Notification of Child Death Form

CDOP Identifier (Unique identifying number assigned by CDOP administrator)

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Notification of Child Death

Notification to be reported to CDOP administrator:

Polly Lowe Herefordshire and Worcestershire Child Death Overview Panel Co-ordinator

Secure email: plowe@worcestershire.gov.uk / cdr@worcestershire.gov.uk

Tel: 01905 843199

Please remember it is a statutory requirement to notify CDOP of all child deaths from birth up to their 18th birthday. If there are a number of agencies involved, liaison should take place to agree which agency will submit the Notification. However, unless you know someone else has done so, please notify CDOP with as much information as possible.

Child's details:

Full name of child				
Any aliases				
Gender	☐ Male	☐ Female	☐ Other	☐ Unknown
DOB / Age	/ / (dd/mm/yyyy) days/months/years			
Gestational age at birth:	Number of completed weeks: Number of completed days:			
NHS No.				
Address				
Postcode				
Name of school/nursery				

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What was the child's ethnic group?	White: ☐ British ☐ Irish ☐ Any other White background
	Mixed: ☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Any other mixed background
	Asian or Asian British: ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Any other Asian background
	Black or Black British: ☐ African ☐ Caribbean ☐ Any other Black background
	Other ethnic group: ☐ Chinese ☐ Any other ethnic group
	☐ Not known/ not stated

Mother's details:

Name	
Surname	
DOB / Age	/ / (dd/mm/yyyy) years
NHS No.	
Address	
Occupation (please specify if high risk occupation e.g. health	

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care professional, First responder, care worker)	

Other significant household and family members (parents, siblings, other relevant adults):

Name	**DOB**	**Relationship**	**Address**	**Occupation** (please specify if high risk occupation e.g. health care professional, First responder, care worker)

Death details:

Date of death	/ / (dd/mm/yyyy)
Time of death	: (24hr)
Where was the child when they died? [1](please include name of hospital if relevant)	
Suspected cause of death	
What was the mode of death?	☐ Planned palliative care ☐ Withholding, withdrawal, or limitation of life-sustaining treatment)

[1] The place where the child is believed to have died regardless of where death was confirmed. Where a child is brought in dead from the community and no signs of life were recorded during the resuscitation, the place of death should be recorded as the community location; where a child is brought in to hospital following an event in the community and is successfully resuscitated, but resuscitation or other treatment is subsequently withdrawn, the place of death should be recorded as the location within the hospital where this occurs

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	☐ Brainstem death ☐ Unsuccessful cardio-pulmonary resuscitation ☐ Found dead ☐ Not known
Was this child known or suspected to have been exposed to COVID-19 in the two weeks before death? (Please also answer this question for babies who may have been exposed in utero)	☐ Yes ☐ No ☐ Not known
If **yes**, please give details of known or suspected exposure	
Did this child show symptoms of COVID-19 in the two weeks before death? e.g. fever, dry cough, wet cough, fatigue, shortness of breath, sore throat, headache, myalgia, arthralgia, rigors, nausea, vomiting, nasal congestion, diarrhoea, haemoptysis, conjunctival congestion	☐ Yes ☐ No ☐ Not known
If yes, please describe the child's symptoms in as much detail as possible and	

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include duration of symptoms and time between symptoms and presentation	
Had this child been tested for COVID-19 at any point?	☐ Yes – tested during life ☐ Yes – tested after death ☐ Yes – tested at post-mortem ☐ No ☐ Not known
If yes, what was the result of the test?	☐ Positive ☐ Negative ☐ Not known
In the case of neonatal / infant death, was the mother tested for Covid-19?	☐ Yes – tested Positive ☐ Yes – tested Negative ☐ Not tested ☐ Not known
Did this child require respiratory support and / or intubation at any point?	☐ Yes ☐ No ☐ Not known
If yes, what was the highest level of respiratory support required?	☐ Oxygen ☐ High flow O2 ☐ CPAP ☐ BIPAP ☐ Invasive conventional ventilation ☐ HFOV ☐ ECMO ☐ Other ☐ Not known
Did this child have a chronic respiratory problem? *(please tick all that apply)*	☐ Asthma ☐ Cystic Fibrosis ☐ Chronic Lung Disease of Prematurity ☐ Other, please specify:

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	☐ No, this child did not have a chronic respiratory problem ☐ Not known
Did this child have any other co-morbidities? *(please tick all that apply)*	☐ Diabetes ☐ Cardiac disease ☐ Neurological/neuromuscular condition (including cerebral palsy) ☐ Genetic syndrome ☐ Malignancy ☐ Immunocompromised ☐ Other, please specify: ☐ No, this child did not have any other co-morbidities ☐ Not known
Was this child known to be a smoker?	☐ Yes, tobacco cigarettes ☐ Yes, vaping ☐ Other - specify ☐ No ☐ Not known☐ Not applicable
Were any significant family members in the house known to be smokers?	☐ Mother ☐ Father ☐ Other significant adult ☐ Sibling ☐ Not known
Was the infant breastfed before the illness?	☐ Yes ☐ No ☐ Not known ☐ Not applicable

Case management:

Is there to be a Joint Agency Response?	☐ Yes ☐ No ☐ Not known

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Death discussed with the medical examiner?	☐ Yes ☐ No ☐ Not known
Death to be investigated by Coroner?	☐ Yes ☐ No ☐ Not known
Post mortem examination?	☐ Yes ☐ No ☐ Not known

Notification details:
Please outline the circumstances leading to notification. Also include if any other review is being undertaken (e.g. internal agency review); and whether any immediate action is being taken as a result of this death. **Please include as much detail as possible of any characteristics of infection that the child displayed in the weeks leading up to death.**

Case alert:

Was there any cause for concern about any element in the child's environment or circumstances of death where action is required for urgent learning?

☐ Yes (if yes, please give details including the name and brand of any product if known)

☐ No

Below are some examples of what to include in response to this question. This list is not exhaustive and is included for guidance only. Please use this to alert the NCMD team of any issue of concern to you.

- *Presence of known or suspected Covid-19 in this child or someone they may have had contact with*
- *Concerns about the functioning of medical equipment e.g. pumps, syringe drivers,*

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wheelchairs, sleep systems, orthotics ▪ *Concerns about any product e.g. nappy sacks, blind cords, apnoea monitors, car seats, sleep positioning devices, swaddling devices, play equipment* ▪ *Concerns about specific medications* ▪ *Concerns regarding clusters of similar deaths known to you*

Details of relevant agency contacts (please give as much information as you have easily available to you):

Agency	**Name and contact details**	√ **Lead Professional** (only one tick is required)
Community Paediatrician		☐
Local Paediatrician/ Neonatologist		☐
Tertiary Paediatrician/ Neonatologist		☐
Other local or tertiary specialists		☐
GP		☐
Midwife		☐
Health Visitor		☐
School Nurse		☐
Obstetrician		☐

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Police – Collision Investigation Unit or Child Protection		☐
Children's Social Care		☐
Nursery/School/College/or Local Education Authority		☐
Others (list all agencies known to be involved)		☐

Referral details:

Date of referral	/ / (dd/mm/yyyy)
Name of referrer	
Agency	
Address	
Tel.	
Email	

The clinical members of the NCMD team may need further information or follow up on some of the information provided. Please confirm your permission for the team to contact you by email or phone if required by completing the section below.

☐ Yes, I give permissions to the NCMD clinical team to contact me by email and my email address is: …….

☐ Yes, I give permissions to the NCMD clinical team to contact me by phone and my telephone number is: ……..

☐ No, I do not wish to be contacted by the NCMD clinical team