East Berkshire CCG Protocol

Health Led Rapid Response for Unexpected Child Death

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The Unitary Authorities of Berkshire through their HOCS and CDOP representatives:

Bracknell Forest, Slough, Windsor and Maidenhead

New protocol following the publication of Child Death Review Statutory and Operational Guidance (England) 2019

NHS
East Berkshire
Clinical Commissioning Group

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1. Introduction

1.1 This protocol is based on ***Sudden unexpected death in infancy and childhood, 2016***, ***Working Together to Safeguard Children, 2018*** and the ***Child Death Review Guidelines 2018***. It forms the basis of the inter-agency response to an unexpected death of a child in Berkshire.

1.2 A flow chart algorithm to summarise the actions described in this protocol is available.

1.3 If there are concerns about abuse or neglect when a child has presented in a critical condition or contributing to the cause of death, leading to safeguarding concerns for surviving siblings, the child protection process Section 47 strategy meeting and any criminal investigation will take precedence over the Health Led Joint Agency Review processes.

1.4 Where there are immediate concerns that abuse or neglect has been a factor in the child's death, the case will be the subject of a joint investigation involving the Police and Children's Social Care. The nature of any criminal or social care investigation will be confirmed during early multi-agency discussion, following the child's death.

2. Definitions

2.1 "Childhood" is defined as the time from live birth (irrespective of gestation) until the attainment of the age of 18 years. By far the largest group of child deaths occur in the perinatal period (0 - 7 days). These infants will not be routinely included in a Joint Agency Response process unless involved professionals express concerns about the circumstances of the pregnancy or the death of the baby.

2.2 In the case of a new-born baby who dies in hospital within 24 hours of birth or shortly thereafter, due to an event related to the birth whilst under medical supervision, and where there is a medical explanation for the death, this should not be treated as an unexpected death.

2.3 If a baby dies in the same circumstances (i.e. whilst under medical supervision), with no immediate medical explanation apparent, and where there is an indication or suspicion of risk factors of Domestic Abuse/substance abuse/concealed pregnancy, this will trigger the Joint Agency Response process.

2.4 If a dead baby is brought into hospital having been born without medical assistance (regardless of gestation) a Joint Agency Response (JAR) process should be triggered. The maternity co-ordinator must be informed to help co-ordinate care for Mother and so that maternity staff are aware that the JAR process is underway. This process can be halted if following examinations it is found that baby was either stillborn or gestational age is below viability.

2.5 In the case of a concealed pregnancy please refer to the 'Berkshire Multi-Agency Guidance on the Management of Concealed Pregnancy' found on the Berkshire LSCB Child Protection procedures website **http://www.proceduresonline.com/berks/**
In all cases of unknown pregnancy, where the mother has presented for the first time in labour and has deliberately or mistakenly concealed their pregnancy and no antenatal care has been provided as a consequence; this must trigger an urgent section 47 enquiry and be referred to Children's Services to lead the investigation and decision making.

2.6 "Responsible consultant" has been used to identify the senior involved clinician, this is most likely to be a Paediatrician but when the death is that of a young person of over 16 years, the clinician may be an adult specialist. Some interpretation of the protocol, depending on age and mode of death, may be required with the support of the Paediatrician on call if necessary.

2.7 "Unexpected death" is defined in Working Together to Safeguard Children 2018 (paragraph 7.21) as the death of an infant or child (less than 18 years old) which:

- Was not anticipated as a significant possibility, for example 24 hours before the death; or
- Where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

2.8 "Death" means the time that death is formally certified. It is not appropriate to instigate this process whilst the child is alive and receiving medical care.

2.9 In cases where the medical team have any concerns that there may be issues of abuse or neglect when a child has presented in a critical condition, especially where there are other children in the household, then early discussion with Police and Children's Social Care (CSC) should take place that may trigger a criminal and /or Section 47 enquiry.

2.10 Information sharing protocols exist between police and social services to ensure that relevant information is shared without the consent of the parents/carers if the public interest is deemed to outweigh the wishes of the parents/carers.

2.11 The Joint Agency Response process will be triggered for any child who is resident in East Berkshire, even if the death occurs elsewhere in the UK or overseas. Legislation allows arrangements for the review of a death in their area of a child not normally resident there.

2.12 A pragmatic approach should be taken to such deaths, entailing discussion between the Child Death Review (CDR) partners in the area where the child is normally resident and those in the area where the child died. In all cases, the CDR partners in the area, where the child is normally resident, is responsible for ensuring that a review takes place at CDOP level. Consideration should also be given to where the most learning can take place and this may sometimes dictate that a different CDOP to the area where the child is normally resident leads the discussion.

3. Immediate decision making and notifications

3.1 Once a child has been declared dead, the Coroner has jurisdiction over the body and all that pertains to it. The police (including specific coroner's officers) will often act on behalf of the coroner and will likewise have jurisdiction over the body in such circumstances as police acting on behalf of the corner.

3.2 The majority of unexpected deaths in childhood are natural tragedies, but a minority are a consequence of ignorance, neglect, abuse or homicide. The investigation should keep an appropriate balance between medical and forensic requirements and the needs of the family in coping with the tragedy. An Account should be taken of possible risks to other children in the household.

3.3 Professionals should approach the investigation with an open mind and families should be treated with sensitivity, discretion and respect. Professionals must be aware that as the number of child deaths due to natural causes decreases, the proportion of such deaths which could be attributed to neglect or abuse is likely to increase.

3.4 There should be a multi-agency approach involving collaboration among: emergency department (ED) staff, ambulance staff, named and designated doctors and nurses in

child protection, coroner, coroners' officers, general practitioners (GP's), health visitors, midwives, paediatricians, pathologists, police, children's social care and education.

3.5 The **Designated Doctor for Child Death** will take the strategic lead for Joint Agency response within Health, but the input at senior level in individual cases will be from the consultant involved in the initial event (responsible consultant).

East Berkshire Designated Doctor for Child Death
Dr Geetha Veerasamy
Tele number: 01753 635530.
Geetha.veerasamy@berkshire.nhs.uk

3.6 The Duty Detective Inspector for the Local Police area will lead for the Police on initial rapid response to Child Death. Subsequent enquiries will be led by the Local Police area Detective Inspector for the Child Abuse Investigation Unit and the Team Manager (referral and assessment) for the local authority.

3.7 Children found dead at home should be taken into the emergency department, not to the mortuary, and resuscitation should be initiated unless clearly inappropriate. There are situations where it is obvious that a body is beyond resuscitation and needs either to remain at the death scene for forensic purposes or to be moved to a mortuary. This will be a decision for the police in consultation with the Coroner.

3.8 On arrival in the emergency department, the parents/carers should be allocated a keyworker to care for them and be a main point of contact and internal procedures carried out to support the family during this distressing time should be followed as per protocol.

3.9 As soon as possible after arrival, the child should be examined by the responsible consultant, a careful history should be taken from the parents and the designated doctor for child death should be informed.

3.10 When the child is pronounced dead, the responsible consultant should inform the parents/carers, and explain police and Coroner involvement and the need for a post-mortem examination.

3.11 A set of investigative samples should be taken as appropriate. Guidelines for medical management and post-mortem samples in the event of sudden unexpected infant/child death are available on the Frimley Health NHS Foundation Trust intranet.-

3.12 In line with current practice, whether the child dies in hospital or elsewhere and is conveyed to hospital, the Consultant Paediatrician/ED Consultant or a senior nurse or doctor on behalf of the consultant should complete the **Emergency Department (ED) check list for unexpected child death** which identifies what information is required, records the name of the keyworker and ensures that parents, families and carers have been given a leaflet of information to help understand and navigate the child death review process information. The checklist also lists the agencies that need to be informed of the unexpected death. These include:

ii. Thames Valley Police (TVP)

iii. Children's Social Care, Berkshire Emergency Duty Team (EDT), Out of Hours child's local authority, Multi-Agency Safeguarding Hubs (MASH) 9am to 5pm, Mon to Fri.

iv. The coroner's officer on call

Further notification of the child's death, should be made to the Pan Berkshire Child Death Overview Panel (CDOP) via the eCDOP on-line portal :

3.13 https://www.ecdop.co.uk/panberkshire/live/Public-

The Pan Berkshire Child Death Overview Panel Coordinator can also be contacted within normal working hours with any queries relating to this notification process.

Lorna Tunstall Tel: 01753 875149, Mob: 07850 209095-
lorna.tunstall@slough.gov.uk

3.14 When a child goes directly to the mortuary the Designated Doctor for Child Death must be informed.

East Berkshire Designated Doctor for Child Death,
Dr Geetha Veerasamy Tele number: 01753 635530.
Geetha.veerasamy@berkshire.nhs.uk

3.15 Key Worker/ support for the family

Supporting and engaging the families who have lost a child is of prime importance

throughout the whole child death review process.
In East Berks CCG the most appropriate professional must be clearly identified to carry out this role; taking into consideration the circumstances of the child's death and professionals who may already have a good working relationship with the family prior to the child's death.

4. Investigation and information gathering

This section details the main investigations that may take place

4.1 Initial Multiagency Process. After immediate decisions have been taken and notifications made, a number of investigation processes may then follow. They will vary depending on the circumstances of the case, and may run in parallel. The timescales of investigations will vary greatly from case to case. The learning arising from investigations will inform the child death review meeting.

4.2 Unexpected deaths. After immediate decisions and notifications have been made, a number of investigations may then follow. These include:

- Safeguarding Investigations
- Criminal Investigations
- Coronial investigation
- Early Response Meeting (within 72 hours)
- Serious Incident Investigation

4.3 Post-mortem examinations may be required in a number of cases, either as part of the coronial investigation or for medical reasons.

4.4 Which investigation process is necessary will vary depending on the circumstances of the individual case. They may run in parallel, and timeframes will vary greatly from case to case.

4.5 The Key worker will provide overarching coordination alongside any investigation to facilitate the family voice and to keep them informed at all stages.

4.6 In deaths where there is more than one investigation, Frimley Health Foundation Trust should appoint a Case Manager to have oversight of procedures; ensuring that those involved are objective.

Joint Agency Response (JAR) Process

(Previously referred to as the rapid response process)

4.7 When the death is due to external causes, is sudden and there is no immediately apparent cause; where the death occurs in custody, or where the child was detained under the Mental Health Act or while deprived of their liberty by the state, the attending doctor should ensure that the coroner and police are notified and there should be a **Joint Agency Response** to the death. As soon as practicable, the Designated Doctor for Child Death must be informed of the death of a child.

4.8 The **Joint Agency Response** is most often triggered in the Emergency Department when a child or young person dies after transfer by 999 ambulance, although it must be triggered in the same way when a child or young person dies unexpectedly in any setting, including at home, a Paediatric Ward, a Neonatal Unit, ICU or an Adult Ward.

4.9 The **Joint Agency Response process** should also be triggered when a child or young person with a life limiting/chronic illness dies unexpectedly, unless there is an 'End of Life Plan' in place.

Gathering of multiagency information

4.10 It is the responsibility of the Designated Doctor for Child Death to liaise with other lead agencies to make a joint decision whether or not to hold a Joint Agency Response meeting and to agree the timing of the initial case discussion meeting.

4.11 In the case of a child who is not usually resident in the East Berkshire area these discussions and any meeting will need to involve their home Local Authority and the relevant police force.

4.12 The decisions made and actions agreed during the initial multiagency information sharing meeting must be recorded by the Designated Doctor for Child Death on the '**Unexpected Child Death Discussion Form'** and copies should be shared with TVP and CSC within 12 hours of the discussion.

4.13 In East Berkshire please contact Dr Geetha Veerasamy Designated Doctor for Unexpected Child Death on 01753 635672 / 01753 635530.

4.14 Please email brief details including the child's initials, DOB, DOD and who should be contacted and how e.g. mobile number, the next working day to gain more information, including a copy of the child's notes to:

Geetha.veerasamy@berkshire.nhs.uk
and copy fph-tr.ChildProtection@nhs.net

4.15 A **Joint Agency Response** discussion about the circumstances of the death between the Consultant Paediatrician/ED Consultant and Designated Doctor for Child Death should be held as early as possible following the death or the next working day if the death occurs out of normal working hours Monday to Friday.

4.16 The Designated Doctor for Child Death continues the Joint Agency Response discussion with CAIU and Children's Services to determine the most appropriate date/time, venue for an initial case discussion meeting.

4.17 If it is necessary to convene a face to face **Joint Agency Response** meeting this will usually be **within 48 hours** of the death depending on the circumstances of the death and the availability of relevant professionals.

4.18 In some cases where the cause of death is fully explained and no concerns have been identified through multi-agency discussion (for example after a road traffic accident), a face to face meeting may not be necessary.

Home visits

4.19 During this discussion, consideration should be given to the need for a home visit. This should usually take place in the case of sudden unexpected death in infancy. If a joint home visit by a health professional and police officer is agreed, this should be undertaken, preferably within 24 hours of the death during working hours Monday to Friday or as soon as possible on the next working day if the death occurred during a weekend or on a bank holiday by the BHFT rapid response home visit professional.

4.20 If a home visit is indicated, there is a Berkshire wide service provided by BHFT who can do these visits during normal working hours Monday to Friday or as soon as possible on the

next working day if the death occurred during a weekend or on a bank holiday. This service is provided by a team of Children's Community Nurses with specific training, supported by the Designated Doctor for Child Death for East Berkshire.

BHFT Rapid Response Service tele number 01628 632012 – in hours

4.21 In the event of an unexpected child death where the child does not die in a hospital setting and a home visit is indicated, the Duty DI, the Local Police Area, TVP should contact the Berkshire Rapid Response Service directly.

4.22 In the event of a Sudden Unexpected Death of an Infant (SUDI) in hospital and it is indicated that a home visit is required; on the next working day, the Duty DI, the Local Police Area, TVP should also contact the Berkshire Rapid Response Service directly to arrange for a visit to the family home.

4.23 During working hours, the Consultant Paediatrician is able to liaise directly with the Designated Doctor for Child Death, if needed.

4.24 A record of these discussions will be made and a record and report from any home visit will be made using standardised documentation available to the rapid response professionals. A copy of this report should be sent to the Designated Doctor for Child Death for the information to be shared with the multiagency team and forwarded to the Pathologist and Coroners Officer.

Decision to hold a health led Joint Agency Response meeting.

4.25 The Designated Doctor for Child Death will make the decision to hold a health led Joint Agency Response meeting following a multi-agency discussion at the gathering information stage of the process (see above.)

4.26 A Joint Agency Response (previously referred to as the rapid response) meeting is arranged and chaired by the Designated Doctor for Child Death.

4.27 The following professionals are always invited to and asked to provide verbal or written reports to initial Health led Joint Agency Response meetings:

Responsible Paediatrician
Child Abuse Investigation Unit, Thames Valley Police

Children's Social Care
BHFT Safeguarding Team
Midwife/Health Visitor/School Nurse
South Central Ambulance Service
Public Health Consultant for locality
General Practitioner and Out of Hours GP Service if relevant
Education (Head Teacher of Child's School or representative) if relevant
Other relevant agencies e.g. CAMHS, Probation Service
East Berks CCG Safeguarding team, Named Professional Safeguarding - to support and monitor the implementation of the new JAR process

4.28 In East Berkshire CCG area:

- The East Berks CCG standard JAR meeting agenda template should be used to structure the discussions and confirm that the family is being supported appropriately with their keyworker as a main point of contact.
- Draft minutes will be circulated to attendees within 5 working days
- Subject to corrections final minutes will be circulated and sent to the attendees, Coroner's Officer and the Designated Nurse for Child Protection within 10 working days.
- All information collected and the standard data set should be shared with Pan Berkshire Child Death Overview Panel by uploading it on the eCDOP portal.

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Other Review Processes

4.29 If there are concerns about abuse or neglect contributing to the cause of death, leading to safeguarding concerns for surviving siblings, the child protection process, section 47 strategy meeting and any criminal investigation will take precedence over Joint Agency Response child death processes.

4.30 In these circumstances Children's Social Care have the responsibility for co-ordinating the overall safeguarding investigation and the police have responsibility for coordinating any criminal investigation. The role of the Designated Doctor for Child Death at this stage is to ensure all activity between agencies is carried out in a co-ordinated fashion.

4.31 If held, the Section 47 Strategy Meeting should take place within 24hrs of the death and the Consultant Paediatrician and/or Designated Doctor for Child Death should be invited. If the Designated Doctor for Child Death is present at the Section 47 Strategy meeting an initial case discussion Health Led Joint Agency Response meeting may be held consecutively or concurrently and chaired by the Designated Doctor for Child Death.

4.32 If it is thought at any time that the criteria for a **Serious Case Review** might apply, the Local Authority are responsible to inform Ofsted of a critical incident and inform relevant personnel; for example the chair(s) and business manager of the relevant safeguarding board under multiagency safeguarding arrangements. **Serious Case Review Procedures** should be followed as per Berkshire Child Protection procedures. **http://www.proceduresonline.com/berks/**

4.33 If it is thought at any time that the criteria for a mandatory single agency review of practice e.g. **Serious Incident Requiring Investigation (SIRI)** for health providers might apply, the Designated Doctor for Child Death should contact the relevant organisation. Any Serious Incident investigations, when initiated, inform the child death review process through providing a detailed analysis of patient safety incidents that may have contributed to the death by the way of a reporting form.

4.34 The coroner will order a post-mortem examination to be carried out as soon as possible, preferably within 48 hours, by the most appropriate pathologist.

4.35 If the post mortem indicates death from abuse or neglect:

- The Police will commence a criminal investigation;
- Action will be taken to safeguard other children in the household;

The relevant Berkshire Safeguarding board chair(s) must be notified, via LSCB Business Manager.

4.36 The post mortem report will be forwarded to the responsible consultant and to the Designated Doctor for Child Death. Either (or both together) should discuss the results of the post mortem with the parents/carers at the earliest opportunity:

- If the Police have taken over as lead agency because of concerns over abuse or neglect then the role for, and conduct of such a meeting, will be discussed;
- If the post mortem findings are unclear or controversial the responsible consultant/Designated Doctor for Child Death and the Coroner/Police will discuss on a case by case basis;

There may be further reasons not to hold a meeting, for example where the Inquest is to take place soon after the release of the post mortem report or when there are issues around litigation.

4.37 The parents/carers will receive written information advising that the child's death will be subject to a review by the Child Death Overview Panel (CDOP) in order to learn any lessons that may help to prevent future deaths of children. The parents may ask for and have a right to receive the minutes of any Health led Joint Agency Response meeting
(see **Child Death Overview Panel Procedure**).**http://bhps.org.uk/cdop/home.html**

4.38 If the child's family have any unanswered questions concerning the death the Designated Doctor for Child Death or the responsible consultant (or both) will meet them to answer their questions. If the family do not wish contact this may be done by letter.

4.39. All information collected and the standard data set should be shared with Pan Berkshire Child Death Overview Panel by uploading it on the eCDOP portal.

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5. Child death review meeting

This is a new stage introduced in accordance with the Child Death Review guidance 2018.

5.1 Although investigations following the death of a child will vary, **every** child's death should be discussed at a child death review meeting (CDRM). This is the final multi-professional meeting involving the individuals who were directly involved in the case.

5.2 It is the responsibility of the organisation where the child's death is declared to arrange the child death review meeting. Where a child has died at home, a Joint Agency Response would normally occur, and the Designated Doctor for Child Deaths would be responsible for arranging this meeting.

5.3 The CDRM meeting should take place as soon as is practically possible, ideally within three months, although serious incident investigations and the length of time it takes to receive the final post-mortem report will often cause delay. The child death review meeting should occur before the coroner's inquest, child safeguarding practice review and the CDOP review.

5.4 The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved, but have common aims and principles in all cases.

5.5 In East Berkshire Child Death Review meetings are held in the following formats:

- Final case discussions following Joint Agency Responses.
- Perinatal mortality review group meetings in the case of a baby who dies in a neonatal unit
- Hospital Mortality Review Meetings following the death of a child in hospital, or similar case discussion.

5.6 The Chair of each of these meeting is responsible ensuring that the details of each child death review meeting should be captured on a draft 'child death analysis form' (formally Form C) and uploaded to the eCDOP system**.**

6. Specific Situations

6.1 The Learning Disability Mortality Review Process **(LeDeR)** adheres to key principles of communication, cooperation, and independence when liaising with other investigation or

review processes. The child death review process will be the primary review process for children with a diagnosed learning disability for children who die from the age of **4 years and over.** In line with local arrangements, the LeDeR panel will be informed the death and it will not be necessary for the LeDeR programme to review each case separately. The local CDR Partners should report that death to local LeDeR panel and to the LeDeR programme at http://www.bristol.ac.uk/sps/leder/notify-a-death

6.2 It is expected that the child death review process will be the primary review process for children with learning disability and that it will not be necessary for the LeDeR programme to review each case separately; the LeDeR will be able to receive appropriate information about the review from CDOP.

Deaths overseas of children normally resident in England

6.3 Arrangements must be made for the review of each death of a child normally resident in East Berkshire, including if they die overseas. When the death has taken place abroad, the East Berkshire Designated Doctor for Child Deaths carries out the co-ordination role for all the agencies involved , including the Coroner and Foreign Office, to enable the review to take place.

Deaths of children in adult healthcare settings

6.4 A very small number of children (nearly always 16 and 17 year olds) die in adult intensive care units (ICUs), the deaths of these children are still subject to the child death review process and are subject to the same process and have the same rigor of review as all other children who die.

6.5 When a child dies in ICU, the responsible Consultant should complete the ICU Patient Death checklist to ensure that the designated doctor for child deaths and all other relevant agencies/professionals are notified.

6.6 Child Death Review meetings for these children should be held in the format of the acute Trust adult Mortality Review meeting and recorded on the standardised CDR Analysis Form. The completed form and any other notes arising from the adult M&M meeting should be uploaded onto eCDOP.

Suicide and self-harm

6.7 Child suicide should be reviewed in the same manner as other child deaths, with the following expectations:

• **All** deaths related to suspected suicide and self-harm should be referred to the coroner for investigation
• **All** deaths related to suspected suicide and self-harm will require a Joint Agency Response

Inpatient Mental Health settings

6.8 This applies to all children in inpatient mental health settings whether they are treated 'voluntarily' as informal inpatients or detained under the Mental Health Act 1983 (MHA). All deaths of East Berkshire children in inpatient mental health settings should be reported to the coroner and trigger a Joint Agency Response. When a child dies while detained under the MHA, the safeguarding practice review process is also initiated.

7. Useful Contacts

Berkshire wide:

Social Care Emergency Duty Team out of hours team 01344 786543

Rapid Response Service BHFT 01628 632012 – in hours

Manager for Berkshire Rapid Response Service, BHFT, Brigid Golden, Head of Specialist Children's Services Mob: 07760 415776 **brigidgolden@berkshire.nhs.uk**

BHFT Safeguarding Team –Mobile: 07771381369 (within working hours Monday to Friday)

Named Professional for Safeguarding, SCAS Antony Heselton, Mob: 07803 760616

antony.heselton@scas.nhs.uk **antony.heselton@nhs.net**

Pan Berkshire Child Death Overview Panel Coordinator, Lorna Tunstall, Slough Borough Council, Observatory House, 25 Windsor Road, Slough, SL1 2EL Tel: 01753 875149, Mob: 07850 209095 **lorna.tunstall@slough.gov.uk** **lorna.tunstall@nhs.net**

East Berkshire:

East Berkshire Designated Doctor for Child Death, Dr Geetha Veerasamy, Child Development Centre, Fir Tree House, Upton Hospital, Slough. 01753 635530.
Geetha.veerasamy@berkshire.nhs.uk

East Berkshire Designated Doctor for Child Protection, Dr Louise Watson, Child Development Centre, Fir Tree House, Upton Hospital, Slough. 01753 635530 **louise.watson@berkshire.nhs.uk**

Wexham Park and Heatherwood Hospitals, FHFT Named Nurse Safeguarding Children, Deirdre Race 01753 634609 **deirdre.race@fhft.nhs.uk**

Wexham Park and Heatherwood Hospitals, FHFT Named Doctor for Child Protection, Dr Amal Quadri 01753 633737 **amal.quadri@fhft.nhs.uk**

East Berkshire CAIU DI, Stuart May, Tel: 01865 854086 Mob: 079741 30293 **stuartmay@thamesvalley.pnn.police.uk**

Named Professional – Safeguarding, Adults, Children and Children in Care CCGs East Berkshire: Jo Barnett Tel 07769 886482 **jo.barnett6@nhs.net**
Bracknell Multi-Agency Safeguarding Hub (MASH) Tel:01344 352005,

mash@bracknell-forest.gov.uk

Slough Multi-Agency Safeguarding Hub (MASH) Tel 01753 875362

Email **sloughchildren.referrals@scstrust.co.uk.**

Royal Borough of Windsor and Maidenhead Multi Agency Safeguarding and Early Help Hub (MASH) Tel 01628 683150 **Email MASH@achievingforchildren.org.uk**

8. References

Working Together to Safeguard Children, 2018 (chapter 5)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_t o_Safeguard_Children-2018.pdf

Child Death Review Guidelines 2018

https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

Sudden unexpected death in infancy and childhood Multi-agency guidelines for care and investigation 2016

http://www.nncdop.com/wp-content/uploads/2016/12/Suddenunexpecteddeathininfancyandchildhoodreport.pdf

Learning Disabilities Mortality Review (LeDeR) 2015

http://www.bristol.ac.uk/sps/leder/