Immediate response by Ambulance and Police following a <u>sudden unexpected</u> child collapse/death.

Assess risks/concerns; resuscitation if appropriate. Police consider scene security. Address needs of sibling/family. Child and carer(s) taken to hospital with paediatric facilities; resuscitation continued or decision to stop.

Confirmed death of a child (0-18 years) Child on end of life care pathway

Immediate Decision Making and Notifications (Section 7)

Consider Immediate Planning Discussion between lead health professional, police and CSC to determine: Is criteria met for a Joint Agency Response?

Yes / No

Note: A JAR should also be triggered at the time of collapse where a child is expected to die.

Yes. Lead health professional and police take initial history, examination and immediate investigations.

Children's Social Care (CSC) to be notified in order to convene an Initial Information Sharing and Planning Meeting (within 24-48 hours of the death).

(Consider the need for section 47 strategy meeting)

Joint Home/Scene of collapse visit by police and health. Lead health professional to provide report for coroner, pathologist and CDOP.

If JAR professionals identify risk or further information needed, CSC to arrange Follow up Initial Information Sharing and Planning Meeting (prior to CDRM)

> Data collected by CDOPs throughout CDR process to be sent to National Child Mortality Database

Investigation and Information gathering (Section 9)
This may include NHS Serious Incidents, Post Mortem
examinations, police enquiries, CDOP's gathering of
reporting forms etc.

*Family should receive feedback following investigation outcomes

Child Death Review Meeting (Section 11)
Final multi-professional review involving

professionals directly involved in the care and/or investigations. For neonatal deaths, this meeting will be PMRT.

(ideally within 3 months, pending necessary investigations, 6-8 weeks once Post Mortem completed and/or any internal investigations)

Coroner's Inquest (if required)

Child Death Overview Panel (Section 12)
Statutory independent review by Child Death Review
Partners for children resident within their LAA.
(6 weeks upon receipt of report from CDRM or
coroners inquest conclusion)

For all deaths: A Notification to CDOP should be submitted via eCDOP within 24 hours. https://

https:// www.ecdop.co.uk /PANSussex/Live/ Public

24-48 hours

Identify the family a key worker
Single point of contact for the bereaved family providing support and engage with child death review process (section 10).