of all data arising from the child death review process, to ensure that lessons are learned following a child’s death, that learning is widely shared, and that actions are taken, locally and nationally, to reduce child mortality. The Child Death Service submit all completed forms associated with the child death review process and the analysis of information about the deaths reviewed (including but not limited to the Notification Form, the Reporting Form, Supplementary Reporting Forms and the Analysis Form) to the National Child Mortality Database.

Electronic Child Death Overview Panel (e-CDOP)

This is an electronic system on which all child deaths are entered to allow for data collection and storage. All notification, reporting and analysis forms are completed directly on e-CDOP. This data then links into the NCMD database to allow oversight and review of all data collected locally and nationally.

NHS Serious Incident

Serious Incidents in health care are adverse events where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. The NHS Serious Incident Framework describes the process and procedures to help ensure Serious Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again. The Serious Incident Investigation may take the form of a Root Cause Analysis (RCA) or other approved methodology.

Perinatal Mortality Review Tool (PMRT)

The PMRT is a web-based tool that is designed to support a standardised review of the care of perinatal deaths in neonatal units from 22+0 weeks gestation to 28 days after birth. It is also available to support the review of post-neonatal deaths where the baby dies in a neonatal unit after 28 days but has never left hospital following birth. At clinicians’ discretion it might also be used for the review of deaths of live-born infants.

5 Roles and Responsibilities

This section explains the roles and responsibilities of the NHS Shropshire Telford and Wrekin Integrated Care Board (NHS STW ICB) and staff with regard to this Policy.

The Governing Body and Committees

- To ensure that NHS STW ICB meets its statutory responsibilities as child death review partners to make arrangements to carry out child death reviews. These arrangements have informed the establishment of the Shropshire Telford and Wrekin Child Death Overview Panel (STW CDOP) to review the deaths of all children normally resident in the relevant local authority area, and if they consider it appropriate, the deaths in that area of non-resident children.
- A Child Death Review Business Group has also been established to provide oversight and assurance to partners of the local CDR processes.

Policy Owners / Authors

- The Designated Nurse for Safeguarding Children and Senior Responsible Officer for Child Death and the Specialist Nurse for Child Death provide professional leadership and management on behalf of NHS STW ICB on all aspects of its contribution to child death reviews ensuring a co-ordinated and integrated contribution across the health economy.

- It is the responsibility of the Designated Nurse for Safeguarding Children and Senior Responsible Officer for Child Death and the Specialist Nurse for Child Death to ensure the policy is kept up-to-date, valid and reflects the latest statutory framework, national guidance, and best practice.

Designated Nurse for Safeguarding Children and Senior Responsible Officer for Child Death

The Designated Nurse for Safeguarding Children and Senior Responsible Officer for Child Death's key responsibility will be on behalf of NHS STW ICB to lead, implement, co-ordinate and manage all child death reviews in accordance with government legislation and local safeguarding partnership policies with the following responsibilities:

- Lead and work as a member of the Child Death Service who are responsible for the child death review process.

- Provide support to the Specialist Nurse for Child Death in the role as lead health professional.

- Should be notified of each child death and sent relevant information.

- In conjunction with the Specialist Nurse for Child Death, advise on the appropriate response to a child death in an adult ICU and attend CDRMs.
- Advise the STW CDOP regarding necessary experts required to inform ordinary and themed panels.
- Advise the STW CDOP in the identification of modifiable contributory factors.
- In conjunction with the Specialist Nurse for Child Death, liaise as appropriate with regional clinical networks to ensure that themed panels are properly coordinated.
- Assist the STW CDOP in the development and implementation of appropriate preventative strategies to reduce child deaths.
- Produce the annual report summarising the activities of the CDOP.

Specialist Nurse for Child Death

The Specialist Nurse's key responsibility in conjunction with the Designated Nurse will be on behalf of the NHS STW ICB to implement, co-ordinate and manage all child death reviews in accordance with government legislation and local safeguarding partnership policies with the following responsibilities:

- Will be responsible for triaging all child deaths - maintaining oversight and progression of all child deaths.
- Will undertake the role of lead health professional and coordinate the health response to a child death that meets the criteria for a joint agency response.
- Will take responsibility for ensuring that all health responses are implemented.
- Will be responsible for ongoing liaison with the police and other agencies.
- Be a reliable and readily accessible point of contact for the family after the death.
- Help co-ordinate meetings between the family and professionals as required.
- Represent the 'voice' of the parents at professional meetings, ensure that their questions are effectively addressed, and to provide feedback to the family afterwards.
- Will ensure outputs from CDRMs (draft Analysis Forms) are shared with the STW CDOP panel.
- Carry out a follow up visit/visits to the family to support and feedback answers to their questions.

- Support and signpost the family and surviving siblings to other professionals for bereavement support.

Designated Doctor for Child Death

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.
The responsibilities of the Designated Doctor for Child Death role include but are not exclusive to the following:

- oversight of the child death review process in accordance with legislation and work with partner agencies to achieve this
- advise on the appropriate response to a death in an adult ICU
- advise CDOP regarding necessary experts required to inform ordinary and themed panels
- advise CDOP in the identification of modifiable contributory factors
- liaise, as appropriate, with regional clinical networks to ensure that themed panels are properly co-ordinated
- assist CDOP in the development and implementation of appropriate preventative strategies to reduce the child deaths
- prepare an annual report with the Chair summarising the activities of CDOP.

Child Death Team Administrator

The responsibilities of the administrator role include but are not exclusive to the following:

- Ensure the effective management of the notification, data collection and storage systems.
- Ensure the effective running of ordinary and themed panel meetings.
- Allocate a unique e-CDOP identifier number to a deceased child following receipt of the Notification Form.
- Seek to establish which agencies have been involved with the child or family either prior to or at the time of death and gain receipt of relevant information via the Reporting Form.
- Arrange the JAR meeting and CDRM in cases that meet the criteria for a JAR and in expected deaths.

All Staff

- This policy is applicable to all NHS STW ICB staff (permanent and temporary) who care for children, or who have a role in the child death review process. All staff should read and follow this guidance so that they can respond to each child death appropriately.

- All NHS STW ICB staff have a responsibility to notify STW CDOP of the death of any child of which they become aware, to share information for the purposes of reviewing the child's death, and to participate in local review arrangements when they have been involved with the child or family.

6 Procedure following receipt of a Child Death Notification

The following describes the whole child death review process.
The flow chart below (fig. 1) sets out the main stages of the child death review process.

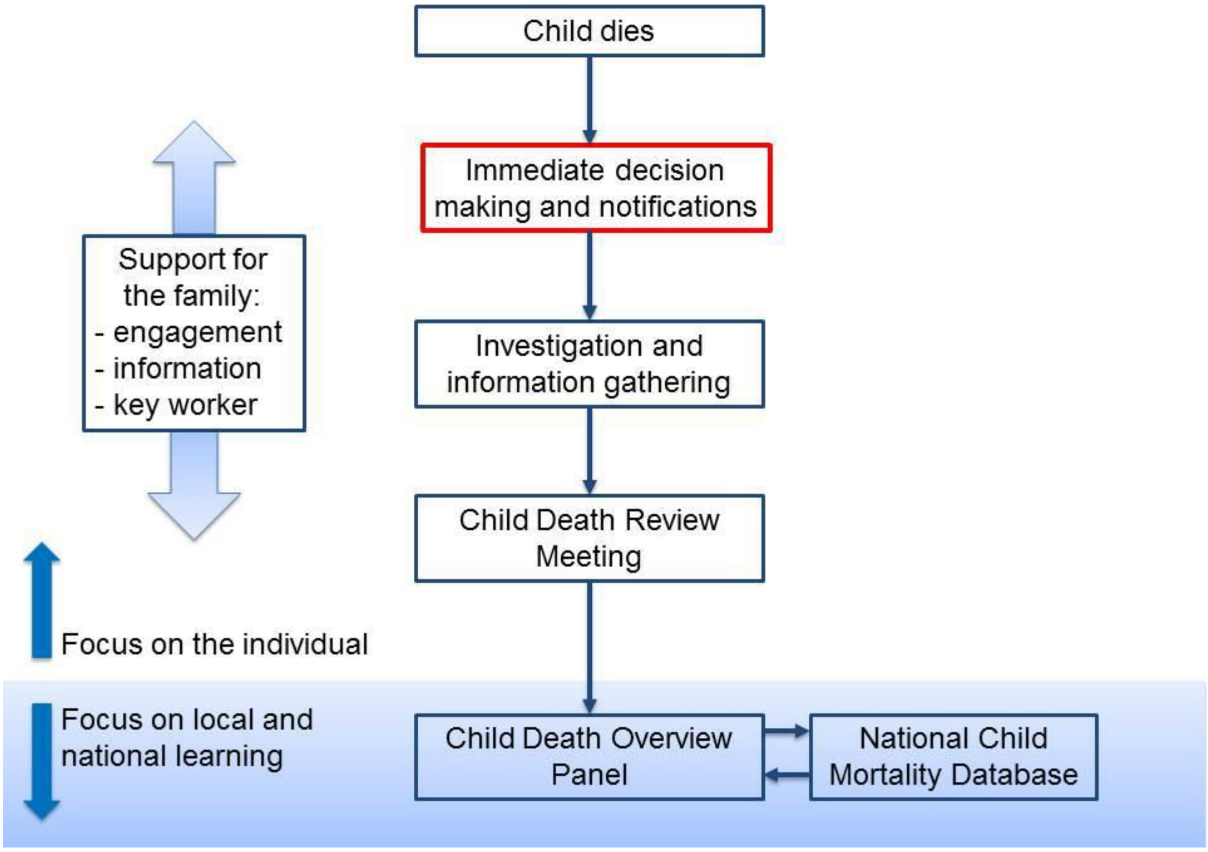


Figure 1 Chart illustrating the full process of a child death review. This includes both the statutory responsibilities of CDR partners to review the deaths of children at an independent multi-agency panel (described here, and throughout, as review at CDOP or equivalent), and the processes that precede or follow this independent review. Further explanation is below.
(Flow chart taken from Child Death Review: Statutory and Operational Guidance (England) (2018)).

1. This following describes the immediate decisions that professionals should make in the hours following the death of any child. This includes deciding whether a MCCD can be issued, or whether a referral to the coroner is necessary.

2. The cause of death for most children who die is understood and the doctor who has attended the child at the end of their life (the “attending doctor”) will be able to issue a MCCD and the death will be able to be registered. Consideration should be given to how best to support the family, and to what information needs to be gathered to inform the CDRM.

3. However, if the death is from external causes, the circumstances are unclear, or safeguarding concerns or problems with care or service delivery are suspected, further investigations will be needed, to understand how the child has died.

4. To respond appropriately to each death, senior professionals attending the child at the end of his/her life should consult with each other in order to determine the correct course of action. This is relevant to all child deaths, wherever they occur.

5. Following a child's death, immediate actions need to be taken such as notification of death and deciding whether other investigations are warranted. In practice, the majority of such discussions will happen in a clinical setting but may require input from other agencies in certain cases.

6. As soon as possible after the death, senior professionals with responsibility for the child at the end of his/her life should:

   - Identify the available facts about the circumstances of the child's death.

   - Determine whether the death meets the criteria for a Joint Agency Response (JAR), and if so, contact the on-call representatives for the police, CDR team and children's social care to initiate the joint agency response.

   - Determine whether an MCCD can be issued, if not, consider whether the death should be referred to the coroner.

   - Determine whether an issue relating to health care or service delivery has occurred or is suspected and therefore whether the death should be referred to the coroner and/or a patient safety incident response framework (PSIRF) investigation.

   - Identify who will act as Key Worker for the family and how they will be supported.

   - Determine whether any actions are necessary to ensure the health and safety of others, including family or community members, healthcare patients and staff.

7. Notification of the child death should be made via westmercia eCDOP by completion of a notification form.

8. If a child who is usually resident in the STW area dies outside of STW CDOP local authority area, it is the responsibility of the Specialist Nurse for Child Death to contact the CDOP representative for that area to arrange a meeting to discuss the case and to decide which local authority area will continue the child death process. This is to ensure reporting forms are completed comprehensively ensuring all information pertaining to the child's death and the circumstances leading up to the event are available to CDOP. This will also support professionals in providing bereavement support and signposting to the child's family.

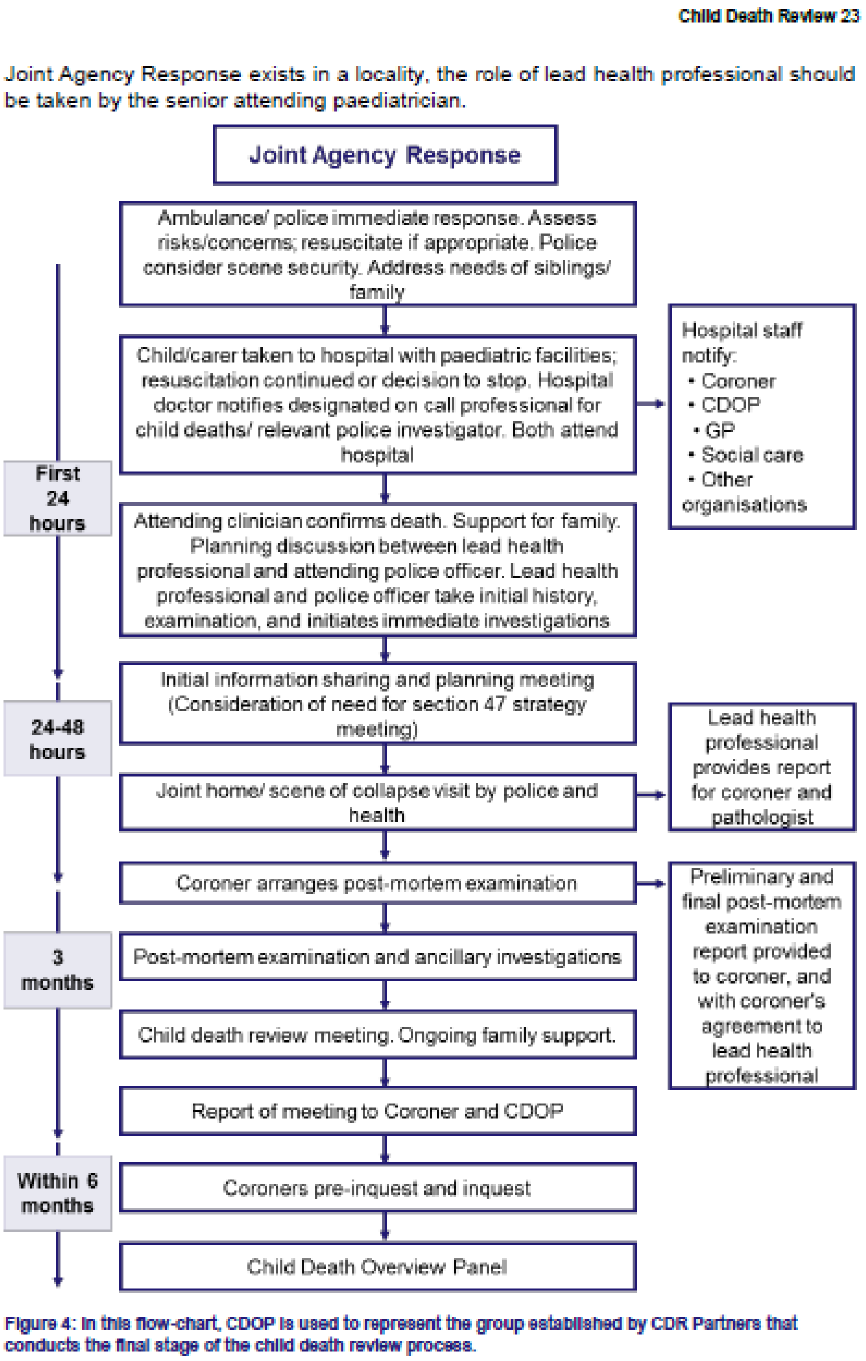
9. After immediate decisions have been taken and notifications made, further investigations may then follow. They will vary depending on the circumstances of the case and may run in parallel. The learning from investigations will inform the CDRM and review by STW CDOP.

10. Alongside this, essential information needs to be gathered for all child deaths. This includes demographic data, and information relating to the circumstances of death and background medical history. This information should be reported to STW CDOP via the Reporting Form, or, for deaths of babies in neonatal units via the Perinatal Mortality Review Tool.

11. In addition, the paediatrician’s Death Discharge Summary should be shared with all health agencies involved i.e STW CDOP, primary and community health care, GP and tertiary centres.

Joint Agency Response (JAR)

The flow chart below (fig. 2) sets out the main stages of the child death process when a Sudden and Unexpected Death in Infancy or Childhood (SUDIC) occurs.



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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.

(Flow chart taken from Child Death Review: Statutory and Operational Guidance (England) (2018)).

1. The “*Sudden and Unexpected Death in Infancy and Childhood: multiagency guidelines for care and investigation (2016)”* gives comprehensive advice and expectations of all agencies involved in a JAR and should be applied in full by all agencies. This Policy should be seen as complementary to the SUDI/C Guidelines and does not replace them.

2. All deceased children who have died outside hospital and who meet the criteria for a JAR should be transferred to the nearest appropriate Emergency Department (ED) to enable the JAR process to be triggered.

3. A JAR should be triggered if a child’s death:

   - is or could be due to external causes.
   - is sudden and there is no immediately apparent cause (incl. Sudden Unexpected Death in Infancy/Childhood: SUDI/C).
   - occurs in custody, or where the child was detained under the Mental Health Act.
   - where the initial circumstances raise any suspicions that the death may not have been natural; or
   - in the case of a stillbirth where no healthcare professional was in attendance

4. In any of these circumstances, the Child Death Service, police investigator, and duty social worker should be contacted immediately to initiate the JAR process.

5. A JAR should also be triggered if such children are brought to hospital near death, are successfully resuscitated, but are expected to die in the following days.

6. In such circumstances the JAR should be considered at the point of presentation and not at the moment of death, since this enables an accurate history of events to be taken and, if necessary, a ‘scene of collapse’ visit to occur.

7. Effective cross-agency working is key to the investigation of such deaths and to supporting the family, and requires all professionals to keep each other informed, to share relevant information between themselves, and to work collaboratively.

8. The Specialist Nurse for Child Death will fulfil the role of lead health professional and ensure that all health responses are implemented and be responsible for on-going liaison with the police and other agencies.

9. Where no out-of-hours health rota for a JAR exists in a locality, the role of lead health professional should be taken by the senior attending paediatrician. This responsibility of lead professional is handed over by the paediatrician to the Specialist Nurse for Child Death at the earliest opportunity when back on duty.

10. Family Connect or Compass (depending on the child's home address) should also be contacted and asked to check their records relating to the child, immediate family members, other members of the household and others with whom the child has lived.

11. Certain factors in the history or examination of the child may give rise to concerns about the circumstances of death. If such factors are identified, they should be documented and shared with the coroner and professionals in other key agencies. All injuries should be recorded, and the lead police investigator should arrange a photographic record.

12. An initial Information Sharing and Safety Planning meeting should take place between the lead health professional/ Specialist Nurse for Child Death, lead police investigator and social care before the family leave the emergency department. This should include consideration of outstanding investigations, notification of agencies, arrangements for the post-mortem examination, and plans for a visit to the home or scene of collapse by the lead police investigator and the Specialist Nurse for Child Death.

13. In circumstances where a child has died, and abuse or neglect is known or suspected, professionals at the Information Sharing and Safety Planning Meeting should notify the safeguarding partners whose responsibility it is to determine whether the case meets criteria for a Child Safeguarding Practice Review.

14. The Specialist Nurse for Child Death should ensure that all relevant professionals and organisations are informed of the child's death, including the coroner, the GP and health visitor or midwife via STW e-CDOP.

15. There are some types of deaths which fall under the jurisdiction of a specific arm of the police force e.g., Road Traffic Collision Unit or British Transport Police. In such situations the Specialist Nurse for Child Death should ensure that there is a co-ordinated approach with other elements of the JAR, and any report arising from their investigation informs the wider Child Death Review process.

16. The aims of the JAR response are to:

    - establish, as far as is possible, the cause or causes of the child's death
    - identify any potential contributory or modifiable factors
    - provide ongoing support to the family ensure that all statutory obligations are met
    - learn lessons to reduce the risks of future child deaths.

7. Assessment of the environment and circumstances of the death (Joint home/scene visit)

1. As soon as possible after the child's death, the Specialist Nurse for Child Death or identified health professional and police investigator should visit the family at home or the site of the child's collapse or death (Appendix 1).

2. The purpose of this visit is to obtain further, more detailed information about the circumstances and environment in which the child died, and to provide the family with information and support.

3. This visit should normally take place within daylight hours. If there is likely to be a delay in arranging the joint visit, the police investigator should consider whether the police should carry out an initial visit to review the environment, ascertain whether there are any forensic requirements and appropriately record what is found. Unless there are clear forensic reasons to do so, the environment within which the child died should be left undisturbed so that it can be fully assessed jointly by the police and Specialist Nurse for Child Death, in the presence of the family.

4. The Specialist Nurse for Child Death with the police investigator should inform the family of the nature and purpose of this home visit. Time should be allowed for the family to go at their own pace, respecting that they may find it difficult to talk through the events or go into the room where the child has died. Allowance should be made for others, such as grandparents or family friends, to be present to support the parents.

5. The Specialist Nurse for Child Death with the police investigator should review the key elements of the history, allowing the family to elaborate on any aspects and to clarify any points that were unclear or missing from the initial history.

6. Note should be made of any observations made by the family in the days before the child's death. They may have taken photographs or video clips on a mobile phone that could shed light on the child's appearance before death.

7. When the family is ready, the police investigator and Specialist Nurse for Child Death should review the environment where the child died. It can be very helpful at this stage for appropriate family members to be present to describe in detail the final events, for example, how the child was put to sleep or how they were found.

8. Consideration should be given to reconstruction of the sleeping environment, for example, with the use of a doll or prop. There is no strong evidence that this provides a more accurate understanding of the mode or circumstances of death, but it may prove helpful, particularly if the account is not clear, or if there are indications of possible overlaying or asphyxiation. Care should be taken not to further distress the family if reconstruction is required.

9. The police lead investigator should consider whether to request crime scene investigators to take photographs or a video of the scene of the child's death, and whether any items should be seized for further forensic investigation. Other possible

relevant recordings, such as room temperature, are detailed within the police-approved professional practice guidance for investigators. It is rarely necessary to seize bedding or clothing, as these rarely add anything to the investigation. However, there may be circumstances when a child’s cot or other sleeping environment needs to be taken for further examination. This should only be taken after the joint visit, so all items can be seen first in situ. Similarly, there may be circumstances where a child’s feeding bottle or other feeds or medications need to be taken for further analysis.

10. After reviewing the information, the Specialist Nurse for Child Death and police investigator should discuss their findings so far with the family, taking care not to jeopardise any further investigation if there are concerns around possible abuse or neglect. The family should be informed of the further investigations that will need to be carried out, including the post-mortem examination, and how and when they will be informed of the results.

11. Information may be given to the family at this stage, in general terms, around possible causes of unexpected child death. It is important, however, to emphasise that it is not possible to give a definitive cause of death until all investigations are complete, and that the ultimate decision on the cause of death rests with the coroner.

12. The family should be given the *When a Child Dies* booklet for parents, families, and carers to help understand and navigate the child death review process. This document should be offered, in a printed format, to all bereaved families and/or carers. The family should be informed that the Specialist Nurse for Child Death will act as their point of contact for support or advice and given contact details for local bereavement support and relevant local or national organisations.

13. Following the home visit, the Specialist Nurse for Child Death and police Senior Investigating Officer (SIO) should review all information gathered to date.

14. Following this review, the Specialist Nurse for Child Death should prepare a report of the initial findings, to include details of the history, initial examination of the child and findings from the home visit, as well as an account of any medical investigations and procedures carried out. This may be done using the SUDIC Home Visit Proforma (Appendix 2).

15. This report should be made available to the pathologist, the coroner and the police investigator as soon as possible, and preferably prior to the post-mortem examination.

8 Information Sharing and Safety Planning Meeting

1. This meeting will be convened within 24 office working hours of the notification of death to the STW CDOP. This meeting will be arranged by the STW CDOP and attendance by agencies is expected. If the identified person in the invite is not available, it is expected a nominated deputy will attend.

2. The meeting will consider the essential information for the purposes of understanding the events leading to incident, will ensure care is available for families, surviving siblings are safeguarded under the statutory guidance of Working Together to Safeguard Children and in the cases of an unexpected death of a school aged child or young person, will include safety planning and vulnerability mapping to ensure the identification and safety of other children within the school and local community who may be significantly affected by the death.

3. The meeting will include core representation from the receiving Hospital, Ambulance, Police, Children's Services, 0-19 Service, GP, Education and CAMHS. Other services identified as significant during a child's life or immediate death such as mental health services, Drug and Alcohol Teams, and British Transport Police will be invited as appropriate. This list is not exhaustive.

9 The Post-Mortem Examination (PM)

1. The aim of the investigation is to establish, as far as is possible, the cause of death. The investigation will concentrate not just on the child, but will consider the family history, past events and the circumstances. These factors can be helpful in determining why a child died. All parts of the process should be conducted with sensitivity, discretion and respect for the family and the child who has died.

2. The PM will be ordered by the coroner and should be carried out by a pathologist with expertise in paediatric pathology. If significant concerns have been raised about the possibility of neglect or abuse having contributed to the child's death, a forensic pathologist should accompany the paediatric pathologist, and a joint post-mortem examination protocol should be followed.

3. Families have the right to be represented at the PM by a medical practitioner of their choice, provided they have notified the coroner of their wishes.

4. The coroner should be immediately informed of the initial results of the PM, which may also, with the coroner's permission, be discussed with the Specialist Nurse for Child Death and lead police investigator as required.

5. If the initial PM findings suggest evidence of neglect or abuse, the police investigation team and children's social care should immediately be informed and further investigations set in process.

6. Once the initial PM findings are known, Specialist Nurse for Child Death and the police investigator should, with the coroner's permission, arrange to meet the family to discuss the initial findings. It is important at that stage to emphasise that

the findings are preliminary, that further investigations may be required, and that it is not possible, at that stage, to draw any conclusions about the cause of death.

7. As part of the explanation about the PM examination given to the family, the coroner's officer and/or Specialist Nurse for Child Death must explain that, according to the coroners (Investigation) Regulations 2013, tissue samples will be taken and that, following the coroner's investigation, the family can determine the fate of the tissue according to the Human Tissue Act 2004 guidelines.

10 Expected Deaths (Deaths that do not trigger a JAR)

1. The Specialist Nurse for Child Death's key responsibility will be on behalf of the STW CDOP to implement, co-ordinate and manage all child death reviews. The Specialist Nurse for Child Death will be notified of each child death and sent relevant information.

2. On receipt of the notification of a child death, the Specialist Nurse for Child Death will triage the death and undertake the role of lead health professional to coordinate the health response to the child death and ensure that all health responses are implemented.

3. The Specialist Nurse for Child Death will be responsible for ongoing liaison with the health professionals currently involved with the child/family and in consultation, agree the timing of contact/visit to the family.

4. The Specialist Nurse for Child Death will be responsible for ongoing liaison with the medical professionals involved with the child/family to ensure that they attend the planned CDRM and ensure outputs from CDRMs (draft Analysis Forms) are shared with CDOP panel.

5. The Specialist Nurse for Child Death will attend the CDRM in the acute/tertiary settings to represent the 'voice' of the parents at the professional meeting, ensure that their questions are effectively addressed, and to provide feedback to the family afterwards. The Specialist Nurse for Child Death will be a reliable and readily accessible point of contact for the family after the death and will carry out a follow up visit/visits to the family to support and feedback answers to their questions.

6. The Specialist Nurse for Child Death will help co-ordinate meetings between the family and professionals as required.

7. The Specialist Nurse for Child Death will support and signpost the family and surviving siblings to other professionals for bereavement support.

11 Parent/Carer Voices

1. The Specialist Nurse for Child Death, or other identified key worker, will support the family and siblings through the child death review process.

2. The Specialist Nurse for Child Death, or other identified key worker, will make and maintain contact and support for bereaved parents the CDR process is complete.

3. The Specialist Nurse for Child Death, or other identified key worker, will provide the family with all relevant information and assist their understanding of the CDR process and how they can be involved.

4. The Specialist Nurse for Child Death, or other identified key worker, will facilitate bereaved families to think about and voice any questions, concerns or other feedback. A feedback form can help with this (Appendix 3).

5. The Specialist Nurse for Child Death, or other identified key worker, will represent bereaved families at the CDR meeting, bringing their questions, concerns or feedback for those present to discuss.

6. The Specialist Nurse for Child Death, or other identified key worker, will offer opportunity for bereaved parents to meet to discuss the outcome of the meeting

12 Child Death Review Meeting (CDRM)

1. Once the results of the PM and other clinical investigations are known, the CDRM is arranged by the Specialist Nurse for Child Death to review emerging findings. The CDRM should ideally take place before the inquest so as to inform the coroner's investigation.

2. The CDRM is a multi-professional meeting where all matters relating to a child's death are discussed by the professionals directly involved in the care of that child during life and their investigation after death.

3. The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved. For example, it could take the form of a final case discussion following a Joint Agency Response; a perinatal mortality review group meeting in the case of a baby who dies in a neonatal unit; a hospital-based mortality meeting following the death of a child in a paediatric intensive care unit; or similar case discussion.

4. The Specialist Nurse for Child Death will in consultation with the medical teams involved co-ordinate, manage and attend all appropriate CDRMs in acute and tertiary settings. They will represent the 'voice' of the parents at these professional meetings, ensure that their questions are effectively addressed, provide feedback to the family afterwards and ensure output from CDRMs (draft Analysis Forms) are shared with CDOP panel. They will ensure all child death processes are followed across STW and ensure that reporting to the NMCD is completed. Notes of the meeting should be taken to help with completion of the draft analysis form.

5. The CDRM is a meeting for professionals. To allow full candour among those attending, and so that any difficult issues relating to the care of the child can be discussed without fear of misunderstanding, parents should not attend this

meeting. However, parents should be informed of the meeting by the Specialist Nurse for Child Death and have an opportunity to contribute information and questions through the Specialist Nurse for Child Death.

6. With the exception of hospital-based mortality meetings, the CDRM should be chaired by a lead professional for the child death review process.

7. The meeting should take place once investigations (e.g., any NHS patient safety incident response framework investigation or post-mortem examination) have concluded, and reports from key agencies and professionals unable to attend the meeting have been received.

8. The meeting should take place as soon as is practically possible, ideally within three months, although NHS patient safety incident response framework investigations and the length of time it takes to receive the final post-mortem report will often cause delay. The CDRM may proceed in the context of a criminal investigation, or prosecution, in consultation with the senior investigating police officer. The meeting cannot take place if the criminal investigation is directed at professionals involved in the care of the child, when prior group discussion might prejudice testimony in court.

9. At the meeting's conclusion, there should be a clear description of what follow-up meetings have already occurred with the parents, and who is responsible for reporting the meeting's conclusions to the family. This would generally be the Specialist Nurse for Child Death who is supporting the family. In a coroner's investigation, such liaison should take place in conjunction with the coroner's office, bearing in mind that the conclusion on the cause of death in such cases is the responsibility of the coroner at inquest.

10. Notes of the CDRM incorporating analysis of information/factors that may have contributed to death, modifiable factors, identified learning and recommendations may be shared with the coroner to assist with the Inquest.

11. In all cases, the aims of the CDRM are:

    - to review the background history, treatment, and outcomes of investigations, to determine, as far as is possible, the likely cause of death.
    - to ascertain contributory and modifiable factors across domains specific to the child, the social and physical environment, and service delivery.
    - to describe any learning arising from the death and, where appropriate, to identify any actions that should be taken by any of the organisations involved to improve the safety or welfare of children or the child death review process.
    - to review the support provided to the family and to ensure that the family are provided with the outcomes of any investigation into their child's death; a plain English explanation of why their child died (accepting that sometimes this is not possible even after investigations have been undertaken) and any learning from the review meeting.

- to ensure that CDOP and, where appropriate, the coroner is informed of the outcomes of any investigation into the child's death; and
- to review the support provided to staff involved in the care of the child.

13 Child Death Overview Panel (CDOP)

1. CDOP is a multi-agency panel set up by CDR partners to review the deaths of all children normally resident in their area, and, if appropriate and agreed between CDR partners, the deaths in their area of non-resident children, to learn lessons and share any findings for the prevention of future deaths.

2. CDOPs should conduct an anonymised secondary review of each death where the identifying details of the child and treating professionals are redacted. This review should be informed by a standardised report from the CDRM, and ensures independent, multi-agency scrutiny by senior professionals with no named responsibility for the child's care during life.

3. The CDOP should be chaired by someone independent of the key providers (NHS, social services, and police) in the area. Panel members should be familiar with their responsibilities and ensure that they read all relevant material in advance of panel meetings. Conflicts of interest should be established at the outset of each meeting and panel members should not lead discussions if they are the named professional with responsibility for the care of the child.

4. Quoracy should usually demand attendance by lead professionals from health and the local authority. The CDOP should meet on a regular basis, determined by the number and type of deaths to be reviewed across a year. The functions of CDOP include:

    - to collect and collate information about each child death, seeking relevant information from professionals and, where appropriate, family members.
    - to analyse the information obtained, including the report from the CDRM, to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths.
    - to make recommendations to all relevant organisations, including where a child has died outside of the local authority area, where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children.
    - to notify the Child Safeguarding Practice Review Panel and local Safeguarding Partners when it suspects that a child may have been abused or neglected.
    - to notify the Medical Examiner and the doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction.
    - to provide specified data to the NMCD.
    - to produce an annual report for CDR partners on local patterns and trends in child deaths, any lessons learnt, and actions taken, and the effectiveness of the wider child death review process; and

- to contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection

5. CDOP, on behalf of CDR partners, may request any professional or organisation to provide relevant information to it, or to any other person or body, for the purposes of enabling or assisting the performance of the child death review partner's functions. Professionals and organisations must comply with such requests.

6. CDOP should aim to review all children's deaths within six weeks of receiving the report from the CDRM or the result of the coroner's inquest. The exception to this might be when discussion of the case at a themed panel is planned.

7. Some child deaths may be best reviewed at a themed meeting. A themed meeting is one where CDR partners arrange for a single CDOP, or neighbouring CDOPs, to collectively review child deaths from a particular cause or group of causes. Such arrangements allow appropriate professional experts to be present at the panel to inform discussions, and/or allow easier identification of themes when the number of deaths from a particular cause is small.

8. Parents should be informed by the Specialist Nurse for Child Death that the review at CDOP will happen, and the purpose of the meeting should be explained. Care and compassion are needed when informing parents about the meeting and its purpose, to avoid adding to parents' distress or giving the impression in error that the parents are being excluded from a meeting about their child. It should be made clear that the meeting discusses many cases, and that all identifiable information relating to an individual child, family or carers, and professionals involved is redacted.

9. It should also be explained to parents that because of the anonymous nature of the CDOP review, it will not be possible to give them case specific feedback afterwards.

10. Parents should be assured that any information concerning their child's death which they believe might inform the meeting would be welcome and can be submitted via the Specialist Nurse for Child Death.

11. CDOP should assure itself that the information provided to the panel provides evidence that the needs of the family, in terms of follow-up and bereavement support, have been met.

12. CDR partners must at such intervals as they consider appropriate, prepare and publish a report on:

    a) what they have done as a result of the arrangements under this section.
    b) how effective the arrangements have been in practice.

13. In addition to these statutory requirements, CDR partners should aim to ensure that the report is written in plain English and includes a summary of the key

learning arising from the reviews, reports from themed panels, and actions that have been taken to prevent child deaths as a result of this learning.

14. STW CDOP should record the outcome of their discussions on a final Analysis Form and submit copies of all completed forms associated with the child death review process and the analysis of information about the deaths reviewed (including but not limited to the Notification Form, the Reporting Form, Supplementary Reporting Forms and the Analysis Form) to the NCMD.

15. If a child dies outside of the STW CDOP local authority area, STW CDOP should ensure that a CDOP summary, including any recommendations/learning, is shared with the Child Death Review Team in the area where the child died. This is to allow them to complete any actions/learning.

14 Family engagement and Bereavement support

1. Every family has the right to have their child's death sensitively reviewed to, where possible, identify the cause of death and to ensure that lessons are learnt that may prevent further children's deaths. Professionals have a duty to support and engage with families at all stages in the review process. Parents and carers should be informed about the review process and given the opportunity to contribute to investigations and meetings and be informed of their outcomes.

2. All staff in all agencies and organisations have a duty to support bereaved parents and carers after their child's death and to show kindness and compassion. Where there have been issues with the quality of care provided, healthcare organisations have a duty of candour to explain what has happened, to apologise as appropriate, and to identify what lessons may be learnt to reduce the likelihood of the same incident happening again. This provision should extend beyond the medical sector to any instances of error in the care of the child.

3. The processes that follow the death of a child are complex, in particular when multiple investigations are required. Recognising this, all bereaved families should have a key worker to whom they can turn for information on the child death review process, and who can signpost them to sources of support.

4. In the case of a child death that triggers a JAR, the key worker will most likely be the Specialist Nurse for Child Death. In the case of an expected death, the key worker will be determined after discussions with professionals. This may be bereavement midwives, Hope House Hospice or their named consultant/specialist nurse.

5. As key worker, the Specialist Nurse for Child Death will:
    - be a reliable and readily accessible point of contact for the family after the death.
    - help co-ordinate meetings between the family and professionals as required.
    - be able to provide information on the child death review process and the course of any investigations pertaining to the child.
    - liaise as required with the coroner's officer and police family liaison officer.
    - represent the 'voice' of the parents at professional meetings, ensure that their

  questions are effectively addressed, and provide feedback to the family afterwards; and
- maintain appropriate boundaries with families and signpost to expert bereavement support if required.

6. An appropriate consultant neonatologist or paediatrician should also be identified after every child's death to support the family. This might either be the doctor that the family had most involvement with while the child was alive or the lead professional on-duty at the time of death. The Specialist Nurse for Child Death should liaise closely with the appropriate doctor and arrange follow-up meetings at locations and times convenient to the family; and clinical expertise (via other professionals if necessary) to be able to:
    - answer questions relating to the medical, nursing or midwifery care of the child.
    - explain the findings, where relevant, of the post-mortem examination and /or other investigations and
    - report back the outcome from the CDRM.

7. At the time of a child's death, other professionals may also provide vital support to the family; these include (but are not limited to) the GP, clinical psychologist, social worker, family support worker, midwife, health visitor or school nurse, palliative care team, chaplaincy and pastoral support team.

8. In all cases, it is the duty of the Specialist Nurse for Child Death to ensure that there is clarity regarding each professional's role; that the family does not receive mixed messages; and that communication is clear.

9. The leaflet *When a Child Dies – A Guide for Parents and Carers* should be given in printed format to all bereaved families or carers.

10. When their child dies, bereaved parents or carers should:

    - have the opportunity to spend time with the child's body in a quiet and private environment.
    - have the opportunity to make memories including taking photographs, hand and footprints and a lock of hair.
    - (if the parents or carers wish) expect a member of staff to remain with them, to provide comfort, and to ensure their basic needs are met.
    - be given the contact details of their single point of contact and the identity of their medical lead, be informed who will be contacting them and when they will be contacted after they leave the hospital or hospice (and what to do should they have any questions in the meantime).
    - know how to make arrangements to view their child's body.
    - be given information on death registration and the coronial process (if applicable).
    - understand why a post-mortem examination may be indicated and, if so, where it is taking place, and when the results might be expected. In the event of a coroner's case this responsibility falls to the coroner's officer.
    - be supported to understand the child death review process and how they are able to contribute to it.
    - be given practical advice in respect to organising the child's funeral.

- have the Specialist Nurse for Child Death accompany them to meetings to provide practical and emotional support.
- be able to access expert bereavement support if required. The Specialist Nurse for Child Death should be able to direct families to the most appropriate support services (Appendix 4).

15 REFERENCES

1. The Baroness Helena Kennedy QC, *Sudden Unexpected Death in Infancy: A multi-agency protocol for care and investigation. The report of a working group convened by The Royal College of Pathologists and The Royal College of Paediatrics and Child Health*. London: RCPath and RCPCH, 2004

2. HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children.* Department for Education, 2023

3. HM Government, *Child Death Review Statutory and Operational Guidance (England),* London, 2018

4. *Children Act 1989*, London, HMSO

5. *Children Act 2004*, London, HMSO

6. NHS STW ICB, *Child Death Service Standard Operating Procedure*, NHS STW ICB, 2025

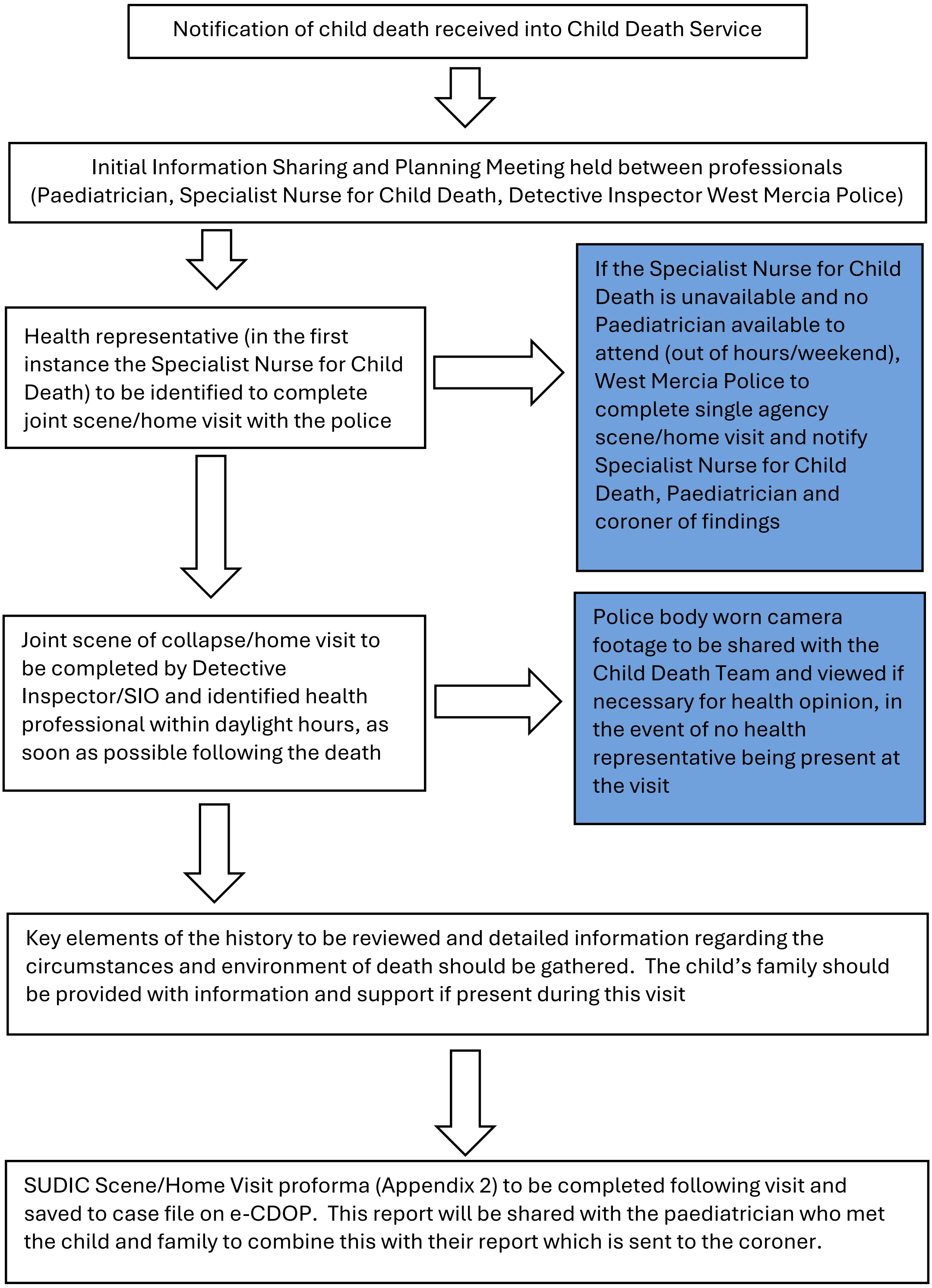
7. NHS STW ICB, *Child Death Service Pathway for SUDIC Scene/Home Visit,* NHS STW ICB, 2025

8. University of Birmingham, *Child Death Reviews Key Worker Toolkit*, Birmingham, 2024

16 APPENDICES

APPENDIX 1

Pathway for SUDIC Scene/Home Visits



Notification of child death received into Child Death Service

Initial Information Sharing and Planning Meeting held between professionals (Paediatrician, Specialist Nurse for Child Death, Detective Inspector West Mercia Police)

Health representative (in the first instance the Specialist Nurse for Child Death) to be identified to complete joint scene/home visit with the police

If the Specialist Nurse for Child Death is unavailable and no Paediatrician available to attend (out of hours/weekend), West Mercia Police to complete single agency scene/home visit and notify Specialist Nurse for Child Death, Paediatrician and coroner of findings

Joint scene of collapse/home visit to be completed by Detective Inspector/SIO and identified health professional within daylight hours, as soon as possible following the death

Police body worn camera footage to be shared with the Child Death Team and viewed if necessary for health opinion, in the event of no health representative being present at the visit

Key elements of the history to be reviewed and detailed information regarding the circumstances and environment of death should be gathered. The child's family should be provided with information and support if present during this visit

SUDIC Scene/Home Visit proforma (Appendix 2) to be completed following visit and saved to case file on e-CDOP. This report will be shared with the paediatrician who met the child and family to combine this with their report which is sent to the coroner.

APPENDIX 2

NHS
Shropshire, Telford
and Wrekin

Integrated
Care System
Shropshire, Telford and Wrekin

SUDIC Home Visit Proforma

Name:

DOB:

DOB:

Address:

Professionals Present for Visit

-

Family members present

-

A: Review of the history

(Builds on the initial history taken in the emergency department, allowing the circumstances leading up to the death to be explored in depth)

Narrative account of the events leading to the death over the last 24- 48 hours

Places the child and their parents/carers have been:

People they have come into contact with:

When and where the child was last seen or heard alive:

Presentation of the child during the last 24- 48 hours -- their mood, disposition and health:

Indicate anything that represents a change from usual practice

(Include exposure to infection, alcohol, smoking (both prescription and elicit), drugs or other harmful substances)

Family History

(Include ages, occupations, relevant medical history, and social background of household members including the child)

B – Environment where the child died

The Room

Size of the room:

Is there room to move around?	
Is there room for an adult to stand beside the cot/bed?	
What is the size of the room?	
What is the orientation of the room? (south/west facing etc)	

Contents of the room:

Is there more than 50% of the floor space visible?	
Is there at least one clear surface?	
What are the contents of the room?	
What is the position of the cot/bed in relation to heaters and radiators?	

Ventilation in the room:

What windows, doors and other openings are there?	
What sources of heating/cooling are in the room?	
When are these switched on and off?	
What temperature are they set at?	
What is the current temperature?	
What is the temperature taken from inside a drawer to estimate the temperature hours before?	

Cleanliness of the room:

Is there rubbish on the floor surfaces?	
Is there an accumulation of unwashed dishes or food?	
Is there excrement on the floor?	

Hazards in the room:

Is there a smell of gas?	
Is there damp or mould?	

Are there any faulty appliances or fixings?	
Any evidence of cigarette, alcohol or drug use?	

Is there any evidence of neglectful care?

The Sleep Environment

Over-wrapping or overheating:

Is there evidence of over-wrapping/overheating?	
How many layers of bedding were on the bed?	

Potential restriction to ventilation or breathing:

Is the sleeping space cluttered?	No
Is there adult size bedding or pillows?	
Is there any risk of smothering?	Yes

Potential Hazards:

Is the cot/moses basket/pram on a secure base?	
Are there gaps in the mattress?	
If a pushchair was used was the baby strapped in securely and safely?	
Is there anything overhanging the sleeping space other than a cot mobile?	
Are there any other hazards in the room?	

Sleeping Position:

What position was the child placed in to sleep?	
What position was the child found in?	
Were there any potential or actual obstructions to the airway?	

Parental support discussed/offered:

Professional completing proforma/visit:

Name:

Designation:

Date:

APPENDIX 3

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Feedback Form

This form is designed to help you think about any questions or comments you may have about aspects of your child's care. You do not have to use this form, answer these questions or limit yourself to the spaces in these boxes. The form is just a way of collecting your thoughts.
Any feedback you give us will help in the review of your child's care and ensure we address your questions as best as we can.
After the review we will send a report to you. If you would like a copy to go to your GP please add their details here:

Your name:	Your name:
GP Name:	GP Name:
Surgery Name:	Surgery Name:
Surgery Address:	Surgery Address:

How to return this to us:
You can discuss your feedback with your keyworker or post the feedback form back to us using the self-addressed envelope. If you would prefer you could scan or take a photo of the form and email it to stw.cdop@nhs.net

Your Keyworker information:
Name:
Phone:
Email:
Name……………………………………..

Is there anything about your child’s care that you still have questions about? This could be about medicines, procedures or treatment plans. It could be about decisions that were made to do or not to do something.

Is there anything you found particularly difficult or challenging about getting the care or treatment your child needed? This could be about accessing the services you needed e.g. specialist doctors or finding out why your child was unwell. It could also be about how information was shared with you or how you were involved (there is another box below that is specifically about these things if you would like to say more)

How well did healthcare professionals communicate with you throughout your child’s care? Did you understand what you were told? How was the information shared? Was this helpful? Did you feel involved in decisions being made about your child’s care?

Do you have any questions about the care your child received towards the end of their life and when they died? They might be about timing, medicines, location, who was involved in their care. It might also be about decisions that were made.

Is there anything you would like us to know about what you felt went well during your child's care? This could be about people or situations.

Is there anything else that you would like to tell us or ask us that isn't included in the other boxes?

Page left blank for you to use if you wish.

Taken from: Child Death Reviews Key Worker Toolkit (2024)

APPENDIX 4

Bereavement Support for Families

Child Death Process

Child Death Review Process	
These leaflets explain the Child Death Review process and what happens next to bereaved families.	When a Child Dies Leaflet.pdf lullaby-cdr-booklet.pdf
HM Coroners	
Information regarding the role of the coroner and the coronial process which may take place after your child has died.	A Guide to Coroner Services for Bereaved People Welcome to the Coroners' Society of England & Wales

When a Child Dies – NHS England	
Leaflet on the process around child death and role of the keyworker.	When a Child Dies Leaflet.pdf

Child Loss

2 Wish	
Support for sudden, unexpected deaths 25 years and under. Provide immediate and ongoing support, such as memory boxes, bereavement rooms within hospitals, counselling, play therapy and complementary therapy. Covers the whole of Shropshire.	Home - 2 Wish
Hope House	
Children's Hospice on the Wales border. Hope House offer bereavement support and a free and confidential counselling service to anyone who has been affected by the death of a baby, child or young person (up to the age of 25 years).	Hope House Children's Hospices

Counselling is also offered to siblings and children.	
Shrewsbury Bereavement Group	
Offers monthly support groups face to face in Shrewsbury. Offering compassionate care, guidance and understanding in a safe space.	Shrewsbury Bereavement Group
Child Bereavement UK	
Supports children and young people (up to age 25), parents, families and educates professionals when a baby or child of any age dies or is dying, or when a child is facing bereavement. Provides resources for families, schools and professionals, books, films.	Child Bereavement UK www.childbereavementuk.org/for-families/info-sheets Support Line: 0800 02 888 40 support@childbereavementuk.org High Wycombe (Head Office) 01494 568900 Milton Keynes 01908 550895
SUDC UK	
Offers immediate connection with professional and peer support. Expert 1:1 guidance, advocacy and research referrals. Family days and supportive SUDC retreats. Community and closed support groups. Care packages, special cards and information.	HOME - SUDC UK Family Registration - SUDC UK
CRUSE Bereavement Support	
Offer support for bereaved families through one-to-one support, support children and young people and grief resources.	Home - Cruse Bereavement Support Tel – 0808 808 1677
Winston's Wish	
Support, guidance and information for anyone caring for a bereaved child or a child facing the imminent death of a family member - for families and professionals. It provides resources and publications for all ages: reading lists, activities, how to tell a child someone has died, how children grieve, should they go to the funeral.	www.winstonswish.org/supporting-you Winston's Wish Freephone National Helpline 08088 020 021 Email: ask@winstonswish.org

They offer specialist support programmes for children affected by deaths related to murder, manslaughter, suicide or the military community.	
Teddy's Wish	
For Families SIDS, Stillbirth, Neonatal death – will send care packages free of charge to families if they contact them. Provide counselling up to 18 months post loss.	Teddy's Wish Baby Loss Charity
Children of Jannah	
Children of Jannah is the first charity especially for Muslim parents who have experienced the death of a child. They offer meeting support groups and downloadable resources.	Home | Children of Jannah
The Child Death Helpline	
The Child Death Helpline aims to provide a quality freephone service to anyone affected by the death of a child of any age. Callers to the helpline might be parents, grandparents, siblings, other family members, friends or involved professionals. It is staffed by trained volunteers, all of whom are bereaved parents.	Home
A Child of Mine	
A Child of Mine is here after the most unimaginable loss, after a baby or child has died. We are here to support families with emotional support, practical information and guidance.	Welcome - A Child of Mine
The Compassionate Friends	
The Compassionate Friends (TCF) is a charitable organisation of bereaved parents, siblings and grandparents dedicated to the support and care of other similarly bereaved family members who have suffered the death of a child or children of any age and from any cause.	The Compassionate Friends | Your loss
4Louis	
4Louis is a UK charity that works across the country to support anyone affected by miscarriage, stillbirth and the death of a baby or child. We also work to improve	4Louis A UK Charity Supporting Families with Child Loss

the care bereaved families receive from health care and other professionals. We provide memory boxes filled with keepsakes and mementos to help families create lasting memories of their loved one.	

Child Suicide

PAPYRUS – Prevention of Young Suicide)	
PAPYRUS is a voluntary UK organisation committed to the prevention of young suicide and the promotion of mental health and emotional wellbeing. HOPE Line UK is a specialist telephone service staffed by trained professionals who give non-judgemental support, practical advice and information to children, teenagers and young people up to the age of 35 who are worried about how they are feeling.	www.papyrus.org.uk Hope Line UK: 0800 068 41 41 Email: pat@papyrus-uk.org SMS:07786 209697
Survivors of Bereavement by Suicide	
For adults bereaved by suicide.	Helpline – open 9am to 9pm Monday to Sunday 0300 111 5065 www.uksobs.org/ Email: support@uksobs.org

Life Limiting Illness – Child Loss

Hope House	
Hope House is a Children's Hospice located on the Welsh border. Hope House offer bereavement support and a free and confidential counselling service to anyone who has been affected by the death of a baby, child or young person (up to the age of 25 years).	Hope House Children's Hospices
Children and Young People's Cancer Association	

This charity covers all aspects of child death when a child is dying or has died from cancer.	Facing the death of your child and bereavement | CCLG - The Children & Young People's Cancer Association
Together for Shorter Lives	
TSL is the leading UK charity that speaks out for all children and young people who are expected to have short lives. Their vision is for children and young people with life shortening conditions to have as fulfilling lives as possible, and the best care at the end of life.	http://www.togetherforshortlives.org.uk/
Rainbow Trust	
Offers support to families in England with life-limiting and life-threatening conditions.	Supporting Children and Families | Rainbow Trust Children's Charity

Still Birth and Infant Loss

SANDS	
The Stillbirth and Neonatal death charity supports anyone who has been affected by the death of a baby before, during or shortly after birth. Services include a Helpline for parents, families and health professionals; a UK-wide network of support groups with trained befrienders; an online forum; and a wide range of leaflets, books and other resources.	https://www.sands.org.uk/ Sands Website | Shropshire Sands https://www.sands.org.uk/support/bereavement-support https://www.sands.org.uk/support/bereavement-support/practical-information Sands Helpline 0808 164 3332 Email: helpline@sands.org.uk
The Lullaby Trust	
The Lullaby Trust raises awareness of SIDS, provides expert advice on safer sleep for babies and offers emotional support for bereaved families.	http://www.lullabytrust.org.uk/ When-a-baby-or-young-child-dies-suddenly-and-unexpectedly.pdf Bereavement Support: 0808 802 6868 Email: support@lullabytrust.org.uk Trauma-Resource.pdf lullaby-cdr-booklet.pdf
BLISS	
Offers support for families of premature or sick babies, including bereaved families.	http://www.bliss.org.uk/

Petals	
Provides counselling and bereavement support to every parent following the loss of a baby.	Petals, The baby loss counselling charity - Petals Charity
Saying Goodbye	
Saying Goodbye provides comprehensive information, advice, and support to anyone who has suffered the loss of a baby, at any stage of pregnancy, at birth or in infancy. Part of the Mariposa Trust.	Saying Goodbye - support for miscarriage and baby and infant loss
SOS – Our Sam	
Our Sam works to raise awareness, understanding and improve support, and access to support for anyone affected by baby loss following miscarriage, stillbirth, termination for medical reasons and neonatal death.	SOS - S.O.S. Baby Loss

Multiple Birth Infant Loss

Twins Trust	
Twins Trust Bereavement Service offers compassionate support to families experiencing the loss of one or more of a set of twins or triplets – this includes peer to peer connections, online communities and resources,	Twins Trust | Bereavement Service

Support for Men

Bereaved Dads Brotherhood	
For fathers who have suffered the profound heartache of the loss of a child. Provides an online community for bereaved fathers – The Tiny Footprints Brotherhood – for grieving fathers to come together.	Bereaved Dads'
StrongMen	
Man2Man is our telephone-based peer support service from a trained StrongMen volunteer with first-hand	UK Mens Bereavement Charity - StrongMen

experience of losing a loved one. Counselling can be offered.	

Sibling Support

Sibling Support	
Offer advice, support and explanations to bereaved siblings. Free resources available for siblings.	Sibling Support
Bear Us in Mind	
An online resource designed to help children who have experienced bereavement, separation or trauma.	Bear Us In Mind

Memory Boxes and Keepsakes

The Harvey Hex Trust	
The Harvey Hex Trust is a national charity who support bereaved children to keep alive their precious memories of their siblings by supplying bespoke, personalised, durable wooden memory boxes and memory bears.	Harvey Hext Trust – Memory boxes for children who have lost a sibling
Remember My Baby	
A UK based registered charity who have professional photographers volunteering their photography services for the benefit of UK parents losing their baby before, during or shortly after birth.	Home | Remember My Baby
The Lovely Keepsake Company	
Personalised jewellery, memory bears, grave items, candles.	Bereavement Gifts – The Lovely Keepsake Company
Someone Remembered	
Provides personalised jewellery and baby charms with engraving.	Personalised Infant and Baby Loss Jewellery | Someone Remembered
Love Keep Create	
Offer a range of keepsake memory bears created from special clothes/baby grows or from almost any item you choose.	Keepsake Memory Bears - Love Keep Create

Funeral and Government Support

Tell Us Once	
A service that lets you report a death to most government organisations (such as DWP for benefits) in one go.	What to do after someone dies: Tell Us Once - GOV.UK
Register Offices in England and Wales	
Find a register office	Find a register office - GOV.UK
Child Funeral Charity	
Child Funeral Charity provides financial assistance to families who have to arrange a funeral for a baby or child from 12 weeks gestation to 17 years old (up to 18th birthday). Families must be referred by a professional who have knowledge of the family and their circumstances.	Child Funeral Charity – Financial Support for Families
Children’s Funeral Fund	
The Children’s Funeral Fund for England can help to pay for some of the costs of a funeral for a child under 18 or a baby stillborn after the 24th week of pregnancy. It is not means-tested: what you earn or how much you have in savings will not affect what you get. The burial or cremation must take place in England.	Support for child funeral costs (Children’s Funeral Fund for England): What it does - GOV.UK