Leicester, Leicestershire & Rutland Joint Agency Response following the death of a child.
(Liveborn of any gestation up to 17 years 364 days).

Joint Agency Response criteria:

- Death in suspicious circumstances.
- Death due to external causes.
- Death which is sudden (not anticipated 24 hours prior) and for which there is no immediately apparent medical explanation (i.e. unable to issue MCCD).
- Death whilst detained under the Mental Health Act or whilst in custody.
- Medically unattended stillbirth.
- Collapse from any of the above with poor prognosis and not expected to survive – JAR to be initiated at point of collapse.

Child declared deceased in Emergency Department (ED).

Child declared deceased on scene - conveyed to Emergency Department (ED). *Direct conveyance to mortuary only in exceptional circumstances following liaison between Police & ED Consultant.*

- Attending doctor to contact on-call Detective Inspector for Child Deaths to initiate the Joint Agency Response.
- Coroner to be notified of the death.
- Multiagency liaison with Childrens Social Care (consideration of need for section 47 strategy meeting).

Within 24 hours/next working day: LLR CDOP to be notified of the death via eCDOP: www.ecdop.co.uk/llr/public

Within 24 hours/next working day from receipt of notification:

- LLR CDOP notify all relevant professionals of the death.
- **Child Death Initial Meeting** held – multiagency meeting to share information, identify actions & coordinate support for family.

Within 48 hours: Joint Home Visit by Police & Child Death Review Nurse

Within 10 days: LLR CDOP request for Reporting Forms sent to all relevant professionals via eCDOP.

Coroner's post-mortem examination, ancillary investigations & governance reviews by all relevant agencies involved, completion of CDOP Reporting Forms. Ongoing support for family.

Once all investigations & information gathering complete:

- **Child Death Review Meeting** held - multiagency meeting to review information, analyse contributory factors, identify any actions needed, including feedback from family.
- Report of CDR Meeting to HM Coroner

Coroner's Inquest

Once inquest completed:

- **Child Death Overview Panel** – multiagency review of anonymised case to identify contributory and modifiable factors and identify any local/regional/national actions to take to reduce risk of future child deaths.