Guideline

Managing the death of a child (including checklist)

Classification :	Guideline		
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Authors Division:	Women and Children's Health		
Departments/ Groups this Document Applies to:	Trustwide		
Date of Approval:	02/2016	**Review Date:**	12/2018
Approval Group:	Paediatric PIG, Paediatric CIG Milton Keynes Safeguarding Children Board, Coroner's Office, Trust Documentation Committee Management Board – February 2016	**Last Review:**	2/2016

Unique Identifier: PAED/GL/21	**Status:** Approved	**Version No:** 3
Scope: All nursing, medical and support staff dealing with child death	**Document for Public Display:** No	

To be read in conjunction with the following documents:

- MKUHT Safeguarding Children Policy
- Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf
- MKSCB Inter-Agency Policy & Procedures http://www.mkscb.org
- Information sharing: advice for practitioners providing safeguarding services to children, young people, parents and carers https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf

Required CQC evidence? Yes	**Key CQC Question:** Safe/Effective/Responsive/Caring

Disclaimer –
Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.

The ultimate responsibility for the use of the guideline and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

This guideline provides detailed information for Emergency Department (ED), Paediatric staff, managers and others within the Trust in the event of any child death.

Executive Summary

The vast majority of sudden unexpected child deaths are the result of natural causes and are a tragedy for any family. All sudden unexpected child deaths need to be fully investigated to exclude homicide, to determine the cause of death, to reassure the family, to ensure future children are protected and to satisfy wider public concern.

Definitions

Childhood" is defined as the time from live birth (irrespective of gestation) until the attainment of the age of 18 years.

"Unexpected death" is defined in Working Together to Safeguard Children 2015 (Chapter 5, paragraph 12) as the death of an infant or child (less than 18 years old) which was not anticipated as a significant possibility for example 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which led to the death.

"Death" means the time that death is formally certified.

“Responsible consultant" has been used to identify the senior involved clinician, this is most likely to be a paediatrician but when the death is that of a young person of over 16 years the clinician may be an adult specialist and some interpretation of the protocol depending on age and mode of death may be required.

Working Together to Safeguard Children (2015) sets out the procedures to be followed when a child dies in the Milton Keynes Safeguarding Children Board (MKSCB) area. There are two interrelated processes:

- A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child
- An overview of all child deaths up to the age of 18 years, in the Milton Keynes Safeguarding Children Board area, by the Child Death Overview Panel.

The overall aim of this policy is to ensure there is a consistent approach in caring for patients and families following the death of a child in hospital.

1.0 Roles and Responsibilities

1.1 The Coroner

The body of a child who has died suddenly and unexpectedly belongs to the Coroner. The Coroner must be informed about any death that is sudden, unexpected, violent and unexplained or where there is reason to believe that it is unnatural or the child has been in hospital for less than 24 hours, or has had surgery. (Referral to HM Coroner Appendix 8)

1.2 Health Care Professionals

The principles that professionals need to work to when dealing with a likely sudden unexpected child death are:

a) To assess whether there is prospect of survival and resuscitate as appropriate
b) To provide coordinated and timely multiagency response and share information with relevant professionals
c) To collect samples/ evidence to help determine cause of death
d) To ensure compliance with the law and forensic requirements
e) To provide bereavement support to the family

1.3 The Designated Pediatrician

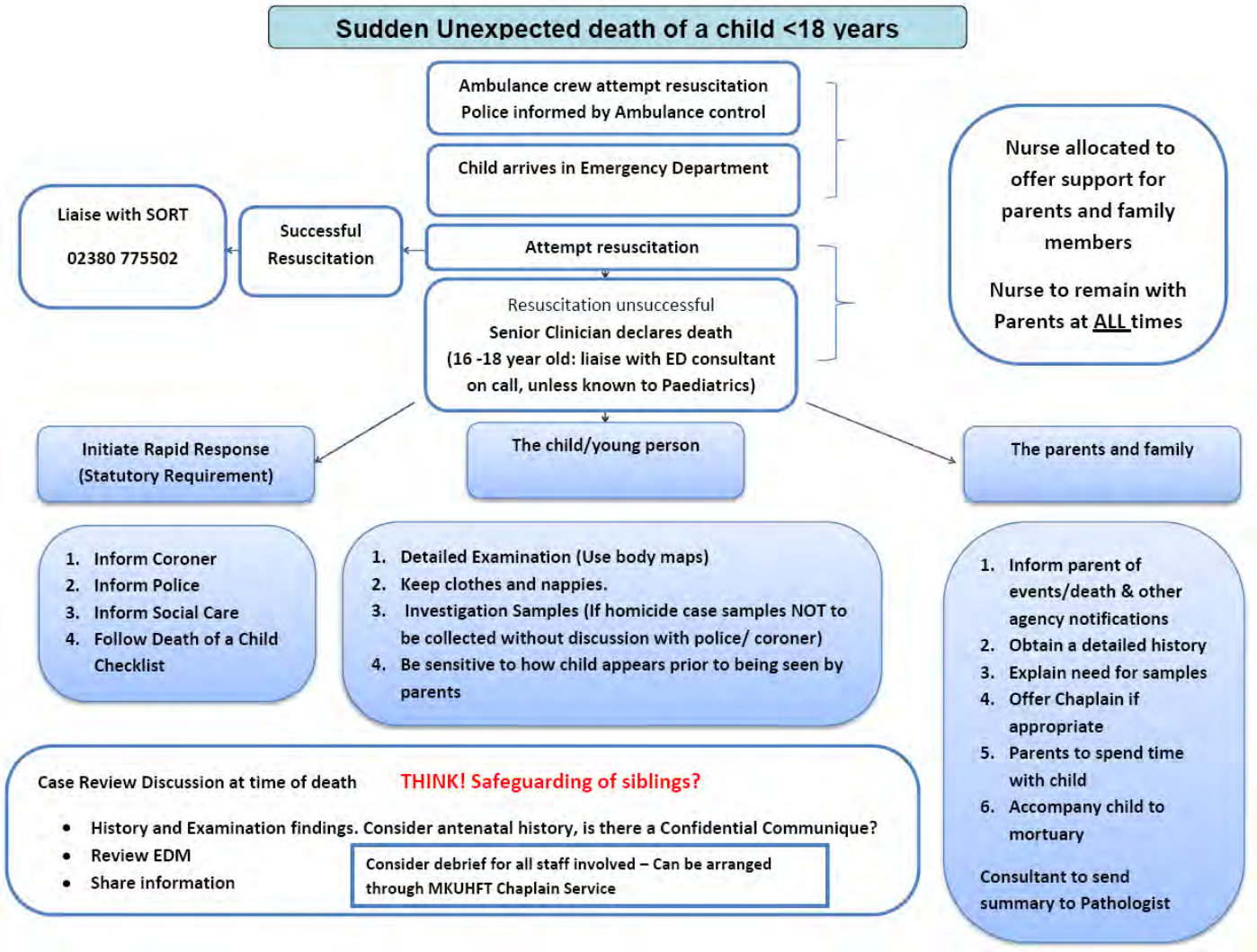
The Designated Paediatrician for unexpected deaths in childhood will take the strategic lead for rapid response within Health, but the input at senior level in individual cases will be from the consultant involved in the initial event as at present (responsible consultant).

2.0 Implementation and dissemination of document

This Policy will be placed on Milton Keynes University Hospital NHS Foundation Trust Intranet site and be highlighted in Safeguarding Children training and induction of staff.

3.0 Processes and procedures

This guideline takes into account of Working Together to Safeguard Children 2015, changes in Coronial procedures and revised interagency working processes following the implementation of Milton Keynes Multi-Agency Safeguarding Hub (MASH)



3.1 Management of a child in Emergency Department in cardiac/respiratory arrest

3.1.1 Prior to arrival in ED

Children found dead at home should usually be taken into the Emergency Department, not to the mortuary, and resuscitation should be initiated unless clearly inappropriate. The ambulance crew should have contacted the police with full incident details as soon as it is apparent that a child is in cardiac/respiratory arrest.

3.1.2 On arrival in ED

- On arrival in the emergency department the parents/carers should be allocated a member of staff (not student or volunteer) to care for them.
- On arrival, the child should be examined, and a careful history should be taken from the parents whilst resuscitation continues.
- In cases where the medical team has any concerns that there are issues of abuse or neglect when a child has presented in a critical condition, especially where there are other children in the household, then early discussion with Police and Children's Social Care (CSC) should take place. This will allow scrutiny of the CSC and Police databases as a minimum precaution and further inter-agency involvement as considered necessary.

These preliminary enquiries can be made without informing the parents if it is considered that this will add to their distress.

- If resuscitative efforts are unsuccessful and the team decision is to stop, the parents will be need to be informed and given an opportunity to be with the child at this time with supervision.

- When the child is pronounced dead ("Death" means the time that death is formally certified), the responsible consultant should explain to the parents/carers that the Coroner, Police and Children's Social Care involvement will be required as well as the need for a post-mortem examination.

- As soon as death has been confirmed, notification should be given to the Coroner (via the Coroner's Officer), the Police, Children's Social Care and the primary care team.

- The child's body should be carefully examined after death with documentation on body maps (Appendix 4).

- A standard set of investigative samples should be taken. This list is available in the emergency department and on the MKHFT safeguarding children intranet pages. It is also included in appendix 3 of this guideline.

- The opportunity to donate tissues or organs would only occur in the situation where life support on an Intensive Care Unit following collapse was being withdrawn and there was an opportunity to seek the Coroner's permission.

3.2 Rapid Response procedure – multiagency approach

Working Together to Safeguard Children (2015) sets out the procedures to be followed when a child dies in the Milton Keynes Safeguarding Children Board (MKSCB) area.
Rapid Response procedure is a rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child
The duty social worker is contacted by the responsible consultant/ team and a Multi-Agency Referral Form (MARF) is completed and forwarded to the Milton Keynes Multi-Agency Safeguarding Hub (MASH). An initial **Case Review Discussion** should be held between the lead professionals (the involved clinician, the senior investigating officer in consultation with the Child Abuse Investigation Unit (CAIU) Detective Inspector (DI) and the MASH at Children's Social Care. This is usually done by telephone by the involved clinician but should be initiated by the agency that has the initial contact with the child if not Health. The circumstances of the child's death and initial discussions involving the clinicians in consultation with the Police Senior Investigating Officer (SIO) needs to be incorporated into the MARF.

In the event of a child dying out of hours, the out of hours duty team will be involved in the case review discussion and refer into MASH for the next working day.
In most cases a multi-agency discussion will take place within the MK MASH. Depending on the outcome of this discussion a strategy meeting under s47 may be convened by Children's Social Care. There will be situations where the circumstances of the death are straightforward and this is not required.

A copy of the medical notes will be made available to the Coroner and the pathologist. The details of the involved clinician MUST be clearly recorded on the medical records. It must be clear on the medical records who the lead clinician is, to facilitate discussion between the pathologist and the lead clinician. This is particularly important in cases where a forensic pathologist is required.

If the death is suspicious or significant concerns are raised at any stage about the possibility of abuse or neglect, a decision will be taken for the police to become the lead agency, and take primacy in the investigation. In these circumstances consultation must take place with the police, to ensure no compromise of information to the parents/carers or those close to them, who may be responsible for or contributed to the cause of death.
In all other cases Health remains the lead agency.

3.3 Care and support for the family and breaking the news

Ensure an appropriate member of staff (not student or volunteer) is allocated to be with the parents and family members at all times

- Ensure the family have privacy
- When the death of the child has been confirmed a senior doctor should break the news to the parents, having first reviewed the available information
- Whenever possible speak to both parents together and always use the child's name
- Explain that any sudden death of unknown cause has to be reported to the Coroner who will require a postmortem to be undertaken
- Explain that information will need to be shared with the police as a matter of routine as the police are required to investigate all sudden unexpected child deaths
- Give the parents the opportunity to be with their child
- Listen to what parents say and do not hurry them
- Remember your non-verbal communication skills
- Make sure parents receive the purple bereavement folder before leaving the hospital. This is available in the resuscitation area of the Emergency department and in the Bereavement Office.
- Ensure the family has had the time they need with their child. Contact other members of the family if appropriate, and with their permission.
- To offer pastoral support, seek advice from the chaplain which can include religious care if appropriate. Parents may have their own religious leader they wish to call.
- Offer support from the Bereavement Officer
- Mortuary staff can be contacted to come and meet the family. This can help the family with regards to arranging further viewing and also establishes a relationship which parents can find supportive. The contact number for the mortuary is 01908 995828. Mortuary staff can also transfer the child with or on behalf of the support team.
- A memory box, locks of hair, photos and handprints can all be made available by the mortuary staff after child has been transferred to their care. This will ensure dignity to the child and the parents/carer.
- A follow up appointment with the consultant can be offered and arranged for parents when they feel they are ready. This is most likely to be within a few weeks of the death or inquest. Arrange transport home.

- A named member of staff must be allocated on the checklist to make a follow up call to the parents within 24 hours of the child's death.

3.4 Nursing responsibilities following the a child or young person's death

- It should be remembered that parents feel their responsibility to their child continues after death.
- Staff should be sensitive to the needs of the parents and the Bereavement Officer will come to offer support to them and staff alike.
- Transfer to the mortuary using an Angel Box or Concealment Trolley as appropriate (Refer to the Support Team Policy for Transportation of deceased to Mortuary)
- No baby or child should be carried to the mortuary.
- The parents may accompany the nurse with the child to the mortuary if they wish, but this is not ideal as they will not be able to enter mortuary itself at this time. However, the parents may have further opportunities arranged to see their child in the mortuary.
- The parents must have the opportunity to return to the ward/department to collect belongings (if appropriate) and to be given all appropriate information before they leave the hospital. Parents contact numbers should be confirmed in case further contact is required.
- The 'Communicating the death of a child checklist' and Death Notification form must be completed by a registered nurse.

3.5 Communicating the Death of a Child

- **In the event of a death of a child in Milton Keynes University Hospital NHS Foundation Trust the checklist in Appendix 1 must be completed, in conjunction with the "Death Notification" form and filed in the patient notes.**

- The "Death Notification form" will be completed by the nurse caring for the family.

- The speed of communication is essential, especially if the death was unexpected or unexplained, to ensure that no inappropriate correspondence is sent to the family.

- In the event of a death of a Milton Keynes child out of area or subsequently following transfer to another unit, the checklist in Appendix 1 must be completed as soon as hospital staff are informed of the death by paediatric department.

3.6 Expected child death

- An expected / planned death at home may be managed by the hospital Children's Community Nurses. In this event the checklist in Appendix 1 must be completed.

- If parents wish to take the baby or child home this can be arranged however they require all appropriate documentation to enable this to happen.

- If an expected death occurs in hospital and they do not need a referral to the coroner as criteria for referral are not met then parents may take their child home.

- If an expected death occurs in hospital and referral to the coroner is required then the child must remain in hospital.

- In all cases appropriate documentation must be completed prior to release.

4.0 Statement of evidence/references

References:

Milton Keynes Safeguarding Children Board. *MKSCB Inter-Agency Policy & Procedures*. [Online]. [Accessed 22 May 2015]. Available from: http://www.mkscb.org

Milton Keynes Safeguarding Children Board. *Milton Keynes Safeguarding Children Board Procedures.* [Online]. Milton Keynes, 2015. [Accessed 22 May 2015]. Available from: http://mkscb.proceduresonline.com/chapters/quick_guide.html

Milton Keynes Safeguarding Children Board. *Procedures 4.1 Rapid Response to an Unexpected Child Death.* [Online]. Milton Keynes: MKSCB, 2015. [Accessed 22 May 2015]. Available from: http://mkscb.proceduresonline.com/chapters/p_unexpec_death.html

Milton Keynes Safeguarding Children Board. *Procedures 4.2 Child Death Overview Panel Procedure.* [Online]. Milton Keynes: MKSCB, 2015. [Accessed 22 May 2015]. Available from: http://mkscb.proceduresonline.com/chapters/p_chi_death.html

Milton Keynes Safeguarding Children Board. *Procedures 2.4 Information Sharing & Confidentiality.* [Online]. Milton Keynes: MKSCB, 2014. [Accessed 22 May 2015]. Available from: http://mkscb.proceduresonline.com/chapters/p_info_sharing.html

MKHFT Overarching Information Sharing Protocol (Last reviewed August 2014)

MKHFT Care for Stillbirth, Termination of Pregnancy, and Neonatal Death after 24/40 Gestation [guideline]. (Last reviewed August 2014)

Department of Health. *Families and post mortems: a code of practice*. [Online]. London: Department of Health, 2003. [Accessed 22 May 2015]. Available from: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4054312.pdf
NOTE: "This code has been superseded by the Human Tissue Authority Code of Practice on Post Mortem Examination." Source: http://webarchive.nationalarchives.gov.uk/ See below:

Human Tissue Authority. *Code of practice 3 - Post-mortem examination*. [Online]. London: Human Tissue Authority, 2014. [Accessed 22 May 2015]. Available from: https://www.hta.gov.uk/sites/default/files/Code_of_practice_3_-_Post-mortem_examination.pdf

HM Government. *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*. [Online]. London: Department for Education, 2015. [Accessed 22 May 2015]. Available from: **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf**

External weblinks: Please note that although Milton Keynes University Hospital NHS Foundation Trust may include links to external websites, the Trust is not responsible for the accuracy or content therein.

5.0 Governance

5.1 Record of changes to document

Version number: 3		**Date:** 12/2015		
Section Number	**Amendment**	**Deletion**	**Addition**	**Reason**
All	Complete Review and update			Update

5.2 Consultation History

Stakeholders Name/Board	**Area of Expertise**	**Date Sent**	**Date Received**	**Comments**	**Endorsed Yes/No**
Dr Keya Ali	Designated Doctor for Child Death	June 2015		Review and amendments to meet current requirements	
Kate Falkner	Head of Safeguarding	June 2015		Review and amendments to meet current requirements	
Kim Weston	Bereavement Officer	June 2015 7/10/15	7/10/15	Inclusion of flow chart from bereavement policy and comments	
Kate Swailes	Matron Children and Young People	June 2015			
Alison Turner	Senior Sister Ward 5	June 2015 7/10/15	13/10/15	Yes	Yes
Jo Smith	Mortuary Manager	June 2015			
Sarah Crane	Chaplain	7/10/15	7/10/15	Yes	Yes
Zuzanna Gawlowski	Paediatric Consultant	7/10/15	14/10/15	Yes	Yes
Karen Rice		October 2015			
Sarah Ashall	Neonatal nurse	October 2015			
Diane Gray	Neonatal nurse	October 2015		Inclusion of neonatal checklist	
Tracy Rea	Bereavement midwife	November 2015		Review of neonatal checklist	

Julie Stones	Newborn Hearing Screening Programme Manager	7/10/15	7/10/15	Yes	Yes
Chrissie Parren	Senior Community Sister	7/10/15	8/10/15	Yes	Yes
Anne Thysse	Head of Midwifery	7/10/15	9/10/15	Yes	Yes
Marian Forster	Senior Staff Nurse	7/10/15	13/10/15	Yes	Yes
Safeguarding Children Board		01/2016	01/2016	Yes	Yes
Coroner's Office		01/2016	01/2016	Yes	Yes

5.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Annual feedback from the CDOP coordinator to be received by MKUHFT	Annual Report	CDOP coordinator	Annually	Safeguarding Committee

5.4 Equality Impact Assessment

This document has been assessed using the Trust's Equality Impact Assessment Screening Tool. No detailed action plan is required. Any ad-hoc incident which highlights a potential problem will be addressed by the monitoring committee.

Impact	**Age**	**Disability**	**Race**	**Gender**	**Religion or Belief**	**Sexual Orientation**
Do different groups have different needs, experiences, issues and priorities in relation to the proposed Guideline?	No	No	No	No	No	No
Is there potential for or evidence that the proposed Guideline will not promote equality of opportunity for all and promote good relations between different groups?	No	No	No	No	No	No
Is there potential for or evidence that the proposed Guideline will affect different population groups differently (including possibly discriminating against certain groups)?	No	No	No	No	No	No
Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular population group or groups?	No	No	No	No	No	No

Appendix 1: Checklist for Communicating the Death of a Child

For staff use only:
Surname:
Forenames:
Date of birth:
NHS No:
or affix patient label

Department/Health or Social Care Professional	Contact Details	Yes	Person/Establishment informed
Police (all unexpected deaths)	**101**		
Coroners Officer (out of hours request the on call sergeant and advise **URGENT**)	**01908 254326** or **01908 254328** Out of hours **101**		
Multi Agency Safeguarding Hub (MASH) (Inform of death, check if child is known to them, complete MARF with circumstances involving death and consultant involved)	**01908 253169/70** (9am -5pm) **01908 265545** (Out of Hours)		
Site Manager	**Bleep 1222**		
Paediatric Bleep Holder	**Bleep 1136**		
Maternity Bleep Holder (Neonatal death)	**Bleep 1440**		
Mortuary	**Ext: 85828 (8am – 4pm)** **Via Switch (Out of Hours)**		
Bereavement Officer (answerphone)	**Ext: 86155** **Bleep 1917**		
Bereavement Midwife: Death <1 month old	**Ext: 87157** **Bleep 1981**		
Midwife for family Death <1 month old	**GP Directory**		
Children's Community Nurses	**Ext: 2703**		
Child Health Department (answerphone)	**Ext: 3078**		
Other hospitals involved in child's care	**Review EDM/ ask parent**		
Consultant on call Paediatrician Complete CDOP Form A (Appendix 2)	**Bleep or via Switch board** **Email: mkcdop@nhs.net**		
CDOP Coordinator	**01908 278699**		
Lead Nurse for Safeguarding Children/ Designated Doctor for Child Death	**Bleep 1101** **Ext:85062** (answerphone)		
Chaplain	**Ext: 86062**		
Datix completed	**WEB:**		
CRS/EDM – Update within 4 hours	Ward clerk or ED reception staff		
Notes endorsed			
ED only – In case of support / medication for family	**GP UC: 01908 303030 /01908 303047**		
Copy of Form 1x matron for paediatrics 1x Lead Nurse for Safeguarding children			
Allocate member of staff: to contact the family the next day for support	**Name:**		
Give Purple Bereavement Folder to parents	ED resus/ bereavement office		

Name……..

Signature……

Designation……..……Date/Time……..

Appendix 2: CDOP Form A Notification of Child Death

Milton Keynes Safeguarding MKSCB

Form A - Notification of Child Death

CDOP Identifier (Unique identifying number) .....

Form A - Notification of Child Death

Notification to be reported to the CDOP Co-ordinator at: Email: mkcdop@nhs.net
Tel: 01908 278699

The information on these forms and the security for transferring it to the CDOP Co-ordinator should be clarified and agreed with your local Caldicott guardian.

If there are a number of agencies involved, liaison should take place to agree which agency will submit the Notification.

Child's Details:

Full Name of Child		
Any aliases		
DOB / Age	/ / days/months/years	NHS No.
Address		
Postcode		
School/nursery etc		
Date & time of death	/ / Time	
Other significant family members		

Referral details:

Date of referral	/ /
Name of referrer	
Agency	
Address	
Tel Number	
Email	

N.B. Page 1 can be removed for the purposes of anonymising the case.
Page 2 should be made available with Form B to the child death overview panel.

Milton Keynes Safeguarding Children Board

Form A - Notification of Child Death

CDOP Identifier (Unique identifying number) .....

Details of the death:

Location of death or fatal event (Give address if different from above)				
Death expected?	☐	Expected	☐	Unexpected†
Reported to Coroner		Y / N / NK /NA ☐☐ ☐ ☐	Date: / /	
			Name:	
Reported to Registrar		Y / N / NK /NA ☐☐ ☐ ☐	Date: / /	
			Name:	
Has a medical certificate of cause of death been issued?		Y / N / NK /NA ☐☐ ☐ ☐	Date: / /	
Post mortem examination:		Y / N / NK /NA ☐☐ ☐ ☐	Date: / /	
			Venue:	

† An unexpected death is defined as the death of a child which was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death.

Notification Details:

Please outline circumstances leading to notification. Also include if any other review is being undertaken e.g. internal agency review; any action being taken as a result of this death.

Appendix 3: Collection of Specimens Following Sudden Death in Childhood

The specimens needed will vary depending on the age of the child and whether the child is on medication. The list below is appropriate for infant deaths but not for older children. For example in the older age group toxicology is important, in children with epilepsy anti-convulsant levels should be obtained so some thought is needed as to what should be done. Sometimes blood is impossible to obtain and the dignity of the deceased has to be considered but the "spots" are easy to obtain.

Blood Tests

- 1-2mls into gold topped tube for toxicology.
- 1ml into aerobic and anaerobic (if sufficient) blood culture bottles.
- 1-2ml into lithium heparin for cytogenetics (if baby dysmorphic).
- 2 "spots" on newborn blood screening card (always available on NNU) for metabolic disorders.

Cerebrospinal fluid
Few drops only for microscopy, culture and sensitivity.

Nasopharyngeal aspirate
Virology.
Culture and sensitivity.

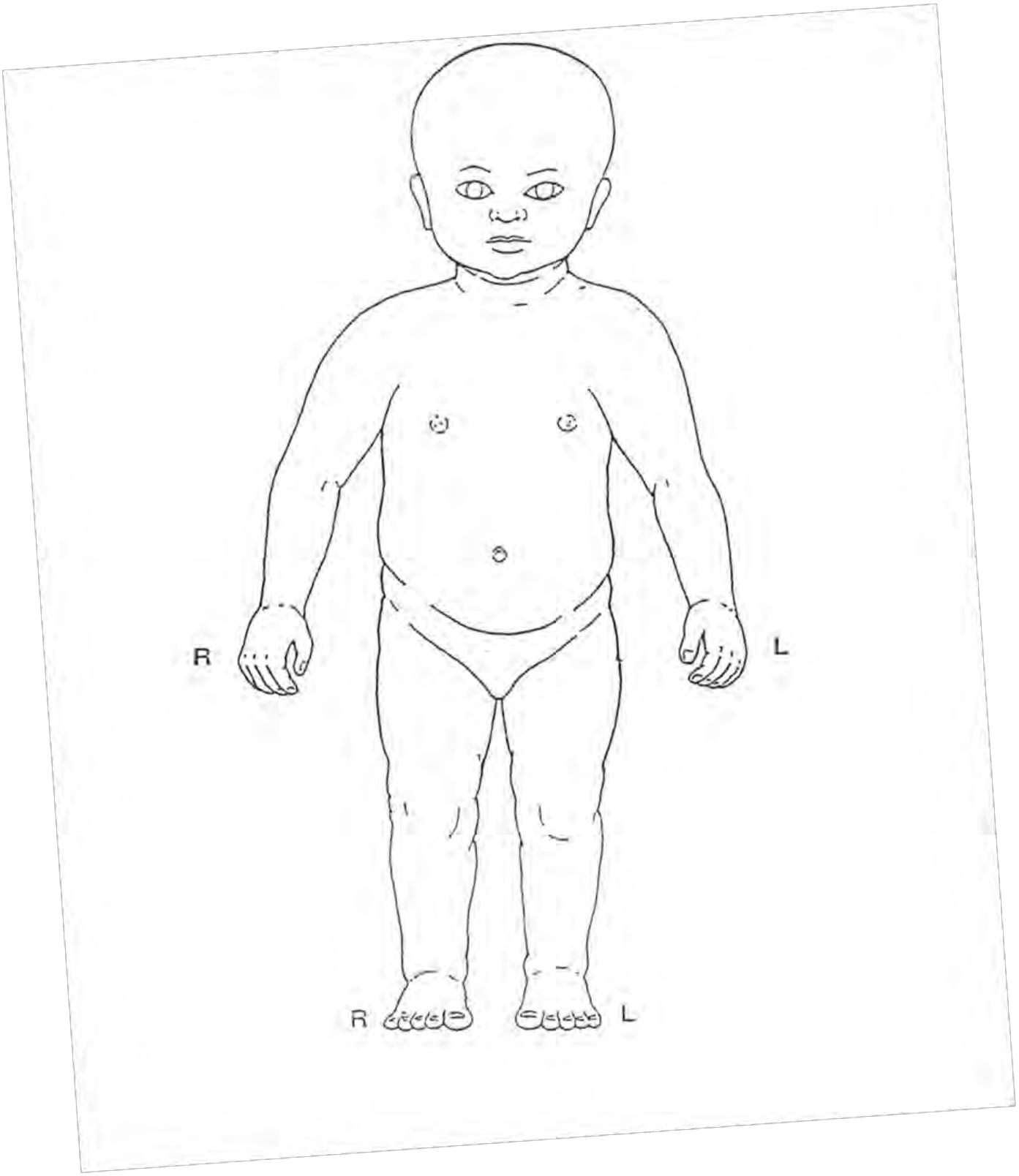
Swabs
Take from any identifiable lesion.

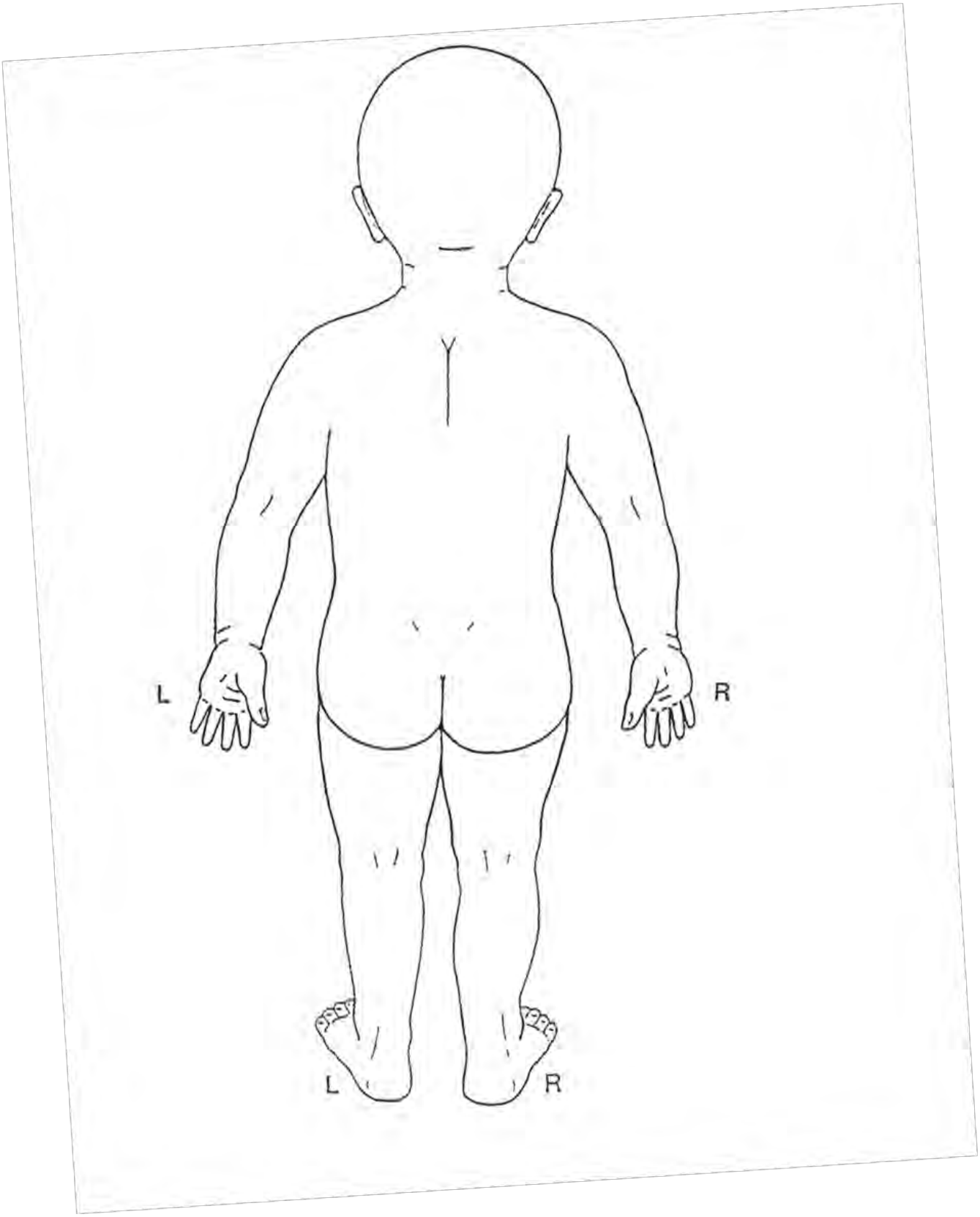
Urine
Send any obtained for toxicology and inherited metabolic disease.

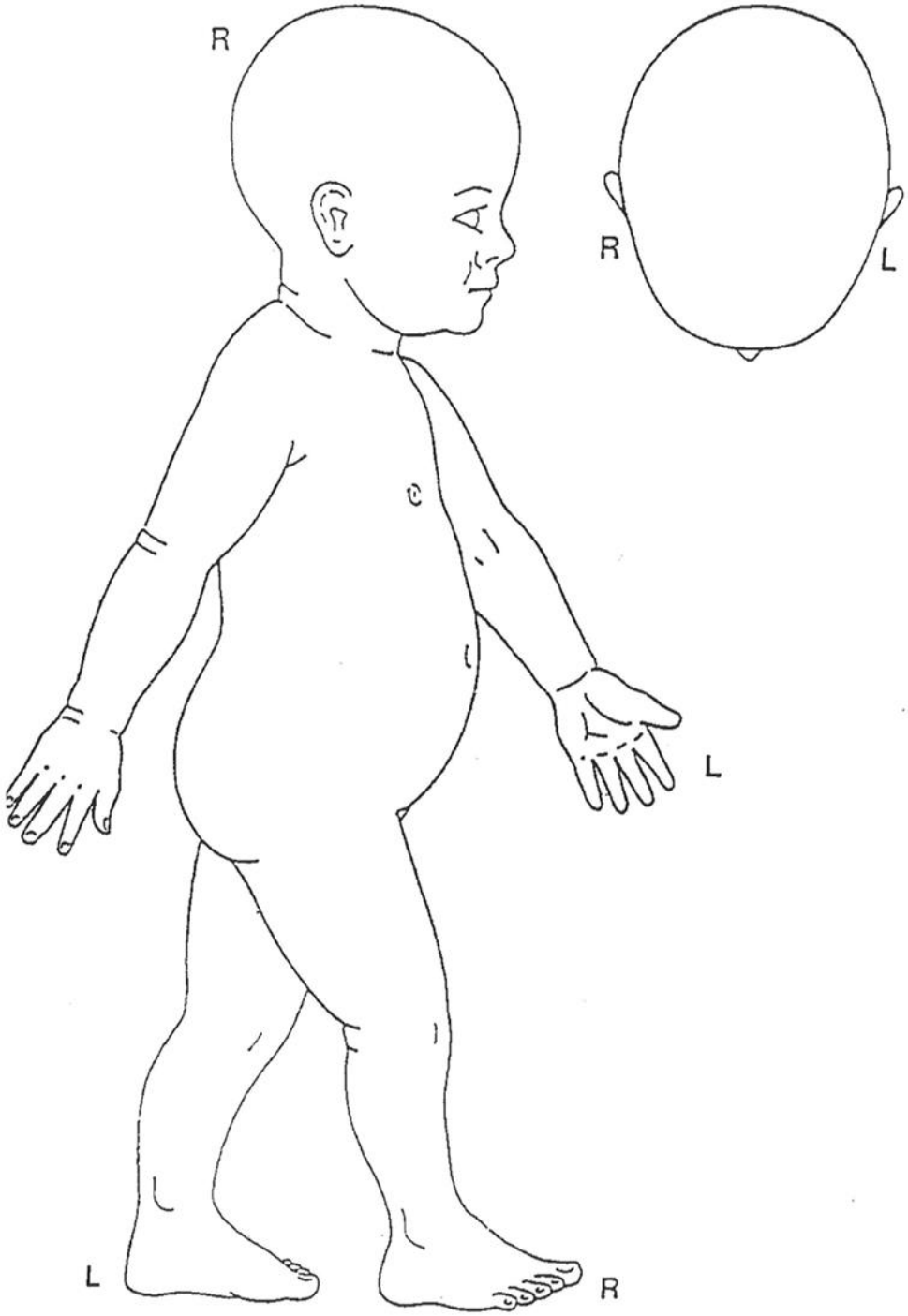
N.B. Blood and urine samples for toxicology will need to be spun down and stores at -20 Celsius.

Sample kits are located in the cupboard in Emergency Department RESUS
If you are unsure of how to obtain these specimens seek advice from the Senior Clinician.

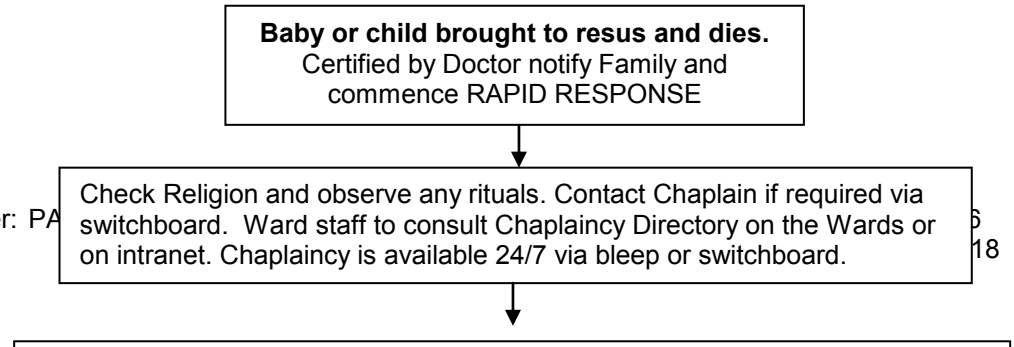
Appendix 4: Body Maps



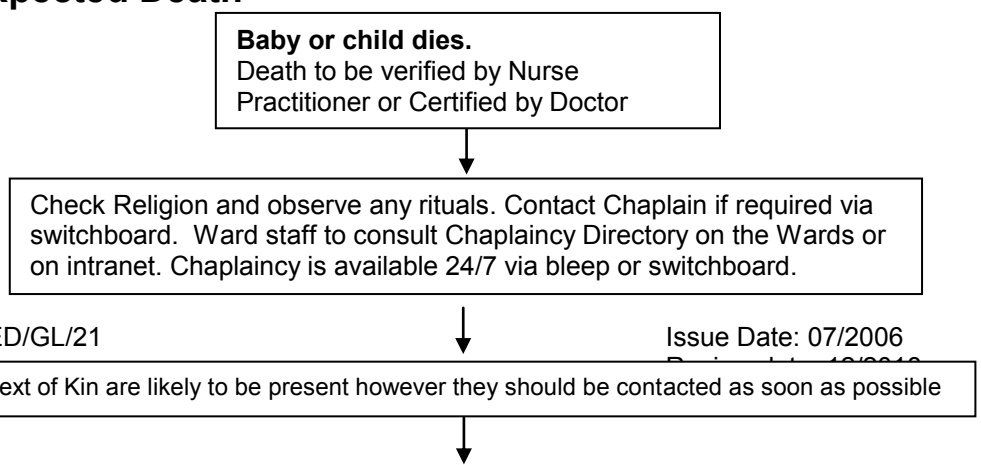




Appendix 5: Unexpected Death of a child



Appendix 6: Expected Death



Appendix 7: Communicating the death of a neonate who has been in hospital since birth

Milton Keynes University Hospital NHS
NHS Foundation Trust

For staff use only

Surname:

Forenames:

Date of birth:

NHS No:

or affix patient label

Checklist for communicating the death of a neonate who has been in hospital since birth

Department/ Health Professional	Contact Details	Yes	Name of person informed
Coroners Officer (all neonatal deaths)	01908 254326/ 254328		
Site Manager	Bleep 1222		
Paediatric Bleep Holder	Bleep 1136		
Maternity Bleep Holder	Bleep 1440		
Mortuary	Ext: 85828 (8am – 4pm) Via Switch (Out of Hours)		
Bereavement Midwife	Ext: 87157 Bleep 1981		
Midwife for family: baby < 1 month	GP Directory		
Bereavement Officer: baby > I month	Ext: 86155 (answerphone) Bleep 1917		
Health Visitor and GP	Fax		
Paediatric doctor to complete • Neonatal death certificate (ASAP) • Crem Form 4 (even if burial)	Send with baby to mortuary		
Child Health Department	Ext: 3078 (answerphone)		
Other hospitals (if relevant)			
Consultant on call Neonatologist	Bleep or via Switch board		
Lead Nurse for Safeguarding Children/ Designated Doctor for Child Death	Bleep 1101 Ext:85062 (answerphone)		
Complete CDOP Form A (Appendix 2)	Email: mkcdop@nhs.net		
CDOP Coordinator	01908 278699		
Death notification book			
Chaplain (if involved)	Ext: 86062		
Datix completed	WEB:		
CRS/EDM – Update within 4 hours	Ward clerk/ maternity reception staff		
Copy of Form 1x matron for paediatrics 1x Lead Nurse for Safeguarding children			
Allocate a member of staff: to contact the family the next day for support	Name:		
NNU bereavement leaflets			
Complete Bounty suppression form			

Name..... Signature.....

Designation..... Date/Time.....

Author: Women's and Children Division | Date of version: Aug 2015 | Hospital Code
Original Date of Approval: | Version: 2.0 | To be filed in patient's notes

Appendix 8: Referral to HM Coroner

- The cause of death is unknown;
- It cannot readily be certified as being due to natural causes;
- The deceased was not attended by the doctor during his last illness or was not seen within the last 14 days or viewed after death;
- There are any suspicious circumstances or history of violence;
- The death may be linked to an accident (whenever it occurred);
- There is a question of self-neglect or neglect by others;
- The death has occurred or the illness arisen during or shortly after detention in police or prison custody (including voluntary attendance at a police station);
- The deceased was detained under the Mental Health Act;
- The death is linked with an abortion;
- The death might have been contributed to by the actions of the deceased (such as a history of drug or solvent abuse, self injury or overdose);
- The death could be due to industrial disease or related in any way to the deceased's employment;
- The death occurred during an operation or before full recovery from the effects of an anaesthetic or was in any way related to the anaesthetic (in any event a death within 24 hours should normally be referred); all fractures get referred surgery or not.
- The death may be related to a medical procedure or treatment whether invasive or not;
- The death may be due to lack of medical care;
- There are any other unusual or disturbing features to the case;
- The death occurs within 24 hours of admission to hospital;
- It may be wise to report any death where there is an allegation of medical mismanagement;
- Any maternal death relating to pregnancy or childbirth;
- Any still birth;
- Clostridium difficile
- Legionella pneumonia.
- Tuberculosis
- Deprivation of Liberty (DOLS)

This note is for guidance only; it is not exhaustive and in part may represent desired local practice rather than the statutory requirements. If in any doubt contact the HM Coroners Office for further advice on 01908 254327 or Kim and Tina in the first instance on x86155.

Some of these referrals will result in attendance at inquests or simply a part A cert being approved. But whichever, the prime importance is to get the death proforma off to the coroners officers as soon as possible as the distress caused to families by delay must be avoided at all costs.

Thomas Ralph Osborne
HM Coroner Milton Keynes

Kim Weston/Tina John
Bereavement officers
Bleeps 1917/1783

Amended June 2015

Appendix 9: Procedure for After Death Care (formerly Last Offices)

This procedure was drawn up with input from local funeral directors, The Coroner and reference to Royal Marsden Manual.

Purpose of procedure guideline is so that all staff carrying out procedure perform it in a standardised way throughout the Trust, and that the deceased is in optimum condition for being released to funeral directors.

Prior to performing After Death Care:

- Confirmation of death must be completed before after death care is provided. – either by Medical Staff, or Night Nurse Practitioner.

  Confirmation of death must be recorded in a patient's medical and nursing notes.

  DO NOT REMOVE ANY VENOUS LINES, TUBING OR CATHETERS.

Procedure for After Death Care

Read in conjunction with
a) Infection control manual

Equipment:

1. Gloves and apron.
2. Bowl, soap, towel x 2, cloths, moisturizing cream
3. Razor, comb, equipment for cleaning nails.
4. Equipment for mouth care
5. Documentation
6. Gown or personal clothing if this has been requested by family.
7. Identification name band. X2
8. Body bag (if patient has infection listed in Infection control policy)
9. Tape, gauze, padded dressings, bandages.
10. Property book envelopes and bags.
11. Bags for linen and waste.

	ACTION	RATIONALE
1	Put on gloves and aprons	To reduce risk of contamination by body fluids and cross infection
2	Lay patient on their back. Remove any mechanical aids and sub cut needles and intra osseous needles, apply pad and tape to needle site. Straighten limbs	To maintain the patients dignity and for future management of the body, as rigor mortis occurs 2-6 hours after death with full intensity within 48 hrs and then disappearing within 48 hrs By keeping the head raised the mouth will stay in a more natural position.
3	Close the eyes by apply light pressure , moistened swabs can be applied	To maintain the patients dignity. Closing the eyes will provide protection if corneal donation is going to take place.

4	Drain the bladder by pressing on the lower abdomen	Because the body can continue to excrete fluids after death.
5	In the event of the patient purging excessively contact mortuary or bereavement officer for advice.	Advice re suction and packing can be given.
6	Exuding wounds should be covered with padded dressing and occlusive dressing	Open wounds pose health hazard to staff that come into contact with body.
7	Leave IVI ,CVP, Hickman and other drains insitu, these should be bunged off and secured firmly	Drainage will continue from sites and this poses a health hazard.
8	ET tubes can be removed, if they have been confirmed in writing to have been in the correct position	To ensure patient is presented in the best manner if viewing is taking place
9	Wash the patient unless requested otherwise. (Police may request this is not done)	For hygiene and aesthetic reasons. As a mark of respect and a point of closure in the relationship between nurse and patient.
10	Clean patients mouth.	For hygiene reasons and also if the patient is to be viewed a dirty mouth causes great distress.
11	Remove all jewellery, unless family request otherwise. Rings and earrings should be taped all other jewellery to be removed and placed in property envelopes and listed.	All jewellery to be recorded on Death Notification Form and removed jewellery listed on Property form and placed in property envelope
12	Dress the patient in gown, unless family request otherwise i.e. pyjamas or nightie.	To meet families wishes
13	Label one wrist and one ankle	To ensure correct patient details.
14	Complete all documentation	To ensure correct patient details.
15	Wrap patient in hospital sheet, ensuring face and feet covered. Use the minimum of tape and do not place tape over face.	To avoid damage to body during transfer to mortuary. Tape over face will cause pressure marks on face, which if the patient is to be view will cause distress
16	Place wrapped body in body bag if required (infectious patients only)	Refer to above listed policies regarding need of bag
17	Tape death notification form to front of body. Place sheet over wrapped body	For ease of identification in the mortuary To maintain dignity
18	Remove gloves and apron Check property and list. Tidy bed area	To prevent cross infection As policy To maintain dignity
19	Request support team to come and remove body	Patients need to be in the fridge by at least 4-6 hours after death, because of decomposition
20	Screen off areas of the ward that body will pass through	To maintain dignity of patient and to cause as little distress to patients and relatives as possible.
21	Record all actions in patients notes, ensure notes filed securely	To ensure all patient records complete.
22	Contact Bereavement office	To ensure they are aware of the death
23	Be aware that patients in close proximity to the death may be upset, so	To ensure undue distress is not caused.

	offer comfort and support, the Chaplaincy may be able to offer support.	