Milton Keynes Hospital NHS
NHS Foundation Trust

GUIDELINES FOR MANAGING THE UNEXPECTED DEATH OF A CHILD

"UNEXPECTED" The death, or the collapse which led to the death, was not anticipated 24 hours previously.

"CHILD" For the purpose of this guideline childhood begins at the moment of live birth and ends on the 18th birthday.

The legislation surrounding child death is based on practice around cot death but has been expanded to encompass deaths throughout the whole of childhood. The aim is to be fair to the deceased by investigating the death thoroughly and to be fair to the bereaved by supporting them fully.

This guideline is based on the Rapid Response to an Unexpected Child Death procedure (Chapter 29 of the Milton Keynes Safeguarding Children Board Inter Agency Child Protection and Safeguarding Procedures) available on the hospital intranet.

- HM Coroner is notified (via the coroner's officer) of all unexpected deaths in children.
- It is important to consider whether there are any investigations that need to be organised immediately post mortem if the cause of death is unclear (see procedures)
- There should be a senior clinician designated "responsible consultant"
- The responsible consultant will ensure that Children's Social Care (duty desk) and the Police (CAIU) are notified. If there are any suspicious features about the death a face to face strategy meeting should be convened by Children's Social Care
- The Coroner and Pathologist will be provided with:-
    - A short summary of the events leading up to and surrounding the death.
    - Contact details for the responsible consultant
    - A report from the strategy meeting if convened
    - Access to relevant pathology results
- When the cause of death is revealed by the autopsy and is straightforward the Coronial service will inform the responsible consultant and will provide them with a copy of the autopsy result. The Coronial service will pass on the consultant's contact details to the bereaved family so that a meeting can be arranged to discuss the death.
- If the full facts are unclear and will not be determined without an Inquest the Coronial service will retain responsibility for communicating with the bereaved family and no action will be needed from the involved consultant.
- If a final debrief for those involved in the initial response is needed, this will not take place until after the Inquest. This would not prevent counselling for team members where significant personal issues exist, but should not centre on the cause or circumstances of the death.

Dr P Latham – Designated Doctor – December 2009

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