# Notification of Child Death

Notification to be reported to CDR Officer at:

Secure email: [cdop@northyorks.gov.uk](mailto:cdop@northyorks.gov.uk)

Tel: 01609 797167 or 07967 469790

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 |  | | | |

|  |  |
| --- | --- |
| 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 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) |
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**Death details:**

|  |  |
| --- | --- |
| Date of death | /    /      (dd/mm/yyyy) |
| Time of death | : (24hr) |
| Where was the child when they died? [[1]](#footnote-2)(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)  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 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:  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 |
| 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.**

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**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, 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 |  |  |
| 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

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 [↑](#footnote-ref-2)