The Royal College of Pathologists
Pathology: the science behind the cure

National Medical Examiner's Good Practice Series No. 6

Deaths of children and neonates

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Contents

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About the National Medical Examiner's Good Practice Series

Medical examiners are senior doctors providing independent scrutiny of non-coronial deaths in England and Wales, with the role now a statutory requirement since 9 September 2024.

While there is extensive guidance available on a wide range of topics for NHS and public sector staff, the National Medical Examiner's Good Practice Series highlights how medical examiners and medical examiner officers can better meet the needs of local communities and work more effectively with colleagues and partners.

The Good Practice Series is a topical collection of focused summary documents, designed to be easily read and digested by busy front-line staff, with links to further reading, guidance and support.

Introduction

This paper focuses on how medical examiners interact with the statutory child death review processes, as well as noting related initiatives and issues to review mortality, such as the statutory child death review process in England, the Procedural Response to Unexpected Deaths in Childhood (PRUDiC) and Child Death Review Programme in Wales. The number of different initiatives, particularly in relation to deaths of children and neonates, leads to questions about how or where medical examiners should align with other processes. It is important to avoid unnecessary overlap, duplication or confusion. Throughout this paper, references to ‘child’ and ‘children’ include newborn babies, infants and children under the age of 18.

The death of a child is a devastating loss that profoundly affects bereaved parents, as well as siblings, extended family and professionals involved in caring for the child. Families experiencing such a tragedy should be met with empathy and compassion. Parents require clear and sensitive communication; they need to understand what happened to their child and assurance that learning from their child’s death will improve care for other children.

The process of expertly reviewing all deaths of children is grounded in respect for the rights of children and their families. Children are clearly a vulnerable population, and such deaths are reviewed and reported though a number of local and national systems. Medical examiners and medical examiner officers need to understand how these reviews function locally, agree how their work interacts with other processes and ensure families are supported in a consistent and sensitive way. The Child Death Review Statutory and Operational Guidance notes that families should be given a single, named point of contact, i.e. the ‘key worker’, for information on the processes following their child's death, and who can signpost them to sources of support. It is important that review processes are coordinated and transparent to avoid causing additional uncertainty or distress to bereaved parents.

Medical examiners, through early identification of issues with care, present an opportunity for the NHS to address issues and concerns. Because they are independent, medical examiners can give the bereaved a voice, ensuring their views are given due consideration. Medical examiners provide insight within days of a death, and early feedback from medical examiner offices suggested this can help prevent complaints and

appeals that may be more painful and damaging if they arise later. Medical examiners help establish as accurately as possible causes of death for the Medical Certificate of Cause of Death (MCCD), which improves national data for health research, and provide guidance about whether the death should be notified to the coroner. In addition, the medical examiner office can help and support clinical teams in raising and escalating concerns to other agencies. Bereaved parents are likely to value having a better understanding of the cause of death and knowing that the recorded cause of death is as accurate as possible with the available information, given that the results of any further investigations are unlikely to be available when the MCCD is completed.

Since the Death Certification Reforms came into force on 9 September 2024, it has been a requirement that all deaths in England and Wales are independently scrutinised by a medical examiner or a coroner. There are no exceptions. By providing independent scrutiny after the death of a child, medical examiners ensure that bereaved parents benefit from their scrutiny and discussion in the same way as those following the death of an adult.

There are 3 important distinctions in the way medical examiners work in comparison to other review processes (which may share some but not all of these characteristics).

- Firstly, medical examiners provide independent scrutiny of all non-coronial deaths. Individual medical examiners cannot review deaths for which they or their clinical team provided care.
- Secondly, bereaved people are put at the centre of the process. Medical examiners give the bereaved an opportunity with someone not involved in provision of care to ask questions about the causes of death and to raise concerns about the care provided before death.
- Thirdly, medical examiners carry out their scrutiny shortly after death. This means that some information may not be available at that time (e.g. placental histology). Medical examiners do not carry out in-depth investigations, but they may be able to detect issues very soon after a death has occurred. Medical examiners complete a proportionate review of the medical records and review the proposed cause(s) of death with the doctor completing the MCCD. Where medical examiners detect issues or concerns, they refer these to established clinical governance processes and/or the

coroner for investigation. In the case of deaths of children, medical examiners can provide information to support child death review meetings.

Recommendations for medical examiners

Medical examiners should:

1. work closely with paediatricians (including paediatric mortality leads in England and, where appointed, in Wales), neonatologists and obstetricians to establish effective interactions between medical examiners and the local child death review processes that maximise the support for bereaved families and minimise potential distress and duplication. Medical examiners should be conscious of local leads for child death (including perinatal/neonatal) and local reporting/investigation arrangements for perinatal deaths and their timescales. Those developing local processes and ways of working should ensure all parties are clear about their roles and the steps that will take place after the death of a child and take care to avoid any potential misunderstandings or gaps. In England, this could include the key worker introducing the medical examiner role to the family, for example with general information or an agreed template letter, to inform bereaved families about the medical examiner or medical examiner officer contacting them.
2. provide independent scrutiny of deaths of children and neonates not taken for investigation by a coroner, as they would for other non-coronial deaths. After the death of a child or neonate, medical examiners (or medical examiner officers on their behalf) should make contact with bereaved families to offer the opportunity of discussion with an independent person in the usual way. Deaths of children will then receive equivalent independent scrutiny to that provided for all other non-coronial deaths; families who are bereaved after the death of an infant or child will have equal opportunity to discuss any concerns with an independent person. As in adult deaths, the medical examiner will help the clinical team navigate the legal requirements of referral to the coroner where there is uncertainty or concern.
3. recognise that, while all deaths require sensitive interactions with bereaved people, the death of a child is likely to be particularly traumatic. Medical examiners and medical examiner officers should ensure that bereaved families are informed clearly that participation in a discussion is entirely voluntary.

4. take advice from child and neonate bereavement leads on their approach to bereaved parents and participate in training opportunities. Training is available from organisations such as Child Bereavement UK.

5. work closely with paediatricians (including paediatric mortality leads) and neonatologists, obstetricians and midwives, to establish processes to capture and disseminate learning, and ensure that actions to improve care for patients are identified and implemented. Medical examiners should understand governance processes in the organisation and routes of independent escalation of concerns.

6. pay particular attention to proposed causes of neonatal death. These should fully reflect the broad clinical background of each death, and medical examiners should exercise due care during their usual scrutiny before the death is registered to consider peripartum issues and antenatal care. Again, interactions with obstetricians or midwives and proportionate review of their records, if feasible before completion of the MCCD, may be an important part of scrutiny. It should be acknowledged that certain information (e.g. placental histology or detailed review of foetal monitoring) might not completed at the time of death for some neonates, and this information will be available for future reviews.

7. when reviewing the sudden unexpected death of a child or a neonate in which there is no immediately apparent medical cause, actively consider whether unnatural events (including malign or criminal activity) may have caused or contributed to death. Where appropriate, this should include exploring this possibility with medical practitioners and other clinicians involved in providing care where appropriate, or checking details further with neonatal or paediatric experts not involved in providing care. Any suspicion of malign activity would require referral to the coroner.

8. participate in meetings or discussions for child death reviews where desired or considered helpful. In England, this reflects arrangements set out in the statutory Child Death Review Guidance. In Wales, information sharing/discussions could take place with the Child Death Review Programme. It should be noted that the National Medical Examiner's Good Practice Guidance states that medical examiners cannot also be their host organisation's mortality lead.

9. where not satisfied that appropriate action is being taken to address a concern they have identified regarding care of a baby or child(ren), escalate concerns in line with

the National Medical Examiner's Good Practice Guidance; and where there is a perinatal death in England, to the local perinatal, neonatal and child death leads and to members of regional-level quality oversight committees. Medical examiners have a role to further escalate concerns raised by clinical team members, or families, in some situations where those individuals do not feel their concerns have been adequately addressed.

10. while this paper specifically addresses the interplay between medical examiners and the statutory child death review process, medical examiners should note there are a range of agencies who may become involved in reviewing the deaths of children and neonates, and that there is potential for bereaved families to find this confusing and even overwhelming. Medical examiners and officers need to be aware of the various reviews, their timescales and the family's point of contact to help navigate them over time. There is more information about other agencies and processes on page 14.

Context and background

There have, sadly, been several independent investigations regarding deaths of babies and children (and related areas such as maternity and neonatal services) that found that care was in significant need of improvement. These include the reports of the Morecambe Bay Investigation, Mid Staffordshire Public Inquiry and other ongoing investigations. Writing for the Royal College of Pathologists' *Bulletin*, Dr Bill Kirkup CBE noted that the 'introduction of medical examiners offers a clear opportunity to ensure that these cases are not lost and can be learned from and, where necessary, instances of systemic failure can be identified. To achieve this, medical examiners will need to retain sufficient independence and remain aware that deaths that appear inevitable after a fraught neonatal course may have been entirely avoidable if the management of labour and delivery had been different.'[1] Since this paper was first published, the Thirlwall Inquiry was set up to examine implications following the trial and subsequent convictions of Lucy Letby. In due course, the Inquiry will report its findings and recommendations. We anticipate that further revisions to this paper are likely to be appropriate when this evidence is available.

Other action has been taken to improve surveillance and learning. This includes the Maternity and Newborn Safety Investigations (MNSI) programme (formerly HSIB maternity investigations), which is part of a national strategy to improve maternity safety across the NHS in England; Getting it Right First Time; the 2023 update to Working Together to Safeguard Children; analysis of the National Child Mortality Database; the UK-wide national Perinatal Mortality Review Tool (PMRT); and in Wales, existing surveillance of child deaths by the Child Death Review Programme.

The latest published data[2] from the National Child Mortality Database in England shows that nearly 75% of deaths of children occur in hospital. The great majority of these deaths

[1] Dr Bill Kirkup CBE. Perinatal mortality − are we learning? *The Royal College of Pathologists Bulletin*, July 2021. Available at: www.rcpath.org/profession/publications/college-bulletin/july-2021/perinatal-mortality-are-we-learning.html

[2] National Child Mortality Database. *Child death review data release 2024*. Available at: https://www.ncmd.info/publications/child-death-review-data-release-2024/

occur in tertiary paediatric and neonatal intensive care units. Categories of deaths are as follows:

- 34% are due to perinatal or neonatal events, the vast majority of which are due to complications of premature delivery
- 25% are due to inherited chromosomal, genetic or congenital anomalies
- 8% are due to malignancy
- 6% are due to acute or chronic medical conditions including asthma, diabetes and epilepsy
- 4% are due to infection
- 18% are due to external causes (homicide, suicide, trauma and sudden unexplained deaths)
- around 8% are classified as 'sudden and unexpected.'

Medical examiners provide independent scrutiny of non-coronial deaths in England and Wales, including those of children and neonates, using the same principles of scrutiny as they do for other deaths. Good working relationships and processes between medical examiners and paediatric and neonatal services, along with obstetricians, midwives and pathologists, help ensure an accurate cause of death is documented and that learning is disseminated and may reduce unnecessary coroner referrals.

The Royal College of Pathologists published guidelines regarding sudden unexpected death in infancy and childhood. This provides a framework for professionals responding to the sudden unexpected death of an infant or young child up to the age of 24 months. The guidelines note that many principles should also normally be applied to unexpected deaths in older children.

The Ministry of Justice conducted a consultation on coronial investigations of stillbirths in 2019. Medical examiners do not scrutinise stillbirths at present, but they will carry out scrutiny of deaths that may include those related to care during pregnancy and birth. It should be noted that distinguishing a stillbirth and a live birth may not be straightforward and requires a sensitive, careful approach, given the emotional impact on families and the implications for the different processes to be followed. Guidance is available for health

professionals to help them assess and document extremely preterm births[3] where, following discussion with the parents, active survival-focused care is not appropriate.

Child death reviews in England

The Department of Health and Social Care (DHSC) published guidance in October 2018 for England, setting out key features of the child death review process and statutory requirements that must be followed.[4] *Statutory and Operational Guidance 2018* reforms were introduced to provide greater consistency to the child death review processes and help the experience of bereaved families. Local authorities and integrated care boards are now required to come together as child death review partners to form child death overview panels (CDOPs).

The process aims to ensure, as far as is possible, that the review of every child's death is standardised to facilitate learning at a local and national level. The child death review process runs from the moment of a child's death to the completion of the review by a CDOP. It includes the immediate actions taken when the child dies, the investigations (coronial, joint agency response, serious incident) that may follow the deaths of children, the local review by professionals who cared for the child, through to the final statutory review at a child death overview panel. The guidance notes that, although investigations following the death of a child will vary, every child's death should be discussed at a child death review meeting. The child death overview panel, under delegated authority of child death review partners in their local area, will also review the death of every child. This review will occur after the medical examiner has completed independent scrutiny and the death has been registered.

In addition to statutory child death review processes, there are further review processes for neonatal deaths from 22+0 weeks' gestation. The PMRT supports local multi-disciplinary review of neonatal deaths and includes input from different care settings related to

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[3] MBRACE-UK. *Determination of signs of life following spontaneous birth before 24+0 weeks of gestation where, following discussion with the parents, active survival-focused care is not appropriate*. Available at: https://timms.le.ac.uk/signs-of-life

[4] HM Government. *Child death review: statutory and operational guidance*. 2018. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf

perinatal management. The PMRT programme was commissioned by the DHSC for England and on behalf of the Welsh, Scottish and Northern Ireland Governments. The tool is free for use by trusts and health boards in England, Wales, Scotland and Northern Ireland. The web-based tool is designed to support a standardised review of care of perinatal deaths in neonatal units from 22+0 weeks' gestation up until 28 days after birth. The PMRT is integrated with the national collection of perinatal mortality surveillance data. Ensuring that parents are aware that a PMRT supported review will be conducted and that any questions or concerns they have about their care are incorporated in the review process is essential. The PMRT team provide material to support trusts/health boards with the process of parent engagement. Medical examiners would not usually be involved in the neonatal mortality review process, but they may point out potential issues for PMRT consideration in their discussion with the family and clinical team. In some circumstances, the medical examiner might be interested in the outcome of the neonatal mortality review and, therefore, relationships with key clinical staff leading obstetric, midwifery and neonatal governance are very helpful.

Guidance recognises that supporting and engaging bereaved families is of paramount importance. All bereaved families should have an identified medical lead and a key worker who provides a single point of contact for the family and should form a trusted relationship with them. Every death of a child in hospital and in the community is reviewed and recorded on the National Child Mortality Database.

The MNSI programme undertakes independent safety investigations relating to term babies (>37 weeks' gestation) who are born following labour with one of the following outcomes: intrapartum stillbirth, early neonatal death or potential severe brain injury.

In addition, MNSI investigates deaths of mothers while pregnant or within 42 days of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (excluding suicide).

The MNSI programme receives referrals from all trusts in England providing maternity care. Their investigations are independent and are required to completed where practicably possible within a 6-month timeframe. Throughout investigations MNSI works closely with the families, NHS trusts and staff involved. MNSI does not place blame on individuals or investigate individual members of NHS staff.

During an investigation, the MNSI team may ask to speak to a medical examiner about their understanding of the care provided and the cause of death, based on the information available when the MCCD was completed. On completion of an investigation, the family and trust will receive a report indicating areas of learning; these are reflected within the findings, safety recommendations and prompts.

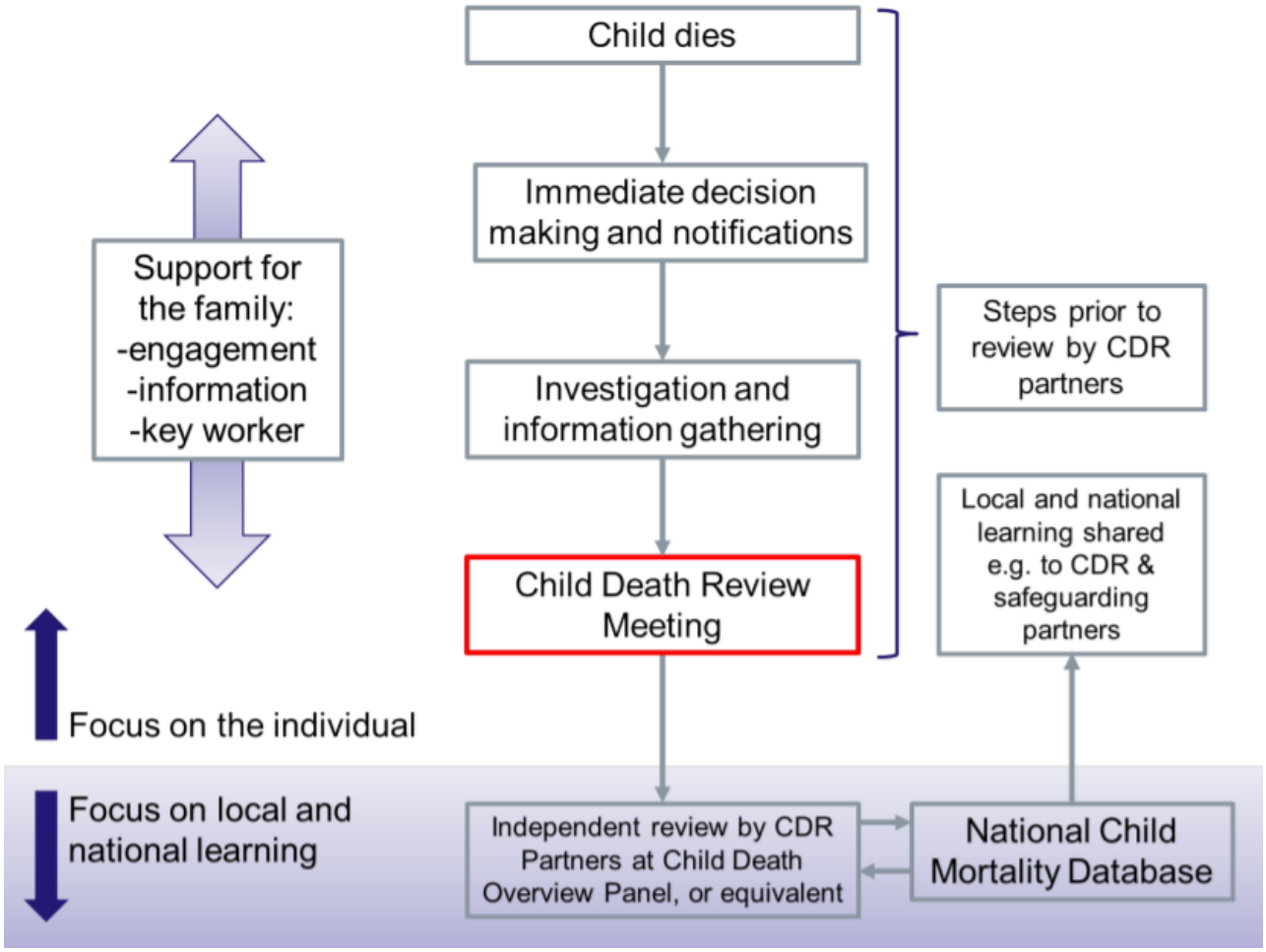
Child death reviews in England and medical examiner regulations

The Government decided the Death Certification Reforms should come into force from 9 September 2024. All deaths in England and Wales must be independently reviewed, either by a coroner, where they have a duty to investigate, or by a medical examiner. Supported by medical examiner officers, medical examiners give bereaved families an opportunity to raise concerns with someone not involved in providing care; ensure the appropriate notification of deaths to the coroner; improve the quality of death certification; and support local learning by identifying deaths and matters that should be considered through clinical governance arrangements. This includes highlighting matters for further consideration through neonatal and child death review processes.

The interactions between medical examiner scrutiny, a child death review in England, or a neonatal review are largely determined by the different objectives and timescales of the processes. Medical examiners are required by statute to carry out independent scrutiny of non-coronial deaths in the days immediately after the death. The child death review process includes immediate decision-making and notifications in its early stages; this time is likely to provide the focus for interaction between medical examiner scrutiny and the child death review process. The statutory child death review guidance notes that medical examiners should be invited to contribute to child death review meetings, which will normally take place some weeks or months after the death.

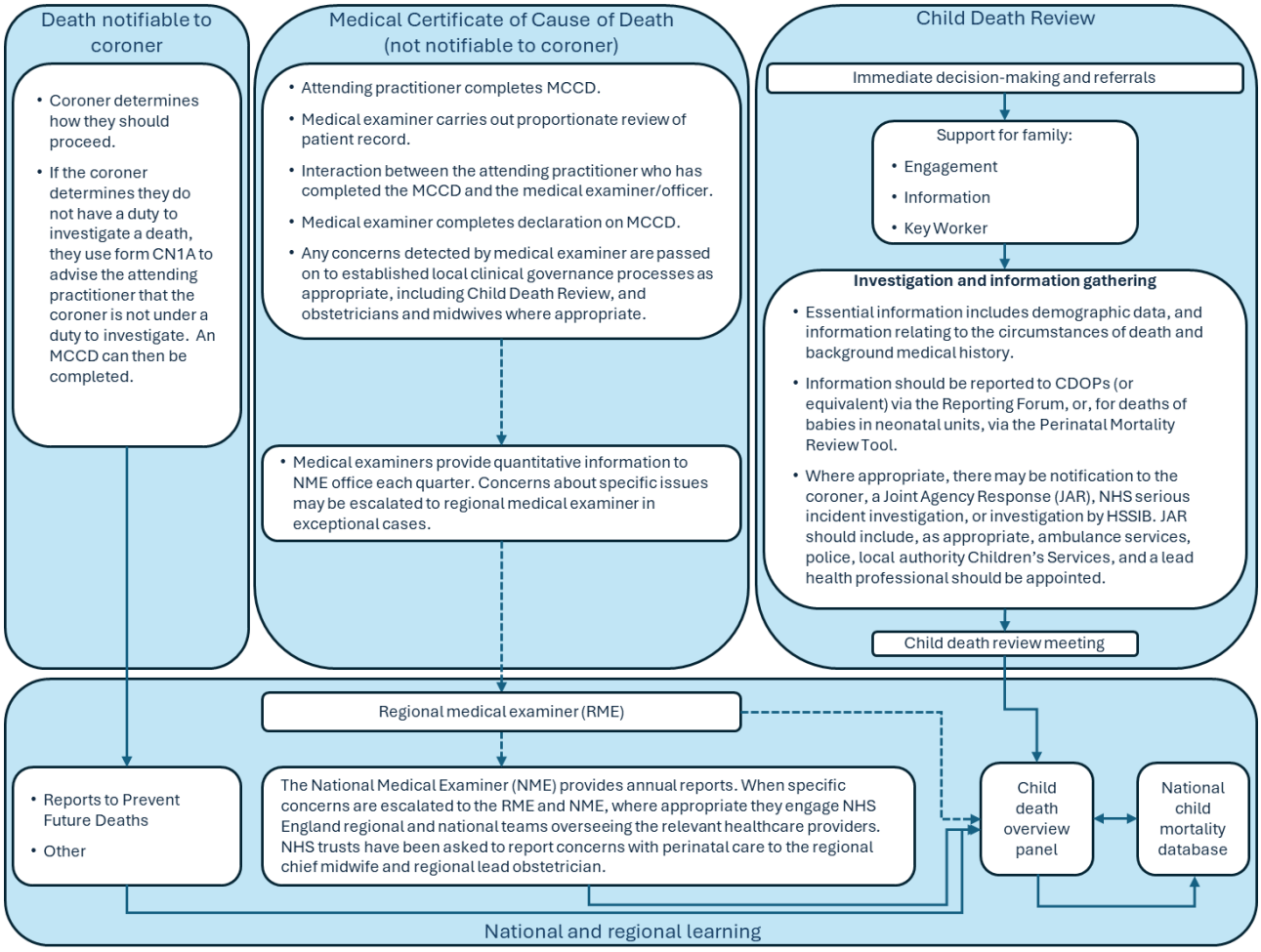
As there are several processes for review of deaths of children, medical examiners need to understand them and establish relationships with key individuals leading other processes to ensure questions or learning can be shared. A diagram setting out the child death review process in England is included in Figure 1 and the relationship with medical examiners is shown in Figure 2. In most cases, paediatric services will remain in contact with families to support them directly, with medical examiner services contributing to helping the clinical teams in writing an accurate and timely MCCD, or aiding decisions related to coroner referral.

Figure 1: Child death review process in England.[5] CDR: Child death review.



[5] HM Government. *Child death review: statutory and operational guidance*, page 16. 2018. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf

Figure 2: Medical examiners and child death reviews in England.



Medical examiner processes after the death of a child or neonate

Medical examiners and officers must give bereaved parents the opportunity to discuss with them any questions or concerns about care or the causes of death, as they do with deaths of adults. However, child death review processes recognise the need for ongoing support through the key worker, to simplify contact with other review processes or professional groups. Therefore, after the medical examiner office interaction with the bereaved family is complete and the death has been registered or the coroner notified, it is expected that the key worker will provide the ongoing point of contact for the family. This does not prevent families contacting medical examiner offices after the registration of death, for example, if new questions arise, but medical examiner offices are not resourced to provide the level of ongoing support that families may require.

At the death of a child, the attending doctor and medical examiner should first decide whether they are able to issue an MCCD. As with all deaths, this will apply if the cause of death is understood, is from natural causes and an attending practitioner involved in the care of the child is available. For neonatal deaths, all babies who have shown signs of life at any gestation will need their birth and death registering and so efforts should be made for a doctor to examine all such babies soon after birth to enable the MCCD to be signed by a doctor who has seen the baby in life. There are 2 versions of the MCCD for child deaths: a neonatal certificate for deaths up to 28 days after birth and the standard certificate. The MCCD for neonatal deaths (<28 days) reflects the different aetiologies of death in this period and includes sections to document 'maternal diseases or conditions affecting infant'.

It should be recognised that the deaths of children with long-term illnesses or life-limiting conditions, even when their death is anticipated, need to be individually scrutinised. It may still be necessary to refer the death to the coroner if there are concerns, or the death meets other statutory criteria. Just as in adult patients, hypoxic brain injury or hypoxic ischaemic encephalopathy would need to be justified by a natural cause, or coroner referral would be necessary.

Medical examiners should gain understanding of paediatric, neonatal and obstetric matters through experience and interaction with local colleagues as they would for other specialty deaths. However, the elements of scrutiny are generic and remain the same (discussion with bereaved people, review of records and interaction with the doctors completing the MCCD) for child deaths, as do the principles around timeliness of care and escalation of concerns.

The National Medical Examiner's guidance notes that medical examiners must remain vigilant for extremely rare but serious incidents where there may be reason to suspect the death results from, or is contributed to by, an unnatural event, including professional misconduct or criminal activity or intent. This is particularly relevant where more than 1 death is perceived potentially to follow a pattern. Referral to a coroner and/or the police will be appropriate in some instances. Where there is reason to suspect criminal activity or intent, the police and relevant regulatory authorities must be informed and the death referred to the coroner with clear information and articulation of concerns. Medical examiners should follow GMC guidance and other appropriate information. If in doubt,

advice should be sought from the lead medical examiner, lead medical examiner for Wales or regional medical examiner in England.

If the death is notified to the coroner and taken for investigation, medical examiners do not provide independent scrutiny. Where the death is not referred to the coroner, medical examiners will be a valuable source of information for the child death review meeting. The relationship between medical examiner scrutiny and the child death review process is shown in Figure 2.

Developments in England

NHS England is implementing a new perinatal quality surveillance model. Trusts have been asked to report concerns with perinatal care to the regional chief midwife and regional lead obstetrician, who will be members of a regional-level quality oversight committee. As noted in recommendations, medical examiners should use this escalation route where appropriate.

Ongoing work relating to digitising the MCCD and a case management system for medical examiners may present further opportunities to streamline arrangements between medical examiners and the child death review process. For example, it may be possible to align child death review databases and new systems relating to death certification to improve efficiency and reduce the risk of duplication, although it is too early at present to identify details clearly. In England, the National Child Mortality Database should be notified of deaths within 48 hours; it will be important to avoid duplication at the point of notification. Medical examiners would normally expect to be notified of deaths within 24 hours, to allow them to complete scrutiny and enable the MCCD to be issued in a timely manner, and sooner if urgent release of the body is requested.[6] Weekend/bank holiday cover arrangements at medical examiner offices should facilitate notification of the National Child Mortality Database within 48 hours.

[6] Royal College of Pathologists. *National Medical Examiner's Good Practice Series No.2 – How medical examiners can facilitate urgent release of a body*. 2021. Available at: https://www.rcpath.org/resourceLibrary/good-practice-series-urgent-release-of-a-body.html

Child death reviews in Wales

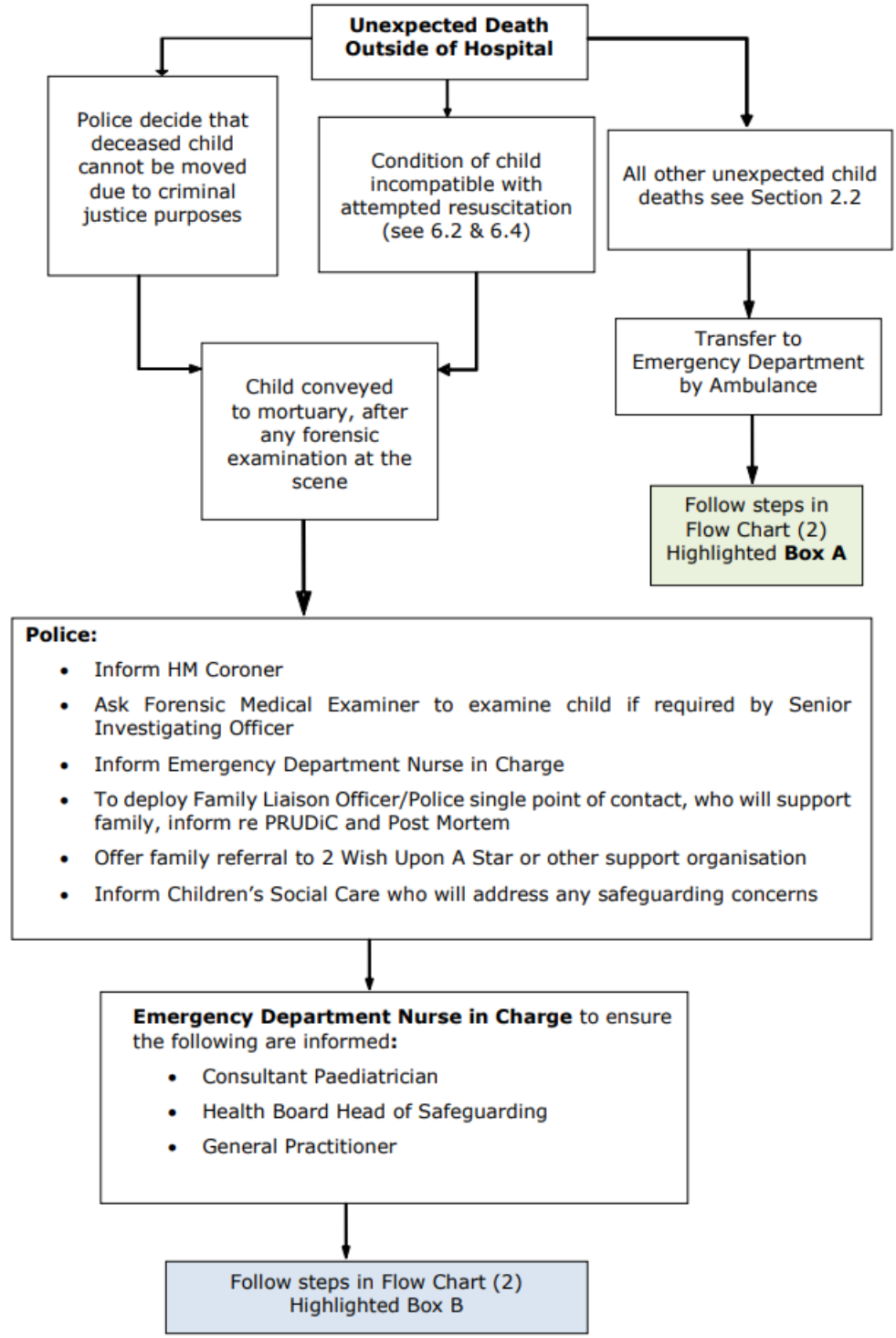
In Wales, the Child Death Review Programme (Public Health Wales) reviews all deaths of under 18 year olds, seeking to identify patterns, trends and modifiable factors to reduce preventable deaths of children in Wales.

The PRUDiC sets a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the process of communication, collaborative action and information sharing following the unexpected death of a child. This procedural response will be followed when a decision has been made by the police that the death of a child is unexpected and the PRUDiC is to be initiated.

PRUDiC is a multi-agency procedural response intended to ensure a minimum standard across Wales and is not agency- or discipline-specific. It outlines what needs to be achieved and gives broad suggestions about the roles of agencies. Any variance should be recorded along with the rationale for digressing from the process. The guidance does not prohibit any existing good practice by agencies or professionals to enhance this procedural response.

PRUDiC sets out a structure within which reasoned judgements can be made when evaluating an unexpected child death on the basis of all available information (Figure 3). It is important, therefore, that all staff remain open-minded when considering any death and avoid reaching conclusions inappropriately outside the agreed processes.

Figure 3: Procedural Response to Unexpected Deaths in Childhood in Wales.[7]



[7] Public Health Wales. *Procedural Response to Unexpected Deaths in Childhood (PRUDiC) 2018*. Available at: www.wales.nhs.uk/sitesplus/documents/888/PRUDiC%202018%20Final.pdf

Find out more

- Bereavement support standards for children's hospitals
- Child Bereavement UK
- Child Death Review Programme (Wales)
- Child Death Review: Statutory and operational guidance (England)
- Consultation on coronial investigations of stillbirths
- Early notification scheme – NHS Resolution
- Implementing a revised perinatal quality surveillance model (England)
- Independent investigation into East Kent maternity services
- Maternity investigations – MNSI
- MBRRACE-UK signs of life guidance
- NHS England Safeguarding accountability and assurance framework
- National Child Mortality Database (England)
- National Medical Examiner's guidance for England & Wales
- Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust
- 'Perinatal mortality − are we learning?' – Royal College of Pathologists' *Bulletin*
- Perinatal Mortality Review Tool (PMRT) – Oxford Population Health, NPEU
- PMRT parent engagement materials
- Procedural Response to Unexpected Deaths in Childhood (PRUDiC) (Wales)
- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
- Report of the Morecambe Bay Investigation
- Sudden unexpected death in infancy and childhood – Royal College of Pathologists.

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Appendix 1 Deaths of children – frequently asked questions

Do medical examiners provide scrutiny of the deaths of children and neonates?

- Medical examiners scrutinise non-coronial deaths of neonates and children in the same way as they do for adults, so that families bereaved after the death of a child have equal access to a discussion with an independent person. Medical examiners complete scrutiny shortly after death. They provide independent scrutiny as they will not have been involved in care of the child prior to death. This is particularly important given the findings of a number of independent healthcare investigations. Medical examiners are likely to provide valuable support to child/neonatal death reviews, which will usually take place later.

What information should the doctor completing the MCCD give to the medical examiner?

- The medical examiner needs access to the patient record.
- In England, chapter 2 of the Child Death Review Statutory and Operational Guidance sets out the immediate decisions that should be taken following a child's death and what notifications should take place. It gives guidance as to which deaths require a joint agency response, when a referral to the coroner is mandated and required notifications. Where the doctor completing the MCCD believes the certificate can be issued, they should provide this to the medical examiner and, in England, provide details of the family's key worker to the medical examiner. Where the consultant paediatrician is uncertain whether a MCCD can be issued, they should discuss the circumstances with the medical examiner or medical examiner officer.

What should the medical examiner do if they have concerns about emerging patterns and trends relating to the deaths of children?

- See recommendation 9. Medical examiners should escalate concerns in line with the National Medical Examiner's Good Practice Guidance.

What happens if the child dies in the community?

- When medical examiners provide independent scrutiny of the death of a child in a non-acute setting, the interactions between medical examiners and the child death review processes will be the same as or very similar to those for deaths in hospital. Children whose deaths trigger a joint agency response in England, or a PRUDiC in Wales, are likely to be notified to the coroner (if the coroner takes the death for investigation, the medical examiner will not provide independent scrutiny).