What to do when a child dies – a guide for the RACH Child Death Review (CDR) team

Introduction

Please make yourself familiar with the documents listed below, the Pan Sussex Child Protection and Safeguarding Procedures Manual section on child deaths, and the local guidelines on the **Brighton Microguide** (Paediatrics & Neonatology > Paediatrics > Child death).

They detail the local as well as best practice and statutory guidance for child deaths:

1. Sudden Unexpected Death in Infancy and Childhood: Multi-agency guidelines for care and investigation. Royal College of Pathologists and Royal College of Paediatrics and Child Health (Nov 2016). Available **here**
2. Child Death Review: Statutory and Operational guidance (England). HM Government (Oct 2018). Available **here**
3. **http://sussexchildprotection.procedures.org.uk/yykyzp/child-death/sussex-child-death-review-practice-guidance/#top**
4. The **Child death guidelines** page on the **Brighton Microguide** > Paediatrics & Neonatology > Paediatrics > Child Death 0-18

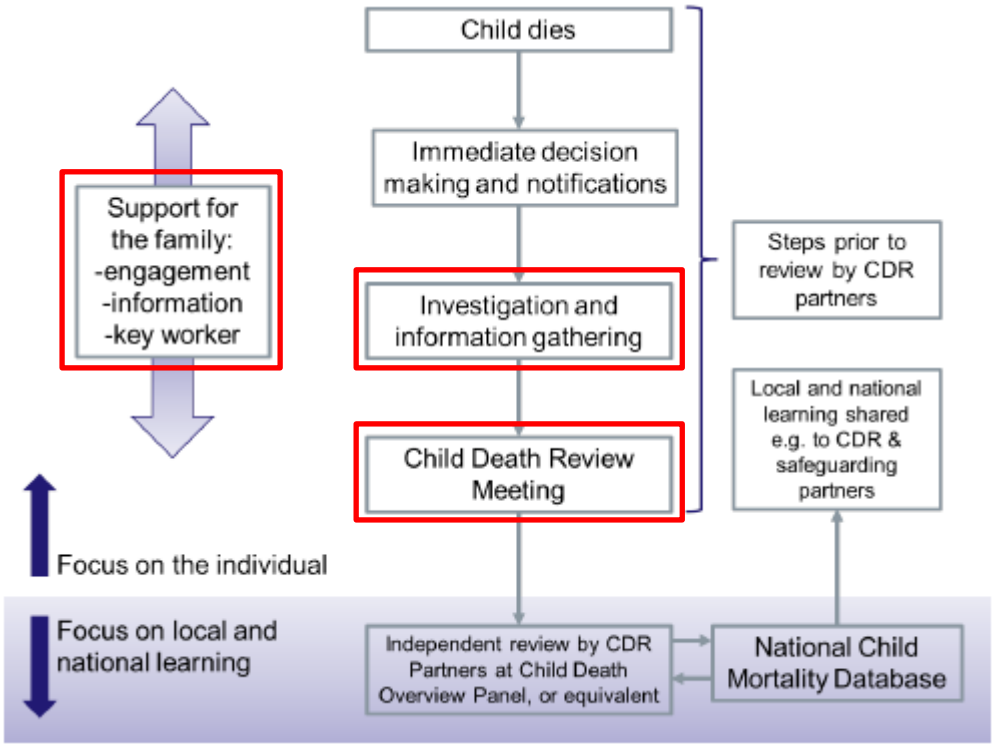
Guidance for clarity over which teams and services at UHSussex East will be responding to different types of deaths and ages of children is available in the **Child Death Pathways** document in the Child death guidelines on **Brighton Microguide**.

Child death key contacts for UHSussex East:

- **Lead Consultant for Child Deaths:** Dr Miki Lazner **michaela.lazner1@nhs.net**; extension 62522
- **Nurse Consultant, Safeguarding Children** UHSussex East: Debi Fillery **debi.fillery@nhs.net**; extension 62363
- **Child Death Review Specialist Nurse** B&H Lyndsey Rogers: **lyndseyrogers@nhs.net**; 07557 660 590
- **Child Death Admin** B&H Zoe Gates: **zoe.gates2@nhs.net**; extension 64556 (Wed/Thurs am, Friday)
- **Child Death Review Lead Nurse** Sussex CCGs: Doffey Reid **doffey.reid@nhs.net**; 01273 238872 | 07867132655
- **Designated Paediatrician for Child Deaths** Sussex: Dr Jamie Carter **jamie.carter@nhs.net**; 01273 238708

Child death statutory processes overview

The core processes for what is expected to occur nationally when a child dies (taken from reference 2 above) are shown below:



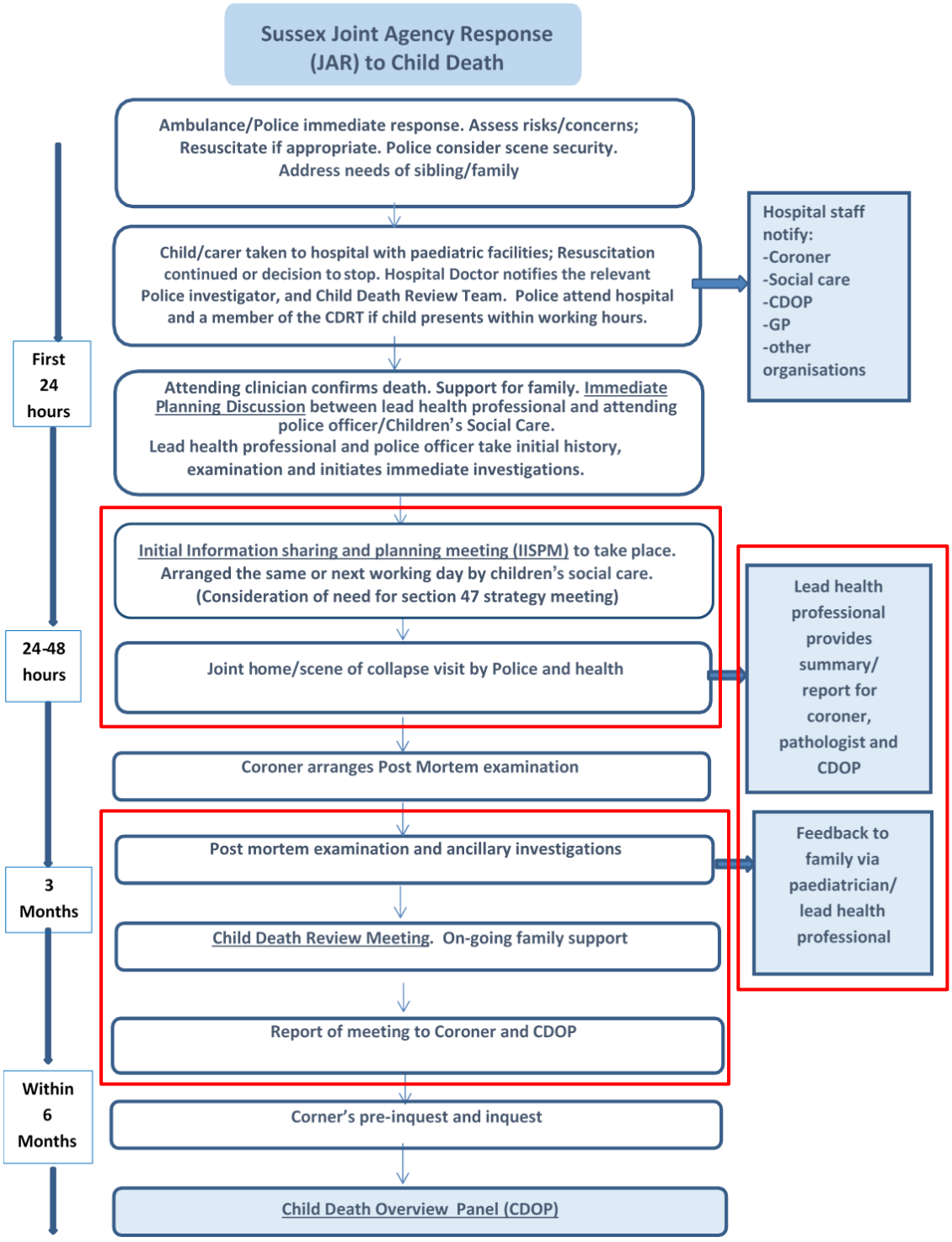
The Child Death Review (CDR) team will be respnsible for the highlighted areas. The response will vary according to whether the death is expected or unexpected. Most deaths will be unexpected, and will therefore fall into the group requiring a **Joint Agency Response**, or JAR.

The following deaths necessitate a JAR:

- are or could be due to external causes;
- are sudden and there is no immediately apparent cause (incl. SUDI/C);
- occur in custody, or 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
- Some cases of collapse or sudden death in a child with a life limiting illness where death was not expected in the preceding 24 hours.

A JAR should also be triggered if such children are brought to hospital near death, are successfully resuscitated, but are expected to die in the following days.

The figure on page 3 taken from the Pan Sussex Child Protection and Safeguarding Procedures Manual explains the JAR processes clearly.



The Child Death Review (CDR) team will be respnsible for the highlighted areas.

What can you expect to have already occurred before you become involved?

There is an expectation that the acute team at the time of death will have done the following:

1. Confirm and document confirmation of death
2. External examination and documentation as appropriate

3. Consider and perform post-mortem sampling as appropriate
4. Document patient history and examination on the SUDIC proforma, a copy of which will go to the coroner as the initial 'report'.
5. Liaise with police who will involve the safeguarding children team
6. Inform the coroner / coroner's officer if not already aware
7. DATIX the death
8. Notifications and handling of the body as per the **notifications and checklist guideline** on the **Brighton Microguide** (Paediatrics & Neonatology > Paediatrics >Child death).

See appendix 1 for the SUDIC proforma

You will be notified within 24 hours of the death by email by the Child Death Review Specialist Nurse (SN) or in their absence, by the Child Death Review Lead Nurse or the Safeguarding Children team.

Core responsibilities of the CDR team

You will work alongside the Child Death Review SN for Brighton and Hove who is based in the Safeguarding Children's department at the RACH.

The main roles of the Child Death Review team will include:

- Being part of a weekly on call rota to provide the service in office hours.
- If a JAR is required, being present at the **Multi-agency Initial Information Sharing and Planning Meeting (IISPM)** alongside the acute team at the time of death if available. This is usually < 24 hours of the death and is convened and chaired by social care but held in the RACH.
- Investigation and information gathering alongside the Child Death Review SN. We are expecting that the SN will develop an expertise at doing the JAR home visits.
- Supporting the Child Death Review SN with bereavement support, collating results and family liaison.
- Chairing the **child death review meeting (CDRM)** and producing a report (the 'child death analysis form') which is completed on line (via eCDOP).
- Sharing any learning from the CDRM.

For specialist or expected deaths, the expectation will be that the requirements and processes will be modified according to the situation.

The core statutory processes will still need to be done and will include supporting the Child Death Review SN with bereavement support and family liaison, collating any results from pre- and post-mortem investigations, offering to meet the family in hospital

to discuss the PM and other results, and chairing the CDRM with associated required outputs.

Ideally the named consultant or primary team for the child will be supported to fulfil the majority of these roles by the CDR team.

Payment

Payment for the role will come from Trust payroll via the CCG. You will need to raise a claim in order to be financially compensated. Please fill out a UHSussex waiting list initiative claim form and send to Jonathon Brooks to be authorised.

Your claim will be reimbursed for the following amounts:

- **Unexpected death** there will be a *5 PA payment to the consultant to be paid per death* – 20 hours of work. Please consider diary carding your work so that we can see over time how much additional work is done in excess of 5 PAs.
- **Expected death** there will be a *1.25 PA payment to the consultant to be paid* as and when deaths occur.

The rota

Is available on the paediatric T drive in the 'Child death 0-18 years' folder. The Child Death Review SN will have access to this and will notify the appropriate consultant once the death is reported.

Please ensure you keep your availability and any swaps up to date on the rota.

Multi-agency Initial Information Sharing and Planning Meeting (IISPM)

This will be arranged and chaired by Children's Services usually the next working day and in normal working hours following the death.

You will be notified of the time and place, and will have a say in where it occurs as health involvement is important. If you are unavailable to attend in person, please arrange to be present via telephone or video conference. It should be held at the RACH. Children's social care and police expect to come to you.

The IISPM will usually involve representatives from health (including primary care team, acute clinician, CDR team member), police, social care, and any other relevant professionals e.g. coroner's officer. A copy of the minutes taken by Children's Services will go to the coroner, pathologist and the Sussex CDOP co-ordinator.

The aim of this meeting is to review all the information available at that stage and identify what further investigations or actions are required. The ongoing support needs of the family will be looked at and all notifications including the Sussex CDOP via eCDOP will be confirmed.

See appendix 2 for a sample IISPM minutes template

Interim processes: information gathering, collating results, liaising with family

During this time period before the CDRM:

- You may be asked to fill in a **'Reporting form'**. This has replaced the old CDOP Form B.
- You should be sent the **results of the PM** if this is done. If you do not get the results, please chase up through your admin support.
- Please ensure you **chase up any post-mortem investigations** performed as part of the Kennedy samples.
  - There is a **results form** that you can use to collate all of the results as they come through. See '**Additional documentation: SUDIC investigations result form**' on the **Child Death guidelines** page on the **Brighton Microguide**.
- You may need to convene a multi-professional **interim meeting**, before the CDRM, if, for example, the post-mortem or JAR investigations raise any concerns that need further investigation or addressing prior to the final processes. See the **Sussex Child Protection Procedures manual** for further information.
- Together with the Child Death Review SN and police investigator, you should arrange to **meet the family** to discuss the initial findings and also address any concerns or questions that they have. You will need the coroner's permission.
- Liaise with the Child Death Review SN to ensure appropriate bereavement support needs are being addressed for the family.

Bereavement support

The Child Death SN will provide the "single point of contact" that is required to provide the link between the CDR team and the family.
Families will expect to be able to contact the SN during normal working hours.

Parents will be provided with written bereavement information at the time of death, but may not have taken it with them or may not have been able to engage with mementos etc. before leaving for home.

The main points of contact with the family will be:

1. The joint home / scene of death visit with the police investigator – we will be expecting that our Child Death Review SN will develop an expertise with this, but the CDR clinician may be required to do in the first instance.

2. The Child Death Review SN will arrange to contact the family to initiate contact and provide ongoing bereavement support, info about the child death review process and the opportunity to contribute to investigations and meetings, and be informed of their outcomes.

3. If we discover that there have been issues with the quality of care provided e.g. through serious or moderate incident review we have a duty of candour to the family as with any SI. This meeting is likely to involve the named consultant.

4. A meeting will need to be arranged to give the family the opportunity to ask questions and to give them the results of the investigations and a preliminary cause of death (unless the coroner has given permission for a medical certificate of cause of death (MCCD) to be written).

Child death review meeting (CDRM)

A meeting of professionals where all matters relating to an individual child's death are discussed by the professionals directly involved in the care of that child during life and those involved in the investigation after death.

- Usually the last meeting before the case is discussed at the Sussex Child Death Overview Panel (CDOP) meeting.
  Should usually occur within 3 months of the death only once all results are available. Relevant results will include the PM, Kennedy samples, or SI investigation.
- **It is the responsibility of the CDR team to arrange and chair the CDRM.**

- Depending on the situation, it may be a separate meeting or may be part of a departmental M&M e.g. for expected oncology or respiratory deaths.
- Family are informed of the meeting but are not invited to attend. They will however be asked to contribute their views / issues via the CD nurse.
- Attendees must include the police and Children's Social Care if they had involvement with the child or family, and paramedics. Other hospital or community staff involved in the medical care of the child should be invited.

- Reports from interested parties who can't attend must be received prior to the meeting.

The aims of the CDRM are:

1. To review the background history, treatment, and outcomes of investigations, to determine, as far as is possible, **the likely cause of death**;
2. To see if there were any contributory and modifiable factors across domains specific to the child, the social and physical environment, and service delivery;
3. To describe any learning arising from the death and, where appropriate, to identify any actions that should be taken by any of the organisations involved to improve the safety or welfare of children or the child death review process;
4. To review the support provided to the family and to ensure that the family are provided with the outcomes of any investigation into their child's death; clear arrangements for follow up need to be provided at the end of the meeting.
    i. to provide a plain English explanation of the likely reason that their child died (sometimes this is not possible even after investigations have been undertaken) and any learning from the review meeting;
    ii. NB. the conclusion on the cause of death in most cases is the responsibility of the coroner at inquest, unless a MCCD has been issued.
5. To ensure that CDOP and, where appropriate, the coroner is informed of the outcomes of any investigation into the child's death; A draft **'Analysis form'** should be drawn up as an output from the meeting. This replaces the old CDOP Form C.
6. To review the support provided to staff involved in the care of the child.

See appendix 3 for a suggested CDRM agenda template.

CDOP meeting

Following the CDRM the case will be anonymised and discussed at one of the Sussex Child Death Overview Panel (CDOP) meetings.

The CDOP is a CCG based multi-agency panel that review the deaths of all children normally resident in Sussex.
Currently Dr Miki Lazner and Dr Susie Pawley are the Paediatrician leads for B&H on the CDOP.
The primary aim of the CDOP is to learn lessons and share any findings for the prevention of future deaths. CDOP shares their findings on a final Analysis form with the National Child Mortality Database (NCMD).

Any questions or concerns, please contact Dr Miki Lazner, Child Death Clinical Lead on **Michaela.lazner1@nhs.net**.

Appendix 1. **Unexpected death hospital pro forma**

UNEXPECTED DEATH OF A CHILD
CLINICAL AND SOCIAL INFORMATION

THIS PROFORMA SHOULD BE USED TO RECORD MEDICAL INFORMATION IN A/E AND AT LATER CONSULTATIONS WITH PARENTS. A COPY SHOULD BE SENT TO THE PATHOLOGIST, CORONER'S OFFICER AND CHILD DEATH OVERVIEW PANEL CO-ORDINATOR

Name of child …….. **Age** …..... **Date of birth** …….

Address …… **Date of death** ……

……

GP …….....

HISTORY OF RECENT EVENTS – OBTAINED FROM ……

When and where child found and by whom? When child previously seen alive and by whom?

……

……

……

Found prone/supine/on side? ……

Sleeping arrangements / bedding ……

What happened next (eg. *Details of attempted resuscitation, ambulance / GP called, etc.)*

……..

……..

Infants - Breast / bottle fed ? …… **When was the last feed ?** ……

Was the last feed taken as usual? * ……

Any recent concerns or symptoms? *(feeding, weight loss,, bowels, respiratory, apnoeas, colour change, temperature, sweating, irritability etc.)*

Use other side if necessary

Name of Child

P.M.H.

Gestation and birth weight ……..

Pregnancy and delivery ……

Neonatal problems …….

Previous illnesses *(visits to GP / A&E / Hospital)* ……...

……

……

……..

……..

Development……

……

FAMILY HISTORY

Mother Age …… **Occupation** ……

Smoker Yes/No

Father Age …… **Occupation** ……..

Smoker Yes/No

Does anyone smoke in the house? ……..

Siblings (names, ages, health) ……..

……..

……..

……..

Any current illnesses in siblings / parents / extended family? ……

……..

Any history of child deaths or sudden unexpected adult deaths in extended family? (If so draw family tree) ……

……..

Family history of genetic conditions / multiple miscarriages? ……

……

Name of Child

Any information about substance misuse or other social / health issues from primary care or other sources?

……..

……..

Who was looking after the child in the previous 24 hours? …….

Is there a social worker? (*details)* ……

…….

MANAGEMENT AT HOSPITAL

Time child arrived at A & E …

Information from ambulance service…….

……

Resuscitation attempts *include details of any puncture marks and interventions on body map and attach copy of resuscitation record*

……

……

Initial observations

- *put any findings on body maps e.g. bruises, abrasions, discoloration,*
- *note cleanliness, clothing, bedding, vomit, blood etc.*

……

……

……

Use other side if necessary

EARLY MEDICAL INVESTIGATIONS

Take blood from a venous / arterial site if possible eg femoral vein. Cardiac puncture can make PM findings difficult to interpret – please record

Routine minimum samples to be taken immediately after the sudden unexpected death of all children up to 2 years of age. These have been agreed by the Sussex Coroners.

Taken	Sample	Send to	Handling	Test	Results
	Blood (Fluoride) 1 ml	Clinical Biochemistry	Spin, store plasma at -20 C	3 OH butyrate, sugar, FFA, Lactate	
	Blood cultures – aerobic and anaerobic 1 ml	Microbiology, locally	If insufficient blood, aerobic only	Culture and Sensitivity	
	Blood from syringe onto 2 Guthrie cards	Paediatric Clinical Biochemistry lab at St.Thomas' Hospital	In usual Guthrie envelopes– do not put into plastic bag.	Acyl carnitines and other Inborn errors of metabolism (IEM)	
	Blood 1ml lithium heparin	Paediatric Clinical Biochemistry lab	Spin, store plasma at -20 C	Amino acids and other tests for Inborn errors of metabolism (IEM)	
	Blood EDTA 1 ml	Genetics, Guys	Do not freeze	DNA extraction- ask lab to save	
	Blood (serum) 1– 2 ml (if Sufficient)	Biochemistry, locally	Spin, store serum at -20° C	Save for toxicology	
	Blood 1 – 2 ml Lithium heparin	Cytogenetics, Guys Hospital	Normal – keep unseparated	Chromosomes	
	CSF a few drops **Consider cisternal tap**	Microbiology locally	Normal	M.C.S.	
		Clinical biochemistry locally	Freeze and save	Inborn errors of metabolism (IEM) Toxicology	
	Urine if available (obtain by squeezing nappy)	Biochemistry	Spin, store supernatant at -20° C	Organic acids and Other (IEM)	
	Swabs from any identifiable lesions	Microbiology	Normal	Culture and sensitivity	
	Nasopharyngeal aspirate	Microbiology	Normal	Viral cultures, immunofluorescence, DNA amplification.	
	Nose and throat swabs	Microbiology	Normal	Culture and sensitivity	
	Skin biopsy	Biochemical genetics lab Guy's	**See below**	Fibroblast culture for IEM / chromosomal abnormalities	

Name of Child

Prioritise cultures and metabolic investigations as delays can comomise or invalidate the results

Tick samples taken and record any needle sites on this proforma or on a body map.

SKIN BIOPSY for fibroblast culture should be taken routinely. A full thickness elipse of skin needs to be taken using full aseptic technique, as contamination can interfere with successful fibroblast culture. Put in a sterile container, ideally in tissue culture, or in sterile saline, and keep in the fridge NOT THE FREEZER. Send urgently via the local biochemistry lab to Guy's Hospital Biochemical Genetics (tissue culture) lab with the request- 'Please culture and store pending further information. Unexpected child death'

Fatty change in the liver at post mortem is open to interpretation. If this is a finding at post mortem the local paediatrician should take responsibility for reviewing the medical history in liaison with the paediatric pathologist and a consultant in paediatric metabolic disorders.

Skeletal survey

A full skeletal survey will be arranged at post mortem. However if there is particular concern that the death of a young child may have unnatural causes, an early full skeletal survey, not a "babygram", and an urgent opinion from a specialist radiologist may be appropriate. Abnormal findings may affect the management of any siblings. Individual Coroners have their own arrangements for skeletal surveys.

CHILDREN DYING UNEXPECTEDLY OVER THE AGE OF 2 YEARS

The Sussex Coroners have agreed that a Consultant Paediatrician should consider which of the investigations listed above are indicated on the basis of the medical history and findings and then proceed to taking samples.

The following guidance about medical investigations in older children has been given by the Departments of Paediatric Histopathology Great Ormond Street and Paediatric Metabolic Medicine Guy's Hospital :

1. Where there is any possibility of infection, taking samples as soon as possible after death improves the chances of growing a responsible organism. In these circumstances, blood cultures, throat and nose swabs and swabs of any skin lesions should be taken routinely in A/E. CSF should be considered if the medical information suggests that meningitis is a possibility.

2. Although inborn errors of metabolism are rare, unless the cause of death is clearly unnatural full metabolic investigations are indicated as described in the protocol above. Samples should be collected as soon as possible.

3. Consider sending blood or urine for toxicology.This can be done at post mortem

Request that investigation results come to the Consultant Paediatrician. Notify the pathologist and Coroner.

MEMENTOS

Mementos should be offered routinely. A photograph, lock of hair and hand or foot prints may be taken. If there are any findings (eg substance, or mark) on the child's body that might be masked by taking mementos, these areas must be avoided. In exceptional circumstances, in unnatural deaths, if police disagree with taking mementos, notify the Coroner's officer who will arrange for these to be taken after the post mortem.

Name of Child

Details of mementos taken / offered and declined by family (delete if appropriate):

Any other information
…….

…….

Information given to parents: ……

……..

……..

Coroner informed ……

GP informed ……..

Health visitor informed ……

Consultant Paediatrician involved/informed ……..

Name and designation of professional(s) completing form ……

Date ……

A copy of this record should go to the pathologist and Coroner via the Coroner's officer

Appendix 2. **IISP meeting minutes template**

Joint Agency Response to Child Deaths
Initial Information Sharing and Planning (IISP) Meeting
Minutes Template

Always refer to the Pan Sussex protocols for managing an unexpected child death, which can be found at: **sussexchildprotection.procedures.org.uk/tkypx/children-in-specific-circumstances/unexpected-child-death**

Case Number			
Name of		**Date of birth**	
NHS No			
Date of death		**Time of death**	

Name of Chair			
Date of		**Time of**	

List of Attendees

There **MUST** be at least ONE representative from the following 3 agencies present, for the meeting to be QUORATE: **Health / Police / Children's Social Care**

Is the meeting Quorate? YES ☐ NO☐

Agency / Service	Name (s)	Role(s)
Children's Social Care		
Police (SIU)		
Health (Paediatrician) Acute/Community		
Specialist Nurse Child		
SECAMB		
CAMHS		
School/ nursery		
GP		
Other police rep eg. British Transport, Major crime		
Health Child Practitioner/ children's community nurse		

Apologies received from: **Information for the meeting sent in by:**

Record of key agency Information shared at the meeting

1. Circumstances leading up to the death of the child
2. Police information from scene/home
3. Initial medical/PM findings
4. Possible underlying medical conditions within the family history
5. Any child protection issues? e.g. history of concerns regarding neglect/abuse
6. Previous unexplained or unusual child deaths in the family
7. Is there evidence of: parental substance misuse/ domestic violence / mental health issues / learning disability etc? If YES, please give details
8. Discussions with the family re Rapid Review (if applicable)

Agreed Bereavement Care Plan

Does this meet the criteria for a referral to the Local Safeguarding Children Partnership for consideration of a Serious Safeguarding Practice Review?

YES / NO

If YES, please state why?

Final Checks

Coronor has been informed of death ☐

Joint Visit has taken place to family home ☐

Date and who attended? **Summary of any key information/issues arising from Joint Visit:**

Initial PM results are known and have been shared ☐

Action Plan

Ref	Action to be taken	By Who	By When
1			
2			
3			

ONCE THE MEETING MINUTES HAVE BEEN COMPLETED THEY SHOULD BE:

A) **DISTRIBUTED TO ALL MEMBERS OF THE GROUP**
B) **SENT TO THE CORONERS OFFICE**
C) **SENT TO THE CHILD DEATH REVIEW COORDINATOR**
BHCCG.SussexCDRteam@nhs.net
D) **UPLOADED ONTO THE RELEVANT CSC CHILD CASE FILE & eCDOP (via CDR Coordinator)**

Date minutes sent and by whom?

Appendix 3. **CDRM agenda template**

SUSSEX CHILD DEATH REVIEW PARTNERSHIP

Child Death Review Meeting

Agenda

1. **Introductions, apologies and purpose of meeting**
2. **Family details**
3. **Summary and chronology of circumstances leading to death:**
   - Ambulance Service
   - Receiving hospital
   - Police
   - Community - home/hospice/primary care
4. **Background information and family history:**
   - Hospital
   - Health – Community care, acute care, primary care and mental health
   - Children's Services
   - Police
   - School / Nursery
   - Coroner
   - Child Death Review Nurse Support – Voice of the family
   - Other Agency Reports – SUI report, HSIB,
5. **Safeguarding review/risk assessment**
6. **Review of actions taken so far:**
   - JAR (Joint Agency Response)
   - Home visit (if needed)
7. **Information sharing and analysis (See Analysis Form for CDR).**
   - Factors intrinsic to the child
   - Factors in social environment including family and parenting capacity
   - Factors in the physical environment
   - Factors in relation to service provision
   - Identify any factors that may have contributed to death
   - Analysis of information to assist in the identification of cause of death (see Categorisation and Cause of death)
   - Information to inform the inquest
8. **Learning points and issues identified (See Analysis Form for CDR)**
9. **Modifiable Factors/Recommendations (See Analysis Form for CDR).**
10. **Actions needed (please add a timeline for completion):**
    - Local services

- Parent's & carer's needs and future care
- Sibling's needs
- Any missing information?
- Control of information
- Potential media interest
- Staff Debrief

11. **AOB**

NB: There should be an explicit discussion of the potential of abuse or neglect either causing or contributing to the death. This should be documented as part of the meeting. Where there are concerns relating to abuse or neglect refer to the relevant Sussex Case Review Panel for consideration of a Child Safeguarding Practice Review.

Prompts

Please note, for this meeting to be effective please ensure that all professionals that have been involved with the care of this child are invited or have contributed to the meeting by completing a reporting form.

If the child has a learning disability and is >4 years old please invite the LeDeR representative for Sussex to this meeting.

Taken from Child Death Review Analysis Form

Factors intrinsic to the child

Please list factors in the child (and in neonatal deaths, in the pregnancy). Consider factors relating to the child's age, gender and ethnicity; any pre-existing medical conditions, developmental or behavioural issues or disability, and for neonatal deaths, the mother's health and wellbeing.

Factors in social environment including family and parenting capacity

Please list factors in family structure and functioning and any wider family health issues; provision of basic care (safety, emotional warmth; stimulation; guidance and boundaries; stability); engagement with health services (including antenatal care where relevant); employment and income; social integration and support; nursery/preschool or school environment.
Please also describe positive aspects of social environment and give detail to examples of excellent care

Factors in the physical environment

Please list issues relating to the physical environment the child was in at the time of the event leading to death, and for neonatal deaths, the mother's environment during pregnancy. Include poor quality housing; overcrowding; environmental conditions; home or neighbourhood safety; as well as known hazards contributing to common childhood injuries (e.g. burns, falls, road traffic collisions)

Factors in relation to service provision

Please list any issues in relation to service provision or uptake.
Include any issues relating to identification of illness, assessment, investigations and diagnosis; treatment or healthcare management; communication or teamwork within or between agencies; and organisational or systemic issues. Consider underlying staff factors, task factors, equipment, and work environment, education and training, and team factors.

Please also describe positive aspects of service delivery and give detail to examples of excellent care

Was there appropriate palliative /end of life care? Was an Advanced care plan put in place at an appropriate time? Was it fit for purpose and appropriately shared/communicated?

Appendix 4. Contact list for Pan Sussex Child Death Review Team

Contact List - Pan Sussex Child Death Review Team

The generic details for the service are as follows:

Email: Sxccg.cdrteam@nhs.net Tel: **01273 238808**

Child Death Review Nursing Team

Contact	Availability	Based	Telephone	Email
Doffey Reid Child Death Review Lead Nurse (Pan Sussex)	Mon – Fri 9-5pm	Hove Town Hall, Norton Road, Hove, BN3 4AH	01273 238872 07867 132655	**doffey.reid@nhs.net**
For new unexpected child deaths, please contact the specialist nurses as below, please see map overleaf for the area covered:				
West Sussex Child Death Review Specialist Nurse	Mon, Tues, Thur, Fri 9-5pm	Stillman house, St Richard's Hospital, Spitalfield Lane, Chichester PO19 6SE	07984 915869	
Lyndsey Rogers Child Death Review Specialist Nurse	Mon-Fri 9-5pm	Royal Alexandra Children's Hospital, Eastern Road, Brighton, BN2 5BE	07557 660 590	**lyndseyrogers@nhs.net**
Avril Hilditch Child Death Review Specialist Nurse	Mon-Fri 8-4pm	Hailsham Health Centre, Vicarage Fields, Hailsham, East Sussex, BN27 1BE	07825 403611	**ahilditch@nhs.net**
Griff Thornton Child Death Review Support Nurse	Mon-Wed & Friday 8-5 Thurs – 8- 12	Wicker House, High Street, Worthing, BN11 1DJ	07823 533146	**Griff.thornton@nhs.net**

Child Death Overview Panel (CDOP)

Mike Newman Child Death Review Coordinator (Pan Sussex)	Mon-Fri 9-5pm	Hove Town Hall, Norton Road, Hove, BN3 4AH	01273 238808 07584 542784	**michaelnewman@nhs.net**

To contact the designated doctors for child death (Dr Jamie Carter & Dr Tracey Ward) please email sxccg.designateddoctorsforchilddeath@nhs.net

Map of Sussex for specialist nurse areas