

# **Joint Guidance Between Staffordshire & Stoke on Trent Local Safeguarding Children Boards**

## **PART 10-A**

### **WHEN A CHILD DIES**

#### **A - Overview Document**

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**Summary**

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## **When a Child Dies**

### **Summary**

1. Each death of a child is a tragedy for the family. Subsequent enquiries/investigations should therefore maintain an appropriate balance between forensic and medical requirements, respecting the family's need for grieving and support and sometimes in managing any uncertainty about the cause of death.
2. The majority of child deaths are from natural causes. A minority of unexpected deaths are the consequence of abuse or neglect, or are otherwise found to have abuse or neglect as an associated factor. Therefore in all cases enquiries should seek to understand:
  - the reasons for the child's death
  - the possible needs of other children in the household
  - needs of other family members
  - whether any lessons are to be learned for future reference
3. Families should be treated with sensitivity, discretion and respect at all times, and professionals should approach their enquiries with an open mind.

### **Safeguarding Children Board Responsibilities**

4. Local Safeguarding Children Boards have responsibilities set out in statutory regulations when a child dies.
  5. From April 2008, collecting and analysing information about all child deaths with a view to identifying:
    - any case giving rise to the need for a serious case review (Part 8)
    - any matters of concern affecting the safety and welfare of children within the authority
    - any wider public health or safety concerns arising from a particular death or from trends in child deaths locally
- (See Part 10 B - Notification and Part 10 E - Child Death Overview Panel Procedures)
6. Putting in place procedures for ensuring there is a coordinated response by the authority, by Board partners and other relevant individuals to an unexpected death.
  7. Training  
SSCB will provide training locally in relation to the management of child deaths as described below.

- When a child dies - A 1-2 hour awareness raising programme which introduces participants to the Rapid Response Procedures for Unexpected Child Deaths and the Child Death Review Processes.
- Responding to an Unexpected Child Death - a 1 day training programme which provides participants with the basic skills to carry out an inter-agency investigation into an unexpected childhood death.
- Reviewing Childhood Deaths - a ½ day training programme which provides participants with the knowledge and skills needed to run an effective Child Death Overview Panel.

### **Definition of an Unexpected Death of a Child**

8. An unexpected death applies to 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.
9. The designated doctor responsible for unexpected deaths in childhood should be consulted where professionals are uncertain about whether a death is unexpected.

### **Designated Doctor for Unexpected Deaths in Childhood (DDUD)**

10. Each PCT has access to a consultant paediatrician who has a designated role to provide advice on:
  - the commissioning of paediatric services from paediatricians with expertise in undertaking enquiries into unexpected deaths in childhood and the medical investigative services such as radiology, laboratory and histopathology services;

and

  - the organisation of such services.
11. The Designated Doctor for Unexpected Deaths in Childhood for South Staffordshire is:

Dr Azhar Manzoor  
 Queen's Hospital  
 Belvedere Road  
 Burton On Trent  
 DE13 0RB  
 Telephone: 01283 511511 Ext 4360  
 Mobile: 07951 924576

12. The Designated Doctors for Unexpected Deaths in Childhood for North Staffordshire are:

Dr Martin Samuels  
Academic Department of Paediatrics (Ward 87, CGH site)  
University Hospital of North Staffordshire  
Stoke on Trent  
Staffordshire  
ST4 6QG  
Telephone number: 01782 552832  
Fax: 01782 553478  
Mobile: 07710 673965

Dr Alexandra Tabor  
Consultant Paediatrician  
Academic Department of Paediatrics  
University Hospital of North Staffordshire  
Ground Floor Annexe, Norton Unit (City General Site)  
Stoke on Trent  
Staffordshire  
ST4 6QG  
Telephone number: 01782 552832  
Fax: 01782 553478

13. The appropriate DDUD should be notified of all unexpected deaths in childhood occurring in their area. This is in addition to the CDOP Co-ordinator, to whom notification should be made using FORM A. (See Part 10-F).

**Agency Champions**  
**Staffordshire and Stoke on Trent**

14. Each member of the Staffordshire Safeguarding Children Board is responsible for advising on the Part 10 procedures within their own agency. Current membership is displayed in the Business Plan.
15. Each member of the Stoke on Trent Safeguarding Children Board is responsible for advising on the Part 10 procedures within their own agency. Current membership is displayed in the Business Plan and on the Stoke on Trent SCB Website.

## **Scope of the Guidance**

16. Guidance at Parts 10 A-F relates to the deaths of all children and young people from birth (excluding those babies who are still born) up to the age of 18 years.
17. Parts C,D and F relate specifically to the processes of a rapid response to deaths which are sudden and unexpected (8-9).