# LSCB Policy and Procedures

## Child Death Review Process and Child Death Overview Panel

**Until the new child death review partner arrangements are published these LSCB Policy and Procedures remain in place.**

**October 2018**

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**Introduction**

Each death of a child is a tragedy and enquiries should keep the appropriate balance between forensic and medical requirements and the supporting the family at a difficult time. Professionals supporting parents and family members should assure them that the objective of the child death review process is not to allocate blame but to learn lessons. Families should be treated with sensitivity, discretion and respect at all times, and professionals should approach their enquiries with an open mind. The Review should help to prevent further such child deaths, and families may find it helpful to read the child death review leaflet

The responsibility for determining the cause of death rests with the coroner or the doctor who signs the medical certificate of the cause of death (and therefore is not the responsibility of the Child Death Overview Panel (CDOP)).

**Responsibilities of Local Safeguarding Children Boards (LSCBs)**

The LSCB is responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by the Child Death Overview Panel (CDOP). The Panel has a fixed core membership drawn from organisations represented on the LSCB and the flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate. The Panel is chaired by the Director of Public Health, who is a representative on the LSCB. LSCB's can choose to work collaboratively with other LSCB's to share child death overview panels. This is seen as best practice as CDOP's are responsible for reviewing deaths from larger populations are better able to identify significant recurrent contributory factors.

In cases where organisations in more than one LSCB are have known about or have contact with the child, lead responsibility should sit with the LSCB for the area in which the child was normally resident at the time of death. Other LSCB's or local organisations which have had involvement in the case should cooperate jointly planning and undertaking the child death review. In the case of a looked after child, the LSCB for the area of the local authority looking after the child should exercise lead responsibility for conducting the child death review, involving other LSCB's with an interest or whose lead agencies have had involvement as appropriate.

LSCB's should use sources available such as professional contacts or the media, to find out about cases when a child who is normally resident in their area has died abroad. The LSCB should inform the CDOP of such cases so that the deaths of these children can be reviewed

**The regulations relating to child deaths**

One of the LSCB functions, set out in regulation 6 of the Local Safeguarding Children Boards Regulations 2006, in relation to the deaths of any children normally resident in their area is as follows:

a) *collecting and analysing information about each death with a view to identifying*

(i) *any case giving rise to the need for a review mentioned in regulation 5(1)(e)*

(ii) *any matters of concern affecting the safety and welfare of children in the area of the Authority and*

(iii) *any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and*

b) *putting in place procedures for ensuring that there is a coordinated response by the Authority, their Board partners and other relevant persons to an unexpected death .*

Every LSCB is required to supply anonymised information on child deaths to the Department for Education. This is so that the Department can commission research and publish nationally comparable analyses of these deaths.

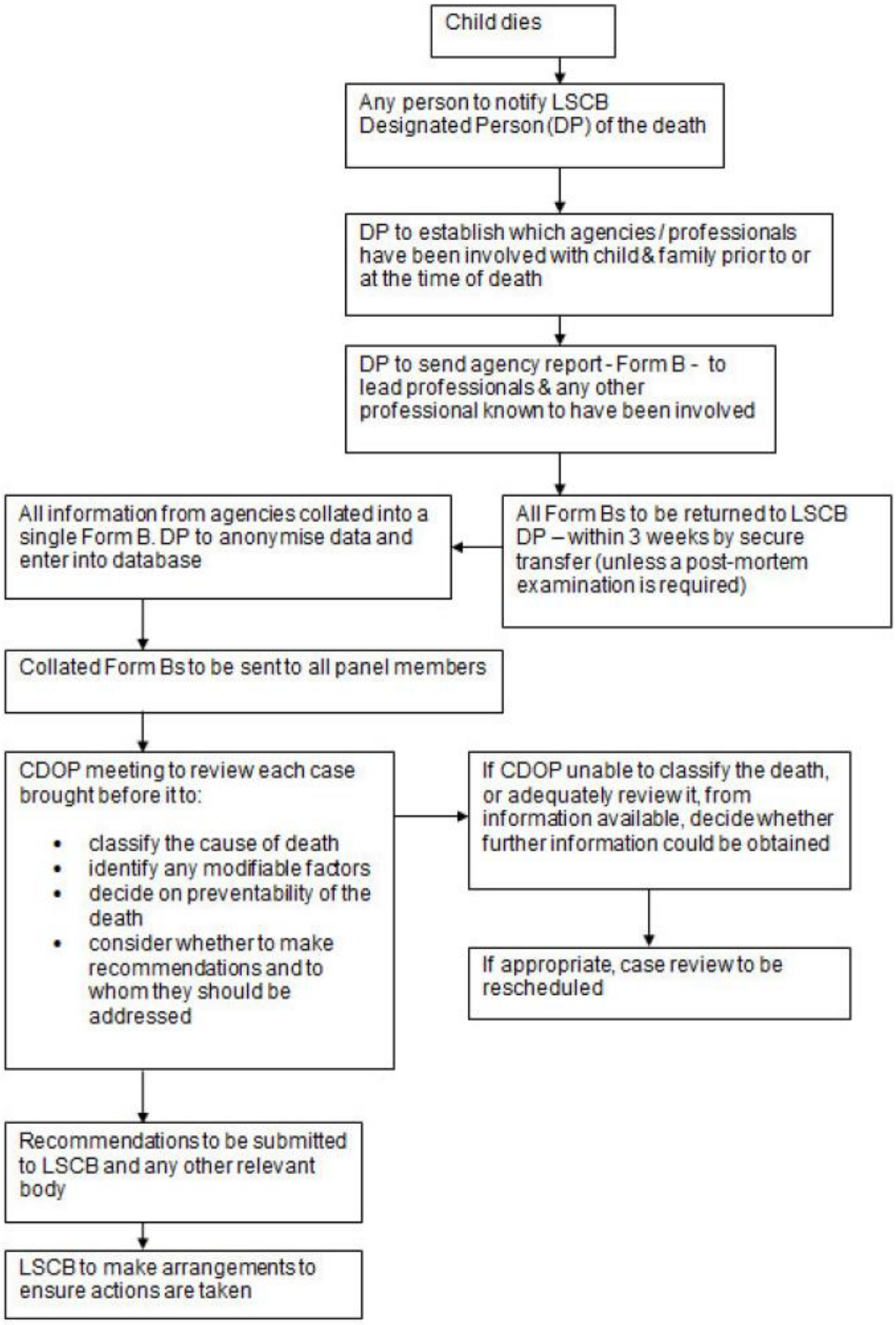
The LSCB should ensure that appropriate single and multi-agency training is made available to ensure successful implementation of these procedures. LSCB partner agencies should ensure that relevant staff should have access to training.

The LSCB is responsible for renewing all child deaths of children normally resident in the area.

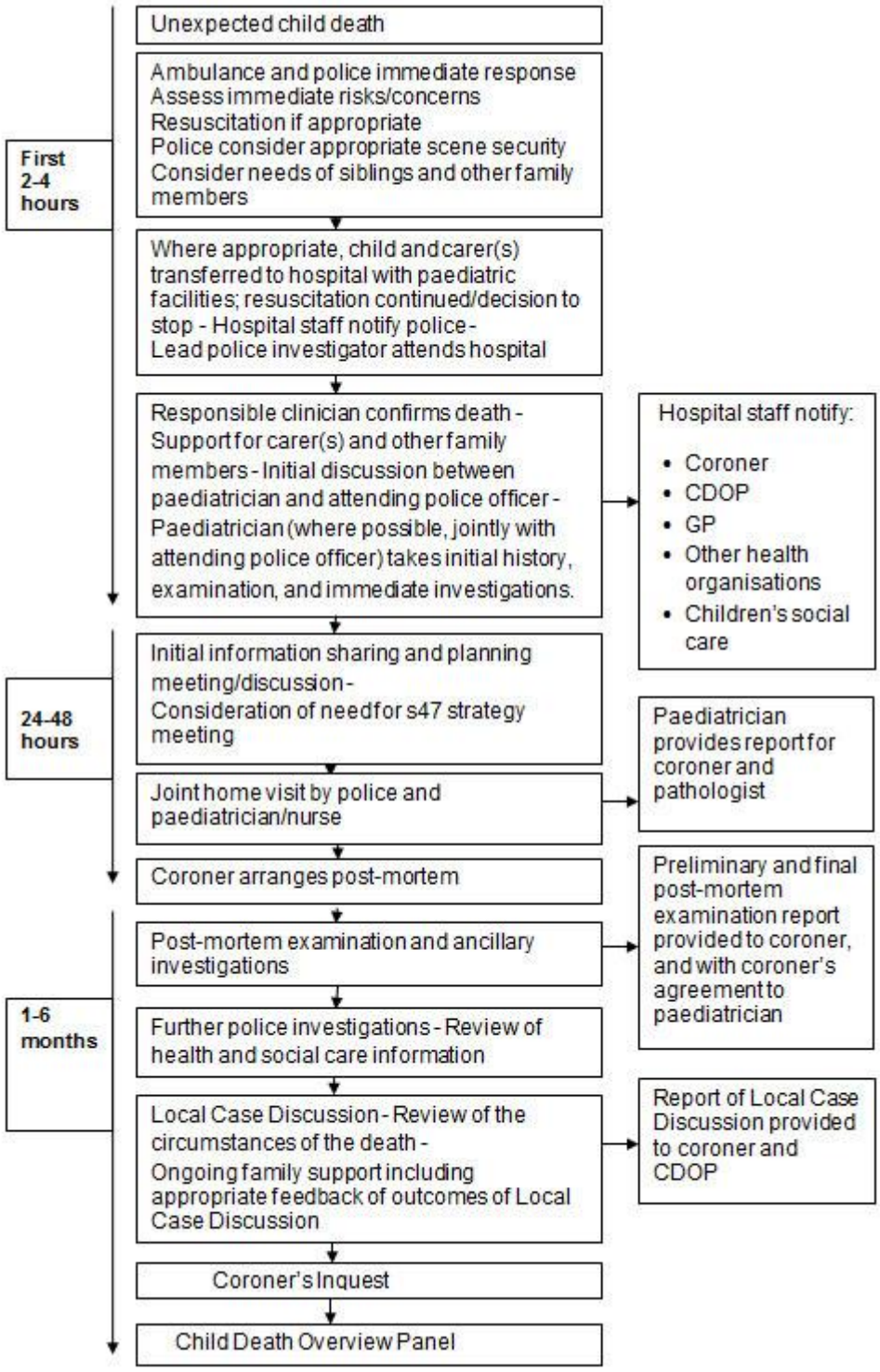
When a child dies and the death is expected the process as outline in flow chart 7 is followed.

When a child dies unexpectedly as per the definition on page 7 of this document, flow chart 8 is followed.

## Flow chart 7: Process to be followed for all child deaths



## Flow chart 8: Process for rapid response to the unexpected death of a child



**Responsibilities of the Child Death Overview Panel**

A review of all child deaths in the LSCB area covered by the child death overview panel will be undertaken. The functions of the CDOP include:

- reviewing all child deaths up to the age of 18 years, excluding those babies who are still born and planned terminations of pregnancy carried out within the law
- collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members
- discussing each child's case and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family
- determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, is any actions could be taken to prevent future such deaths
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- making recommendations to the LSCB or other relevant bodies promptly so that actions can be taken to prevent future similar deaths where possible
- identifying patterns or trends in local data and reporting these to the LSCB
- where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required
- agreeing local procedures for responding to unexpected deaths of children and
- cooperating with regional and national initiatives to identify lessons on the prevention of child deaths.
- The CDOP should include Public health and child health representation

In reviewing the death of each child, the CDOP should consider modifiable factors, for example in the family and environment, parenting capacity or service provision and consider what action could be taken locally and what action could be taken at a regional level.

The aggregated findings from all child deaths should inform local strategic planning, including the joint strategic needs assessment, on how best to safeguard and promote the welfare of children in the area. Each CDOP should prepare an annual report of relevant information for the LSCB, this information should inform the LSCB annual review.

The CDOP panel will meet on a quarterly basis and will be chaired by the Director of Public Health, this is to ensure that the panel maintains a public health perspective and is more able to identify trends over time and develop preventative approaches to child deaths in the area.

The learning from reviewing child deaths will be incorporated into the LSCB Annual Review, they will be covered as appropriate in relevant training for multi agency staff as part of the LSCB Learning and Improvement Framework (Chapter 4)

**Definition of preventable child deaths**

For the purpose of producing aggregate national data, this guidance defines preventable child deaths as those in which modifiable factors may have contributed to the death. These are factors

defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced.

**Action by professionals when a child dies unexpectedly**

**The Definition of an Unexpected Child Death**

An unexpected death is defined as the death of an infant or child (less than 18 years old and excluding stillbirths) which:

- *'was not anticipated as a significant possibility for example 24 hours before the death; or*
- *where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.*

*The designated paediatrician responsible for unexpected deaths in childhood should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt, these procedures should be followed until the available evidence enables a different decision to be made."*

AS set out the LSCB Regulations 2006, LSCB's are responsible for putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to a child death.

NLSCB have had access to a DP for SCD via a collaborative approach., The consultant paediatrician on call at the time of an unexpected death acts as the lead clinician for the rapid response and case review process for each individual case; with the Designated Doctor taking a lead role in terms of acting as medical advisor to the Child Death Overview Panel, and assisting in trend analysis.

When a child dies suddenly and unexpectedly, the consultant clinician (in a hospital setting) or the professional confirming the fact of death (if the child is not taken immediately to an Accident and Emergency Department) should inform the consultant clinician/ Consultant of the Week with responsibility for unexpected child deaths at the same time as informing the coroner and police. The police will begin an investigation into the sudden or unexpected death on behalf of the coroner. The Consultant of the week or paediatrician should initiate an immediate information sharing and planning discussion between the lead agencies (i.e health, police and local authority children's social care).

The joint responsibilities of the professionals involved with the child include:

- responding quickly to the unexpected death of a child;
- maintaining a rapid response protocol with all agencies, consistent with the Kennedy principles and investigative practice from the Association of Chief Police Officers
- making immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the coroner;
- liaising with the coroner and pathologist
- undertaking the types of enquiries/investigations that relate to the current responsibilities of their respective organisations;
- collecting information about the death
- providing support to the bereaved family and referring to specialist bereavement services where necessary and keeping them up to date with information about the child's death and
- gaining consent early from the family for the examination of their medical notes.

If the child dies suddenly or unexpectedly at home or in the community, the child should normally be taken to Accident and Emergency rather than the mortuary, unless it is deemed inappropriate to take the child to A&E. In some cases when a child dies at home or in the community, the police may decide that it is not appropriate to immediately move the child's body, for example because forensic examinations are needed.

As soon as possible after arrival at the hospital, the child should be examined by a consultant paediatrician and a detailed history should be taken from the parents or carers. The purpose of obtaining this information is to understand the cause of death and identify anything suspicious about it. In all cases when a child dies in hospital, or is taken to hospital after dying, the hospital should allocate a member of staff to remain with the parents and support them through the process.

If a child has died at home or in the community, the lead investigator and senior health care professional should decide whether there should be a visit to the place where the child has died, ideally within 24 hours and who should attend. This should almost always take place for cases of sudden infant death. After this visit the senior investigator, visiting health care professional, GP, Health visitor or school nurse and local authority children's social care representative should consider whether there is any information to raise concerns that neglect or abuse contributed to the child's death.

Where a child dies unexpectedly, all registered providers of healthcare services must notify the Care Quality Commission of the death of a service user- but NHS providers may discharge this duty by notifying NHS England.

Where a young person dies at work the Health and Safety Executive should be informed. Youth Offending Teams review of safeguarding and public protection incidents (including the deaths of children under their supervision) should also feed into the CDOP process.

If there is a criminal investigation, the team of professionals must consult the lead police investigator and Crown Prosecution Service to ensure that their enquiries do not prejudice any criminal proceedings. If the child dies in custody, there will be an investigation by the Prisons and Probation Ombudsman (or by the Independent Police Complaints Commission in the case of police custody). Organisations who worked with the child will be required to cooperate with that investigation.

In addition for any child who dies in a secure children's home, the Prisons and Probation Ombudsman will carry out an investigation. In order to assist the Ombudsman to carry out these investigations, secure children's homes are required to notify the Ombudsman of the death and to comply with the requirements at regulation 40(2) of the Children's Homes (England) Regulations 2015 to facilitate that investigation.

**Child Deaths by Suicide**

In cases of child deaths by suicide and careful consideration has determined there is sufficient information or evidence to suggest that a suicide cluster or contagion is underway (see appendix 2 for definition) the following responsibilities of notification to the Director of Public Health (DPH) / Public Health Hub must be adhered to:

- The police should notify the DPH / Hub if a cluster or contagion is apparent at the time of death
- Any agency/service (via a Service Manager) should notify the DPH / Hub if a cluster or contagion becomes apparent following the death e.g. through disclosure or new information
- The CDOP should notify the DPH / Hub if a cluster or contagion becomes apparent through analysis of the case by the Panel

For further information see the North Lincolnshire Suicide Cluster Community Action Plan Practice Guidance on the LSCB website under 'supplementary policy and procedures'.

***NB:*** *It is important to consider whether an early declaration of a suicide cluster could cause unnecessary panic and alarm.*

| **Specific responsibilities of relevant professionals** when responding rapidly to the unexpected death of a child | |
|---|---|
| Designated paediatrician for unexpected deaths in childhood | Ensure that relevant professionals (i.e. coroner, police and local authority social care) are informed of the death; coordinate the team of professionals (involved before and/or after the death) which is convened when a child dies unexpectedly (accessing professionals from specialist agencies as necessary to support the core team).<br><br>Convene multi-agency discussions after the initial and final initial post-mortem examination results are available. |

**Involvement of the Coroner or Pathologist**

If a doctor is not able to issue a medical certificate of the cause of death, the lead professional or investigator must report the child's death to the coroner in accordance with the protocol agreed with the coronial service. The coroner must investigate violence or unnatural death, or death of no known cause and all deaths where a person is in custody at the time of death. The coroner will then have jurisdiction over the child's body at all times. Unless the death is natural a public inquest will be held.

The coroner will order a post mortem examination to be carried out as soon as possible by the most appropriate pathologist available (this may be a paediatric pathologist, forensic pathologist or both) who will perform the examination according to the guidelines and protocols laid down by the Royal College of Pathologists. The coroner will inform the LSCB team of intention to carry out a post mortem examination. The designated paediatrician will collate and share information about the circumstances of the child's death with the pathologist in order to inform this process.

If the death is unnatural or the cause of death cannot be confirmed, the coroner will hold an inquest. Professionals and organisations who are involved in the child review process must cooperate with the coroner and provide him/her with a joint report about the circumstances of the child's death. **Where possible this should not be led by the clinician who was responsible for the care of the child when they died**. This report should include a review of all medical, local authority social care and educational records on the child. The report should be delivered to the coroner within 28 days of the death unless crucial information is not yet available.

**Disclosure of information**

Professionals should provide the coroner with all the evidence the coroner requires to carry out his or her statutory duty to establish who died, where, when and how. Coroners have a power (under section 32 and Schedule 5 of the Coroners and Justice Act 2009) to require someone to provide evidence to the coroner or give evidence at an inquest

**Action after the post mortem results**

Although the results of the post mortem belong to the coroner, it should be possible for the paediatrician, pathologist and lead police investigator to discuss the findings as soon as possible and the coroner should be informed immediately of the initial results. If these results suggest evidence of abuse or neglect as a possible cause of death, the paediatrician should inform the police and children's social care immediately. He or she should also inform the LSCB Chair so that they can consider whether the criteria are met for initiating a serious case review. This notification can be made to the Service Manager for the LSCB by contacting 01724 298293.

Shortly after the initial post mortem examination results become available, the designated paediatrician for unexpected child deaths should convene a multi agency case discussion, including all those who knew the family and were involved in investigating the child's death. The professionals should review any further available information, including any that may raise concerns about safeguarding issues.

A further multi agency case discussion should be convened be the designated paediatrician or paediatrician acting as their deputy, as soon as the final post mortem examination results is available. This is in order to share information about the cause of death or factors that may have contributed to the death and to plan future care of the family. The designated paediatrician should arrange for a record of the discussion to be sent to the coroner, to inform the inquest of the cause of death and to the relevant CDOP, to inform the child death review. At the case discussion, it should be agreed how detailed information about the cause of the child's death will be shared and by whom, with the parents and who will offer parents ongoing support.

**Specific responsibilities of relevant bodies in relation to child deaths**

| | |
|---|---|
| **Registrars of Births and Deaths (Children and Young Persons Act 2008)** | Requirement to supply LSCB with information which they have about the death of persons under 18 they have registered or re registered.<br><br>Notify LSCB's if they issue a *Certificate of No Liability to Register* where it appears that the deceased was or may have been under the age of 18 at the time of death<br><br>Requirement to send the information to the appropriate LSCB (the one which covers the sub district in which the register is kept) no later than seven days from the date of registration. |
| **Coroners (Coroners and Justice Act 2009)** Coroners (Investigations) Regulations 2013 **)** | Duty to investigate and may require evidence and an inquest.<br><br>Coroner's duty to notify the LSCB for the area in which the child died or where the child's body was found within three working days of deciding to investigate a death or commission a post-mortem.<br>Coroner's duty to share information with relevant LSCBs. |
| **Registrar General (section 32 of the Children and Young Persons Act 2008)** | Power to share child death information with the Secretary of State, including about children who die abroad. |
| **Clinical Commissioning** | Employ , or have arrangements in place to secure the expertise |

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|---|---|
| **Groups (Health and Social Care Act 2012)** | of, consultant paediatricians whose designated responsibilities are to provide advice on:<br>• commissioning paediatric services from paediatricians with expertise in undertaking enquiries into unexpected deaths in childhood and from medical investigative services; and<br>• the organisation of such services. |
| **Designated Paediatrician for unexpected deaths in childhood** | Ensure that relevant professionals (i.e. coroner, police and local authority social care) are informed of the death; coordinate the team of professionals (involved before and/ or after the death) which is convened when a child who dies unexpectedly (accessing professionals from specialist agencies as necessary to support the core team).<br><br>Convene multi agency discussions after the initial and final post mortem results are available. |

**Principles**

When dealing with an unexplained child death, all agencies need to follow five common principles:

a) Sensitivity and open minded balanced approach
b) An inter-agency response
c) Sharing of information
d) Appropriate response to the circumstances
e) Preservation of evidence

Families should be treated with sensitivity, discretion and respect at all times, and professionals should approach their enquiries with an open mind.

Families should be offered support and advice following the death of their child, and a designated professional, should maintain contact at regular intervals with the family and other professionals to ensure that the family is kept informed regarding information about the child's death and to ensure that the family know where to get appropriate help and support.

At an appropriate time, families should be made aware that their child's death will be subject to multiagency review meeting, this should also include appropriate information to explain the process.

**Notification of a child death**

It is the responsibility of the Consultant Paediatrician of the week to ensure that relevant professionals are informed of the death of a child. Once the Consultant Paediatrician has informed the relevant agencies, those agencies should follow their own internal notification for informing the appropriate managers/ services.

The LSCB Chair is responsible for determining who should receive a child death notification as per national requirements on **all** child deaths using the form A (Contact LSCB for a copy) and sending it to the person designated by the Independent Chair who is the Service Manager for the LSCB. Official notifications of an **unexpected** child death should be made as soon as possible or within **24 hours** of the child's death (unless it is a weekend and then the notification must be made on the Monday

morning). The notification timescale for **expected** child deaths to the designated person is 3 working days.

All notifications will be made using the nationally agreed notification form A and must be emailed securely using encryption or Government Connect. In addition agencies are asked to contact the LSCB Manager or Support Officer on 01724 298293 to inform them that a notification has been sent.

Individual agencies are responsible for ensuring that their staff are aware of the CDOP procedures and operate in compliance with these.

**Notifiable incidents**

The local authority is required to notify OFSTED of any children which meets any of the following criteria:

- a child has died (including cases of suspected suicide) and abuse or neglect is known or suspected
- a child has been seriously harmed ad abuse or neglect is known or suspected
- a looked after child has died (including cases where abuse or neglect is **not** known or suspected): or
- a child in a regulated setting or service has died (including cases where abuse or neglect is **not** known or suspected)

**Initial information sharing and planning meeting 24-48 hours (Rapid Response meeting) following an unexpected child death**

An initial information sharing and planning meeting coordinated by the Designated Paediatrician or Consultant of the Week, will be held within held within 2 working days and following the initial post mortem results. This meeting will be chaired by the Designated Paediatrician and the meeting should also include:

- the police
- Children's Social Care Service
- any other relevant healthcare professionals such as the school nursing or health visiting service
- any other relevant professional group that have had significant contact with the child/family
- any other relevant representative that is relevant based upon the individual circumstances of the death.

The purpose of this case discussion is to review any information that has come to light that may raise additional concerns about safeguarding issues and discuss the support to be offered to the family. The designated paediatrician should arrange for a record of the discussion to be sent to the coroner to inform the inquest and cause of death and to the relevant CDOP to inform the child death review. At the case discussion , it should be agreed how detailed information about the cause of the child's death will be shared, and by who, with the parents and who will offer the parents ongoing support**.** If the initial post-mortem findings or findings from the child's history suggest evidence of abuse or neglect as a possible cause of death, the police child protection team and Children's Social Care Service should be informed immediately and the serious case review processes in Chapter 4 of the LSCB procedures will be followed.

If there are concerns about surviving children living in the household the LSCB guidelines and procedures set out in Chapter 1 of the LSCB procedures that are written in accordance with statutory

guidance Working Together to Safeguard Children 2015 and these should be followed with respect to these children.

If, after careful consideration, there is sufficient information or evidence to suggest that a suicide cluster or contagion is underway (see appendix 2 for definition), the police should notify the Director of Public Health / Public Health Hub for consideration of instigation of the community action plan or feeding in to an existing community action plan. The police should inform the rapid response meeting of the referral.

For further information see the North Lincolnshire Suicide Cluster Community Action Plan Practice Guidance on the LSCB website under 'supplementary policy and procedures'.

At this stage the core data set should be collated/updated by sending out the Form Bs to relevant agencies (supplied by the LSCB) and, to be returned within 3 weeks.

**Case Discussion following the final results of the post mortem examination becoming available**

A further case discussion meeting should be held, as soon as the final post mortem result is available. The timing of this discussion will vary according to the circumstances of the death. This may range from immediately after the post-mortem to eight to twelve weeks after the death. The type of professionals who will be involved in this meeting will depend on the age of the child. The meeting discussion should include those who knew the child and family, and those involved in investigating the death i.e. GP, health visitor or school nurse, paediatrician(s), pathologist, senior investigating police officers and where appropriate social workers.

This meeting should be convened and chaired by the designated paediatrician. At this stage the collection of the core data set should be completed and, if necessary, previous information corrected in a manner that enables this change to the information to be audited**.**

The main purpose of the case discussion is to share information to identify the cause of death and/or those factors that may have contributed to the death and then to plan future care for the family. Potential lessons to be learnt may also be identified by this process. Another purpose is to inform the Inquest.

There should be an explicit discussion of the possibility of abuse or neglect either causing or contributing to the death, and if no evidence is identified to suggest maltreatment this should be documented as part of the minutes of the meeting.

It should be agreed how detailed information about the cause of the child's death will be shared, and by whom, with the parents and who will offer them ongoing support.

The results of the post mortem examination should be discussed with the parents at the earliest opportunity, except in those cases where abuse is suspected and/or the police are conducting a criminal investigation. In these situations the paediatrician should discuss with Children's Social Work Service, the police and pathologist what information should be shared with the parents and when. This discussion with the parents will usually be part of the role of the paediatrician responsible for the child's care and she or he will, therefore have responsibility for initiating and leading the meeting**.** A member of the primary health care team should usually attend this meeting.

A record of the case discussion and the record of the core data set will be made available to the local Child Death Overview Panel. This information will then be analysed and decisions made about what actions (if any) could be taken to prevent similar deaths in the future.

**Interface between the Child death Overview Panel Process and the Serious Case Review Process.**

If it is thought at any time, that the criteria for a serious case review might apply, the Chair of the LSCB should be contacted and the case be referred to the Serious Case Review Sub Committee who will consider whether the criteria to undertake a serious case review has been met.

Any case whereby it has been determined that the criteria for a Serious Case Review has been met, will be managed as per the Chapter 4 of the LSCB Procedures. The findings from this review will be shared with the CDOP at the point where the Executive Summary for the SCR is to be made available, following agreement by the LSCB.

**General advice for all professionals when dealing with the family**

This is a very difficult time for everyone. The time spent with the family may be brief but actions may greatly influence how the family deals with the bereavement for a long time afterwards.

A sympathetic, supportive and non-judgmental attitude whilst maintaining professionalism towards the investigation is essential.

Remember that people in the first stages of grief may be shocked, withdrawn, depressed, hostile, aggressive, or hysterical. Professionals should also be aware of how differing cultural beliefs may impact upon expressions of grief.

All professionals must record history and background information given by parents/carers in as much detail as possible. The initial accounts of the circumstances including timings must be recorded verbatim if possible. It is normally appropriate for the parent/carers to want physical contact with his/her dead child. This should be encouraged, albeit with observation and support by an appropriate professional.

The child should always be handled as if he/she were still alive, remembering to use his/her name at all times as a sign of respect.

In those child deaths where the cause of death is unknown, the coroner must be consulted. It is the coroner's decision to authorise a post mortem to establish the cause of death and to decide on the type of pathologist needed for the post mortem.

Staff from all agencies need to be aware that, on occasions, in suspicious circumstances, the early arrest of the parents/carers may be essential in order to secure and preserve evidence and thus effectively conduct the investigation. Agency professionals must be prepared to provide statements of evidence promptly in the above circumstances.

**Information Sharing**

The legislative framework for sharing information throughout the CDOP process is set out within Statutory Guidance Working Together to Safeguard Children 2015 and the Children and Young Persons Act 2008 and HM Governments Information Sharing Practice Guidance 2009.

Information within the CDOP is regarded as personal sensitive information about individuals and will be treated as such.

- All information sharing will comply with Caldicott guidelines.
- All information will be regarded as confidential and case discussion meetings and CDOP panel members will be required to sign a confidentiality agreement on each case.

- All information held on individuals will be stored as per the Data Protection Act 1998 and will be stored for a period of 6 years.
- Information sharing between the LSCB the Coroner, the Registrar and Independent Reviewing Team (child protection) will be as per the agreed protocols (see appendix 3 )
- The executive summary of the CDOP annual review will be fully anonymised so that identifiable information is removed.

## Appendix 1

### Factors which may indicate a concern

Certain factors in the history or examination of the death may give rise to concern about the circumstances of the death. If any such factors are identified, it is important that these factors are documented and shared with senior colleagues and relevant professionals in other key agencies. Police officers in carrying out an initial assessment should also consider the factors outlined below. Some of the indicators will be sufficient on their own to raise suspicion whilst others may require a combination.

The following is not exhaustive and intended as a guide:

a) Signs of injury – e.g. signs of serious trauma, strangulation marks, cigarette marks, bruising to areas of the body indicative of child harm. Unexplained injury or any unexplained bruising, burns or bite marks. It is very important to remember that the child may have serious internal injuries without any external evidence of trauma.

b) Previous child deaths.

c) Previous near miss S.I.D.S. in the infants life. These could include incidences of choking necessitating resuscitation, claims of the child having stopped breathing, claims of objects being lodged in the throat,

d) Previous Child Protection concerns within the family relating to the child or siblings. It is important to check whether the child is subject to a child protection plan, previous A&E attendances and the hospital records to the child. A&E staff must inform the child protection SUDIC Nurse of all child deaths and she will arrange for this information to be collated regarding siblings. She will also contact the Health Visitor to gain additional relevant information.

e) The time of death – This would include appropriate delay in seeking help, it would also be unusual for SIDS to occur other than during night hours

f) Inconsistent explanations. An early record of events from the parents/carers is essential including details of the child's recent ill health. All comments should be recorded. Any conflicting accounts should raise suspicion but it must not be forgotten that any bereaved person is likely to be in a state of shock. Repeated questions to parents/carers by different police officers should be avoided.

g) Evidence of drugs/alcohol abuse, particularly if the parents/carers are still intoxicated.

h) Evidence of parental mental health problems, including fictitious illness.

i) Presence of blood. The presence of blood may arouse suspicion particularly from the nose or ears. Note that a pinkish, frothy, residue around the nose or mouth is a normal finding in some children whose deaths are due to soft suffocation.

j) Neglect issues. Observation about the condition of the accommodation (from ambulance staff), general hygiene and cleanliness, the availability of food, adequacy of clothing and bedding and temperature of the environment in which the child is found is important. It is also important to consider any other children and their condition. This will assist in determining whether there may be any underlying neglect issues.

k) Related information – this may include information on Phoenix, the Domestic Abuse Register, or information held by the Family Protection Unit.

## Appendix 2

### Definition of a suicide cluster and contagion

The term **suicide cluster** describes a situation in which more suicides than expected occur in terms of time, place or both. A suicide cluster is defined as a series of three or more closely grouped deaths, however two suicides occurring in a specific community or setting and time period should be taken seriously in terms of possible links, particularly in the case of young people. It is important to establish any connections at an early stage.
Suicidal behaviour can be spread via the internet and social media, with the potential that a greater number of suicides could occur in a specific time period, and be dispersed geographically (**mass clusters**).

Evidence suggests that some population groups are particularly vulnerable to suicide clusters, including young people, people with mental health problems and prisoners.
Relatedly, clusters of suicidal behaviour are more common in certain settings, including schools, psychiatric facilities, prisons and workplaces.
Prevention measures may need to be taken after a single suicide in a group vulnerable to imitation or so called "**copycat behaviour**".

Research estimates that between 1 and 5% of all suicides by young people occur in the context of a cluster, and that 6% of suicides in prisons and 10% of suicide by people with mental illness are due to imitation or clustering effects. Therefore early identification and action are required to contain the impact.

It has been proposed that **suicide clusters are due to 'contagion'** or the process where one person's suicide influences another person to engage in suicidal acts.

Contagion may be particularly likely to occur in circumstances where the second person is already contemplating a suicidal act, or is particularly vulnerable or impressionable. The mechanisms by which contagion operate are not fully understood, and may vary considerably from person to person.

**Potential risk factors that may create a contagion;**

- An expression of grief or a means of escaping from pain after experiencing the suicide or a serious attempt to end one's life; particularly a friend or relative
- Imitation of another's suicidal behaviour as a way to deal with a range of emotions or events
- A suicide involves a person with similar characteristics (e.g. gender, age, social circumstances) to other people who have died. Such deaths may have occurred within an individual's social network or people that became aware of through media or other influences
- A desire to be recognised, for identity, or to be part of a group, which may occur if previous suicides are perceived to have achieved recognition for those who have died
- Exposure to a particular method, providing a 'suggestion' for that method to be used again.
- A celebrity or person of local influence either by suicide or other cause
- Media attention
- Published methods of committing suicide

## Appendix 3

### Protocol for working with H.M. Coroner – Northern Lincolnshire

**Introduction**

Chapter 5 of 'Working Together to Safeguard Children' sets out the procedures to be followed by Local Safeguarding Children's Boards (LSCB's) following the death of a child in their area. This function will be carried out by the Child Death Overview Panel. This panel has a duty to work closely with the coronial service when fulfilling their role.

This protocol sets out that working arrangement between LSCB's within Northern Lincolnshire and H.M. Coroner for Northern Lincolnshire.

**Liaison and Consultation**

The LSCBs, via the Child Death Overview Panel, will ensure that there is appropriate discussion and liaison with the Coroner (or his officers) on all matters concerning the death of children as they relate to LSCB functions. This communication can be facilitated by any appropriate means (telephone, e-mail, letter, fax etc) and will usually occur within normal working hours – unless there is an urgent out of hours requirement.

**Notification of Deaths**

To enable the LSCBs to fulfil their functions, systems are in place to ensure that all relevant deaths are notified from LSCB professionals. As a failsafe, H.M. Coroner will provide monthly data to a named individual within the LSCB on the deaths of all children under 18 years of age. This notification will include the full name, date of birth, date and place of death of the child.

**Unexpected Deaths**

Following an unexpected death, the rapid response team will consult with the Coroner at the earliest opportunity to agree;

- what immediate enquiries need to be undertaken to evaluate the reasons for and circumstances surrounding the death, and by whom
- the arrangements for family liaison and the information given to the family, and by whom
- timescales for the above.

The LSCBs will update the Coroner at timely intervals upon their findings and intentions (e.g. Management Review, Serious Case Review etc.), so that LSCB and Coronial functions are working together for the benefit of bereaved families, and the performance of respective functions.

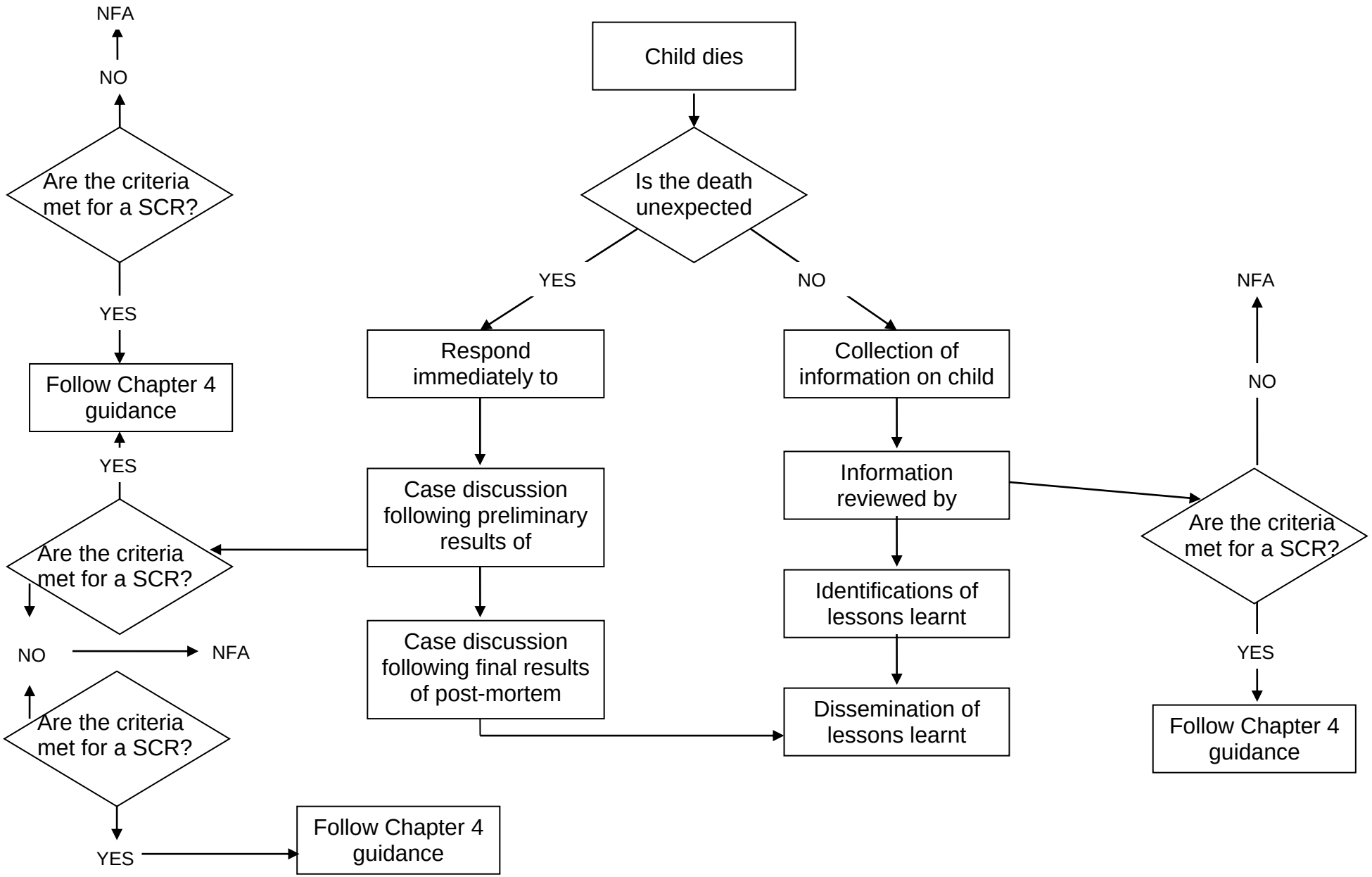
**Information Sharing**

The LSCB and the Coroner will share information relating to the death of all children under 18 years of age, not only for the purpose of Child Death Overviews and Serious Case Reviews, but also to increase understanding and knowledge about trends or issues, that may inform LSCB actions around the prevention of future deaths.

**Review**

This protocol will be reviewed annually by LSCB Child Death Overview Panel and H.M. Coroner.

**Appendix 4** **Flow chart 6: Interface between the child death and serious case review processes**



## Appendix 5

**Useful telephone numbers**

**Protecting Vulnerable People Team (Police)**

Scunthorpe: 01724 241700

**Local Safeguarding Children Boards**

Scunthorpe: 01724 297240

**Children's Services**

North Lincolnshire: 01724 296500

**Extended Hours Team**

North Lincolnshire 01724 296555

**Northern Lincolnshire & Goole Hospitals NHS Trust**

**Named Doctors** (Contact via the Hospital Switchboards)

Scunthorpe General Hospital 01724 282282

**Named Nurses**

Scunthorpe: 01724 282282 ext. 5443

**North Lincolnshire Clinical Commissioning Group**

Designated Nurse 01652 251216/ 07789 615434

Named Doctor 01652 251036

**Coroner's Office**

Scunthorpe & Grimsby: 01472 324005 (24 hour phone line)