PROCEDURE FOR NOTIFICATION FOR CHILD DEATHS

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Responsible Director:	Directors of Acute Service Directors of HSCPs
Approved by:	Child Protection Forum
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Replaces previous version: [if applicable]	First version

Procedure for notification for child deaths

1. Purpose of Procedure

1.1 This procedure sets out communication processes within NHSGGC when there is an unexpected child death. It should be noted that not all of these cases will result in child protection investigations. It does not cover expected deaths e.g. terminally ill children. The aim is to avoid unnecessary distress to patients e.g. re-appointments etc. The central point of communication is the Child Protection Unit (CPU). All unexpected child deaths should be reported to the CPU. When there is a sudden unexpected death in infancy (SUDI) the SUDI policy is followed.

http://www.sudiscotland.org.uk/index.aspx

2. When the locus of the death is in the Community

2.1 For children age 0-5 years when community health staff are informed of a child death, the member of staff should advise the Heath Visitor (Named Person), GP and Team Leader. The Team Leader should advise the CPU of the details. The Child Protection Advisor, CPU should;

1. Check with social work if child is known to them and advise accordingly
2. Activate an early sharing and collation of information
3. Provide advice to the Team Leader on record management i.e. record details on EMIS web or equivalent. Police Scotland may request access to records for further investigation.
4. Advise the Service Manager to alert relevant professionals of the child's death
5. Offer support
6. Send an email to the Director of Nursing advising of details of death. The email should be copied to:
    - Clinical Director, CPU
    - Head of CPU
    - GP with Special Interest Child protection (GPwSICP)
    - Service Manager (to inform other relevant managers and named person/lead professional)
    - Any other relevant professional.

2.2 For children aged 5-16 years (school aged) the process is the same as above except that the school nurse is advised instead of the health visitor and the named person is a professional from the child's school.

3. When the locus of the death is the Acute Sector

3.1 Most children die in a hospital/Emergency Department setting. The doctor/nurse in charge of the child should contact the CPU and advise them of details. The Child Protection Advisor should advise the Team Leader and GP and follow steps 1-6 as outlined above.

4. Parents having further pregnancies/children following a child death where there have been child protection or welfare concerns.

4.1 We need to ensure that there is a system in place to track parents who move when pregnant again or who may become pregnant again, attend different ante-natal services and have different primary care staff involved that may be unaware of previous concerns. Health information within adult records must indicate previous child protection issues or a child death within the family. Information needs to be inserted into Trakcare.

4.2 While it is recognised that this is a national issue, this NHSGGC process will begin to address the recommendation within this health board and will share relevant information with other health boards in Scotland.

4.3 As described above, contact should be made with the CPU following the death of any child where there have been child welfare and protection concerns.

4.4 Information should be shared by CPU with Head of Midwifery Services in all Health Boards within Scotland to potentially allow identification of subsequent vulnerable pregnancies presenting in their area. Information will be recorded in the CPU database.

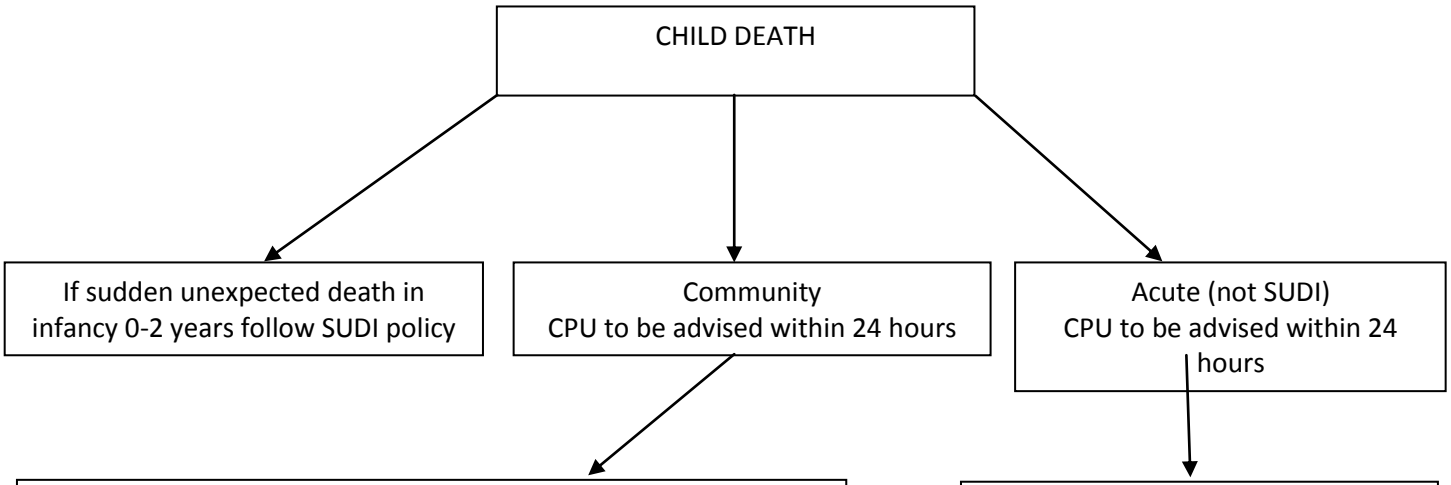
5. **Death of children that are looked after**

5.1 The local authority has particular responsibility regarding the deaths of children that are looked after and information on this can be accessed via the following link CLICK HERE TO ACCESS.

6. IT Systems

- Team Leader should record details on EMIS web
- Clinician that has declared the child death should record it on Trakcare and Portal.
- GPwSI should contact the GP Practice and advise them to add the appropriate READ Codes to maternal and paternal GP records. Where there is a child protection concern this should also be recorded in the GP record.
- Child Protection Advisor or GPwSi should advise CPU administrative staff to put an alert on Trakcare
- DATIX system should be used to record the incident

6.1 Procedure for notification for child deaths flowchart



COMMUNITY
Age 0-5 yrs

CPA should

1. Check with social work if child is known to them - advise
2. Activate an early sharing and collation of information
3. Provide advice to the Team Leader on record management i.e. record details on EMIS web or equivalent. Police Scotland may request access to records for further investigation.
4. Advise the Service Manager to alert relevant professionals of the child's death
5. Offer support
6. Send an email to the **Director of Nursing** advising of details of death. The email should be copied to;
    - Clinical Director, CPU
    - Head of CPU
    - GPwSi CP
    - Service Manager (to inform other relevant managers and named person/lead professional)
    - Any other relevant professional.

Age 5-16 yrs

For school aged children the process is the same except that the school nurse is advised instead of the health visitor and the named person is a professional from the child's school.

Midwifery services

Where there have been child protection/ welfare concerns linked to the child death CPU will inform Head of Midwifery Services in all Health Boards within Scotland.

ACUTE (NOT SUDI)
Age 0-5 yrs

The doctor/nurse in charge of the child should contact the CPU and advise them of details. The Child Protection Advisor should advise the Team Leader and GP and follow steps 1-6 as outlined for community.

Age 5-16 yrs

For children aged 5-16 years (school aged) the process is the same as above except that the school nurse is advised instead of the health visitor and the named person is a professional from the child's school.

Midwifery services

Where there have been child protection / welfare concerns linked to the child death CPU will inform Head of Midwifery Services in all Health Boards within Scotland.