CHECKLISTS

Lead Health Professional (Most Commonly Consultant Paediatrician) Checklist

(Page 1 of 2). This is a guide to the required actions post death. It does not form part of the medical record.

0 – 4 Hours Post Death (*these are the most important actions and need to be done in a timely manner)*	
Ensure nursing staff caring for child and family are aware of this guidance and provide copies of relevant checklist that they need to complete.	
Verify death and document verification in Cerner on Ad Hoc Form *(Ad Hoc Form – Assessments – Confirmation of Death)*	
Complete immediate decisions proforma in Cerner *(Ad Hoc Form – Paediatrics – Child Death immediate Decisions Proforma)*	
Inform CHIS (scwcsu.candmchis2@ I&S of death with name, NHS No, date of birth and death of child (this process triggers all urgent notifications)	
Refer to coroner if needed. In hours – 0 I&S. Out of hours via switchboard. Email: coroners@ I&S	
Complete 'Summary of Death Certification' form for ME in Cerner unless death referred to coroner. *(Ad Hoc Form – Assessments – Summary of Death Certificate Form)*	
Provide transfer letter if child's body being taken home / moved to hospice bereavement suite (ensure copy scanned to evolve)	
Identify and address any immediate actions necessary to ensure the health and safety of others, including family or community members, healthcare patients and staff.	
Consider needs / potential risk to siblings – are there any immediate safeguarding concerns?	
Document full history, and examination and any resuscitation / treatment given in Cerner	
Complete e-CDOP referral https://www.ecdop.co.uk/PANCheshire/Live/Public	
Complete SUDIC documentation (if needed)	
Ensure all parties with parental responsibility are notified of the death.	
Hot debrief of staff involved – complete datix for any immediate issues identified	
Complete discharge letter in Cerner. (In key discharge details select, Discharge method "Patient Died"; Discharge destination "Mortuary"; ensure to click "Finalise")	
4 – 24 Hours Post Death	
Inform ME of death if death occurred outside the hospital (coch.medicalexaminer@ I&S	
Complete authorisation for release form, if no coroners referral (see appendix)	
Complete MCCD (available from bereavement office in hours) and send to ME *(Not needed if case referred to coroner, must not be released to family until review by ME)*	
Consider if hospital PM appropriate, discuss with family and consent if needed and document discussion and decision in Cerner	
Dictate summary letter to GP (cc. Child Health, HV / School Nurse, other services child known to) including details of what happened and likely cause of death. Mark as urgent for typing.	
Complete Badgernet entry for NNU / labour ward deaths (if death in trust prior to discharge, even if not admitted to NNU)	
Identify 'key worker', provide contact details to parents and inform key worker(s) of death.	

LEARNING FROM CHILD DEATHS

All child deaths that occur within COCH will be reviewed both internally and externally;

1. Datix to be completed following every child death (including children going down SUDIC pathway following ALTE)
2. Immediate decision proforma completed around time of death will detail any immediate learning. Lead professional completing this is responsible completing and undertaking Duty of Candor (if needed) as well as ensuring any issues are escalated urgently and urgent learning disseminated appropriately
3. After action review (AAR) to be organised by Governance Business Partner with attendance of Head of Paediatric Nursing or Matron, Ward Manager of NNU/Ward 30/ED (depending on age of child/location of death), child death review lead as well as Anaesthetic / ED / Paediatric consultant involved in the case. This will focus on immediate local learning. This meeting cannot take place without the presence of an acute paediatric consultant who has reviewed the case and an ED representative if death occurred in ED.
4. Lead Consultant and/or Paediatric Child Death Lead to attend Rapid Response Meeting (if held). Learning recorded in notes of meeting which are distributed following the meeting and uploaded to evolve.
5. All neonatal deaths of Welsh babies need a PRUDIC discussion.
6. Death to be discussed at weekly Executive Lead Safety Meeting
    a. Any immediate actions to be recorded and disseminated to relevant parties following this meeting
    b. Decision to be taken at meeting as to whether any further local investigation needed
7. Outcome of steps 1-6 reported in next quarterly W&C mortality report. Child death lead (currently Katherine Davis) and Director of Midwifery and Paediatric Nursing (currently Natasha McDonald) responsible for this.
8. Death to undergo internal review at next appropriate RHD. Representative from Risk Department to be present to ensure actions logged and actioned appropriately.
9. Child Death Review Meeting (CDRM) to be arranged, this should be within 3 months but likely to be significantly delayed if awaiting PM report. CDRM to be held as hybrid online / in person meeting with multi-agency involvement. For deaths subject to the PMRT process this takes the place of the CDRM meeting.
10. Outcome of 8 and 9 should be reported in the quarterly W&C Mortality Report.

It is the role of the allocated Key Worker to represent parental views at the above meetings, and feedback to parents.

If a child known to COCH dies elsewhere, after initial presentation and transfer from COCH, steps 3, 4, 6 and 8 should take place. The hospital/hospice where the child dies is responsible for arranging the CDRM.

If a child known to COCH dies elsewhere with no involvement from COCH in final admission (e.g. death in Alder Hey following elective admission for routine surgery, planned palliative care death in hospice) case to be reviewed by Child Death Review Lead and a decision taken as to what steps are needed to review the death locally.

No meetings should take place without the presence of an acute paediatric consultant with knowledge of the case.