NHS
Shropshire, Telford and Wrekin

Integrated Care System
Shropshire, Telford and Wrekin

Child Death Service Standard Operating Procedure

Document	
Title	Child Death Service Standard Operating Procedure
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Related Trust Policy	Child Death Service Policy
Approval	
Approved by (Committee/Director)	Child Death Overview Panel Business Group
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Amendments		
No	Date	Amendment
1	31.12.24	Minor amendment
2	06.02.25	Minor amendment
3	14.02.25	Minor amendment
4	20.05.25	Designated Doctor details added

1. Process

The process set out in this document 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) or any equivalent arrangements put in place by 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 with 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 process 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.

2. Definition of a Child

The child death review process covers children; a child is defined in the Children Act 2004 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 the baby was born alive.

If these enquiries determine that the baby was born alive the death must be reviewed.
This does not include:

- stillbirths (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)
- terminations of pregnancy (of any gestation) carried out within the law (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)

3. Process for Unexplained deaths

The "Sudden and Unexpected Death in Infancy and Childhood: multiagency guidelines for care and investigation (2016)" give comprehensive advice and expectations of all agencies involved in a Joint Agency Response (JAR) and should be applied in full by all agencies. This Child Death Review Guidance should be deceased children that meet the criteria for a JAR should be transferred to the nearest appropriate Emergency Department to enable the JAR to be triggered.

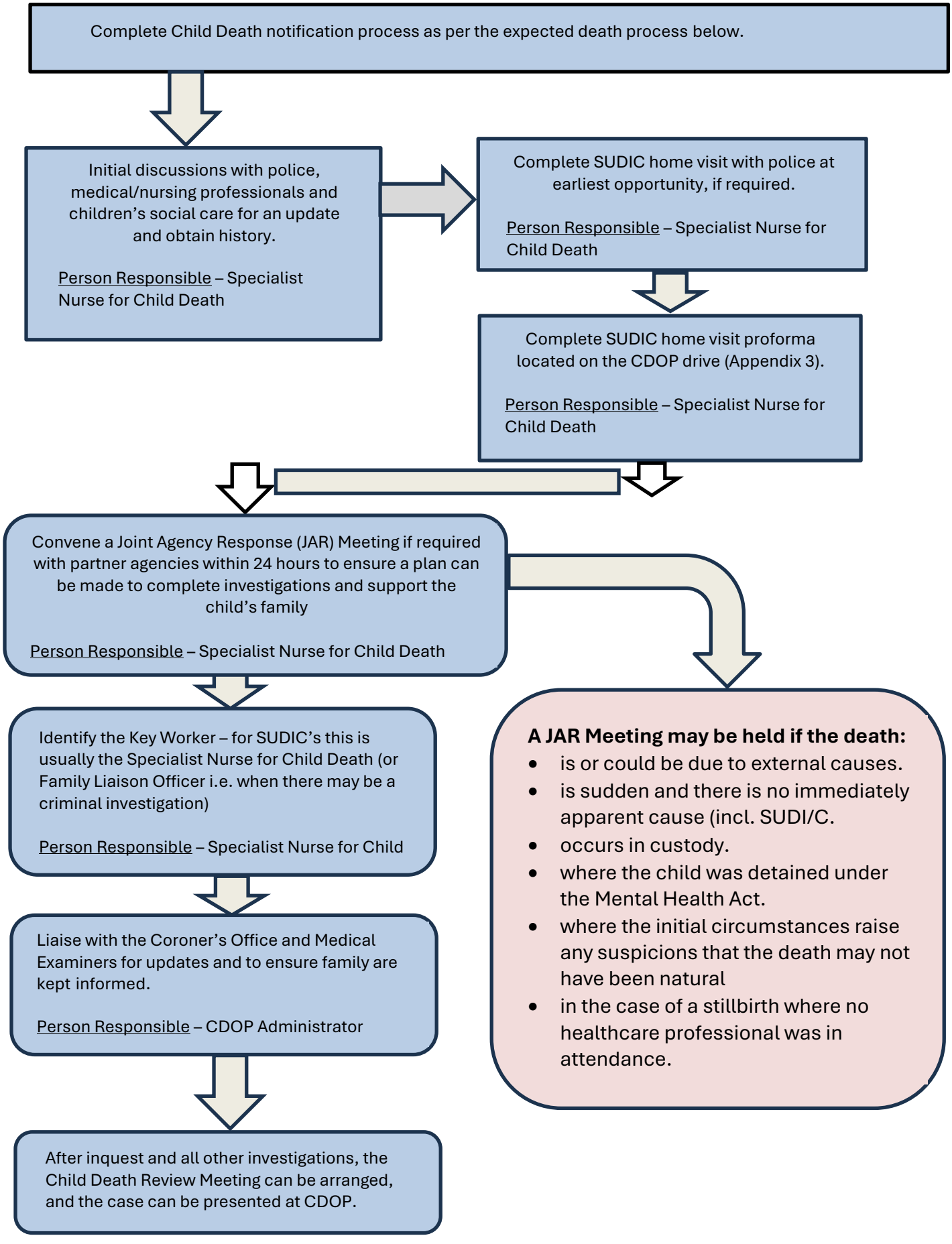
A Joint Agency Response should be triggered if a child's death:

- is or could be due to external causes
- is sudden and there is no immediately apparent cause (incl. SUDI/C)
- occurs in custody
- 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
- in the case of a stillbirth where no healthcare professional was in attendance.

In any of these circumstances, an on-call health professional, police investigator, and duty social worker should be contacted immediately to initiate the joint agency response.

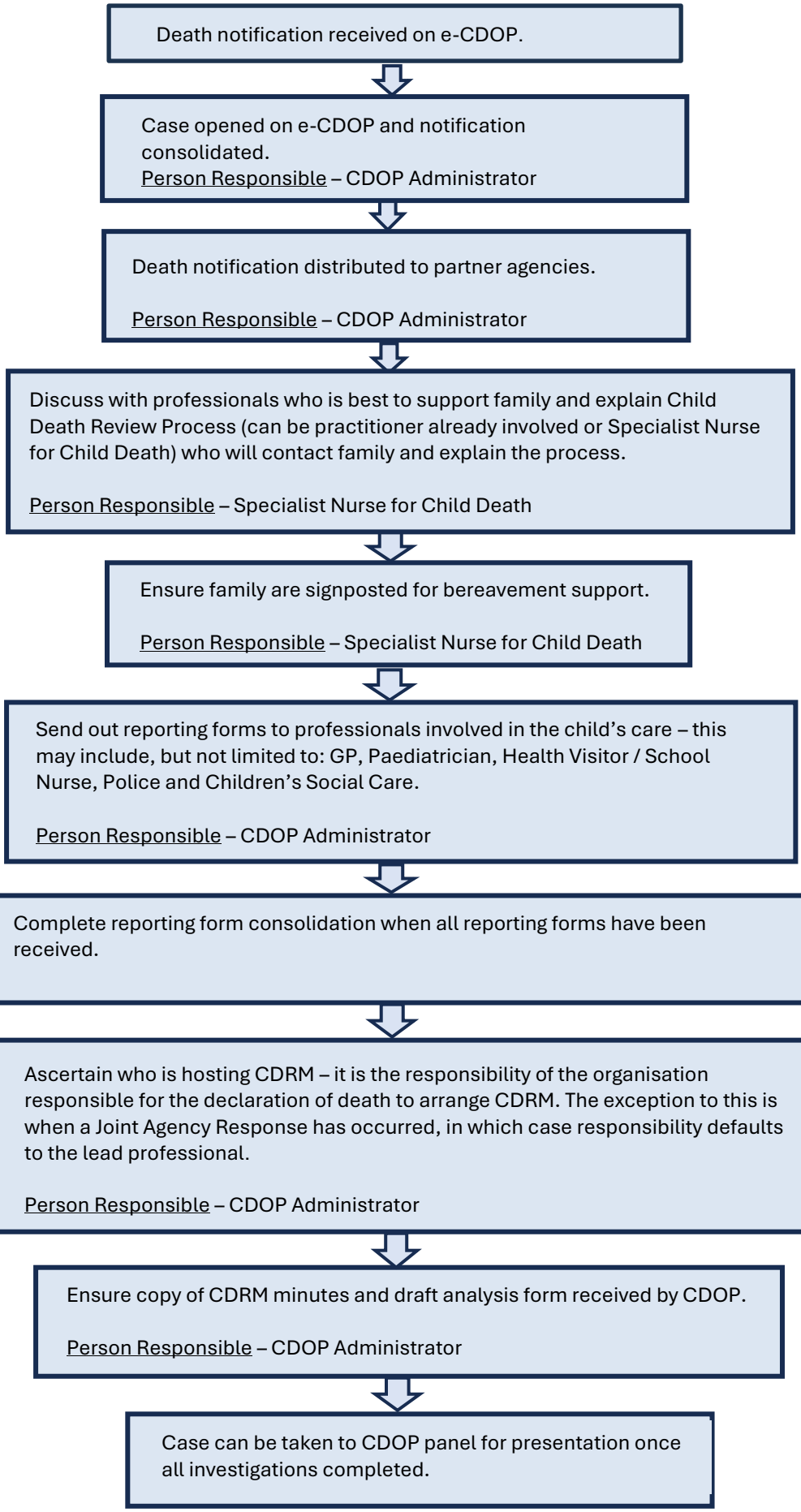
Flow Chart for Unexpected Child Deaths in Shropshire Telford and Wrekin

Following receipt of the Child Death notification:



Flow Chart for Expected Child Deaths in Shropshire Telford and Wrekin

Process for Expected Deaths



Useful Information

- NHS Shropshire Telford and Wrekin CDOP email: stw.cdop@nhs.net

- Designated Doctor for Child Death – via SATH switchboard
- Specialist Nurse for Child Death: 07917010518

- West Mercia Police – 999

- Family Connect (Telford) – 01952 385385
- Emergency Duty Team – 01952 676500
- COMPASS (Shropshire) – 0345 678 9021
- COMPASS (Out of Hours) – 0345 678 9040 (select option 1)

References

- Child Death Review: Statutory and Operational Guidance (England):

https://assets.publishing.service.gov.uk/media/637f759bd3bf7f154876adbd/child-death-review-statutory-and-operational-guidance-england.pdf

- Sudden Unexpected Death in Infancy and Childhood: Multi-Agency Guidelines for Care and Investigation:

https://www.rcpath.org/resourceLibrary/sudden-unexpected-death-in-infancy-and-childhood-report.html

- NHS STW ICB *Child Death Service Policy*, NHS STW ICB 2025

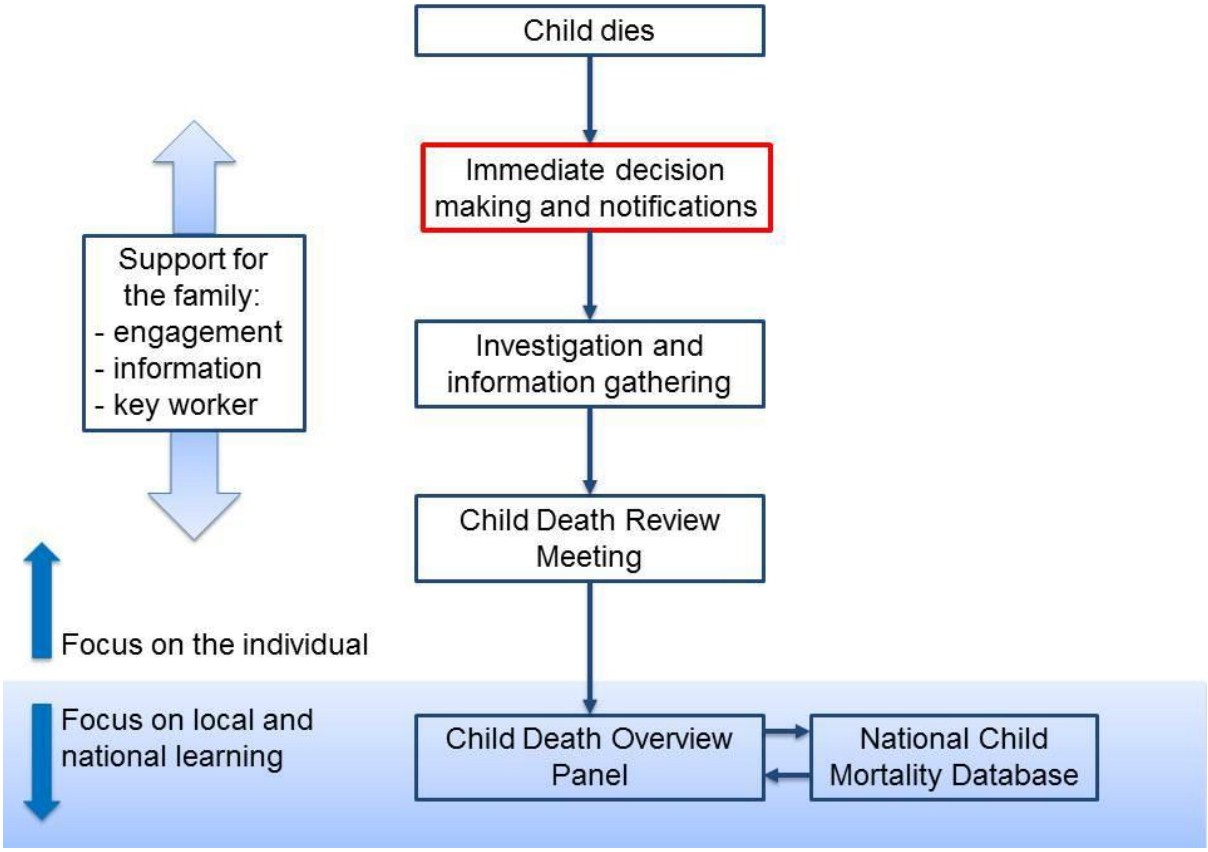
- NHS STW ICB, *Child Death Service Pathway for SUDIC Scene/Home Visit,* NHS STW ICB, 2025

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

Appendices

Appendix 1

The flowchart below sets out the main process of Child Death Reviews and the CDOP.



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

Appendix 2

The flowchart below sets out the main process for a SUDIC and when the JAR process is initiated.

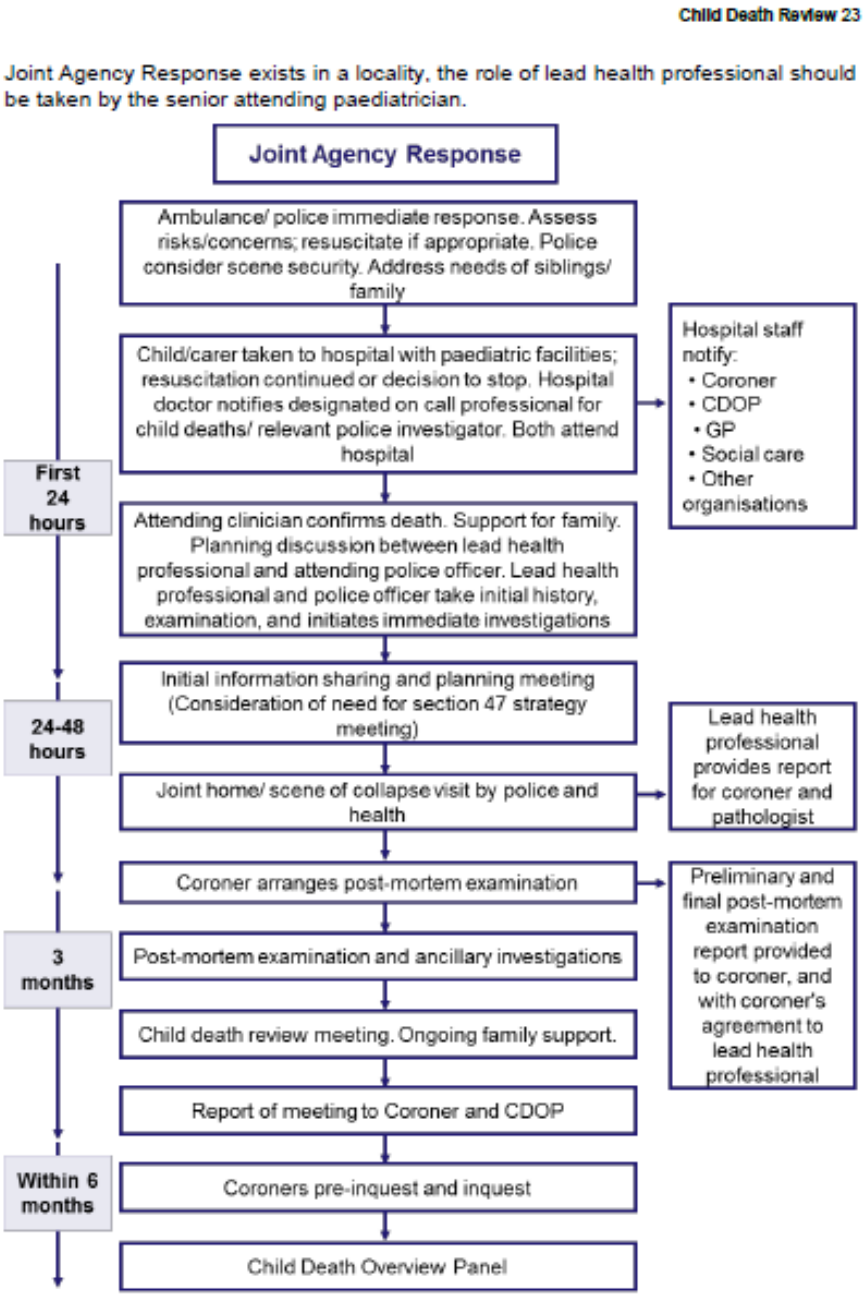


Figure 4: In this flow-chart, CDOP is used to represent the group established by CDR Partners that conducts the final stage of the child death review process.

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

Appendix 3

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: