Child Death Review Processes

OSCB (Oxfordshire Safeguarding Children Board) is charged under the Children Act 2004 to establish a Child Death Overview Process.

The recent publications of Working Together to Safeguard Children, 2018 (chapter 5) and the Child Death Review Guidelines 2018, introduced changes to the death review guidelines.

This is a simple guide to the initial process in the event of a child death and the role of the Child Death Overview Panel. Each agency has its own policies and procedures to follow in the event of a child death. Please refer to these within your own agency.

1. Child Death Review Process

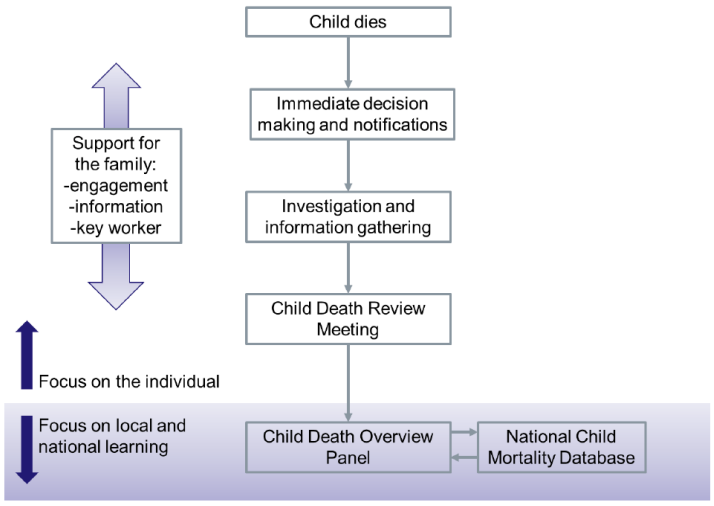


Figure 3

From April 2008, Local Safeguarding Boards have had a mandatory function to manage a Child Death Review Process. Deaths of all children, up to the age of 18 years (excluding babies who are stillborn and planned terminations carried out within the law) whose home address is in Oxfordshire, need to be reviewed taking into account all available information for each death. The principles underlying the review of all child deaths are:

- Every child's death is a tragedy for the family and for the wider community
- By reviewing child deaths we can learn lessons to prevent future child deaths
- Joint agency working draws on the skills and particular responses of each professional group
- Child Death Reviews should lead to positive action to safeguard and promote the welfare of children

The overarching goal of this process is to reduce the number of child deaths. The review aims to ensure that there is a full understanding of the events leading to the child's death. Any recommendations arising from a review should lead to improved services for children and their families, both at local and national level.

The Child Death Overview Panel (CDOP) is also required to receive notifications about the deaths of children not normally resident in the Oxfordshire area, but who die in Oxfordshire. Notifications are received via the eCDOP system and the CDOP coordination team at the OCCG will ensure that the LSCB CDOP Panel in the area linked with the child's home address is notified. That LSCB CDOP Coordinator will then be responsible for coordinating the information gathering and complete the review process.

2. Notifications

All deaths of children in Oxfordshire, or whose home address is Oxfordshire, must be reported to the CDOP coordination team by following the public notification link https://www.ecdop.co.uk/OxonBucks/Live/Login and completing a Notification Form (A).

The form should be completed as soon as possible after the child's death and must include information about their child, family and key professionals who knew the child, e.g. GP.

This notification alerts the CDOP coordination team at OCCG of the death. They will advise the Designated Doctor for Child Deaths, who will review the circumstances of the death and advise on the appropriate support and review pathway for each child death situation.

Advice and further information/guidance on initial notification, if required, can be made via occg.cdopoxfordshire@nhs.net

All partner agency leads for Child Deaths will then be routinely notified through eCDOP. They will each undertake single agency checks and:

- Review their agency involvement and record this on the eCDOP system, agreeing who will attend any Joint Agency Response (JAR) meeting on their agency's behalf where appropriate
- Agree who will complete the Reporting Form B and by what date (within the three week statutory requirement) and arrange completion through eCDOP system
- Consider if this incident needs to be escalated within their agency
- Oxfordshire Children's Social Care (CSC) will receive a notification via the eCDOP system. CSC will undertake a check of all partner agencies involved with the family and will submit a case note to eCDOP advising of the agencies involved and providing contact details for the allocated professionals
- CSC will also share information with Senior Managers within CSC using the internal Need To Know policy. The Safeguarding Manager for CSC will consider if this constitutes a 'notifiable incident' to Ofsted

Initial bereavement support is facilitated by professionals involved with the family at the time of the death. Within 48 hours a key worker should be identified for each family. This support needs to be reported to the CDOP Coordinator via the eCDOP system. Guidance for providing bereavement support can be found in **Section 4, useful links**.

Unexpected/ unexplained / sudden deaths

All unexplained deaths of children under 18 years old in Oxfordshire should be reported to the police by contacting the Police Enquiry Centre (PEC) on 101.

An unexplained death is defined (in Chapter 5, of Working Together to Safeguard Children 2018) as the death of an infant or child (less than 18 years old) which:

- is or could be due to external causes
- is sudden and there is no immediately apparent cause (including Sudden or Unexpected Death in Infancy/Childhood)
- occurs in custody, or where the child was detained under the Mental Health Act
- occurs where the initial circumstances raise any suspicions that the death may not have been natural
- occurs in the case of a stillbirth, where no healthcare professional was in attendance

If there is an unexplained death of a child at home or in the community, the child should normally be taken to an Emergency Department, rather than a mortuary. In some cases when a child dies at home or in the community, the police may decide that it is not appropriate to move the child's body immediately, for example, because forensic examinations are needed.

In a criminal investigation, the police are responsible for collecting and collating all relevant information pertaining to the child's death. Practitioners should consult the lead police investigator (senior investigating officer) to ensure that their enquiries do not prejudice any criminal proceedings.

Before the child's family leave the Emergency Department there must be an Initial information sharing and planning meeting/discussion between the Paediatrician and Police as a minimum with a consideration of need for s47 strategy meeting. Pending confirmation of that plan, safeguarding procedures will be followed by CSC on a case by case basis, to ensure welfare of siblings and linked individuals.

If the results of any investigations suggest evidence of abuse or neglect as a possible cause of death, the Paediatrician should immediately inform relevant safeguarding partners and liaise directly with the local authority about a potential referral to the Child Safeguarding Practice Review Panel.

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

- Safeguarding Investigations
- Criminal Investigations
- Coronial investigation
- Joint Agency Response Meeting (within 72 hours)
- Serious Incident Investigation
- Post-mortem examinations may be required in a number of cases, either as part of the Coronial investigation, or for medical reasons

The Key Worker will provide overarching co-ordination, alongside any investigation, to facilitate the family voice and to keep them informed at all stages.

Police investigation

The police will begin an investigation into the unexplained death of a child on behalf of the Coroner. The Coroners (Investigations) Regulations (2013) place a duty on Coroners to inform the LSCB for the area in which the child died or the child's body was found, where the Coroner decides to conduct an investigation or directs that a post mortem should take place. The Coroner must provide to the LSCB all information held by the Coroner relating to the child's death. Where the Coroner makes a report to prevent other deaths, a copy must be sent to the LSCB.

- The involvement of the police is routine and does not assume suspicion
- Where the death is unexplained, the police will be the lead agency. It will be the responsibility of all relevant partner agencies to support the police investigation. It is therefore, vital that staff maintain accurate records of their involvement with the family, so that all relevant information can be obtained effectively and in a timely manner
- The family may well be in need of support services and any other children within the family may be in need of protection. Inter-agency collaboration is therefore essential. Staff need to be aware that on occasions, the early arrest of the parent/s-carer/s may be essential in order to secure and preserve evidence as part of an investigation
- Staff should always identify and enquire about the siblings and ensure they are being cared for appropriately, taking account of possible risks to other children in the household

The following documents may assist the police in carrying out their investigations:

- ACPO Guide to Investigating Child Deaths 2014
- Working Together to Safeguard Children 2018

- NPIA Guidance on Investigating Child Abuse & Safeguarding Children second edition 2009
- Sudden Unexpected Death in Infancy & Childhood: Multi-agency Guidelines for Care and Investigation 2016

Joint Agency Response Meeting

A Joint Agency Response Meeting (JAR) will be arranged within 72 hours, to confirm the joint agency support plan and any additional investigation processes (Coroner, Police etc.). Attendees for the JAR will be determined by Designated Doctor for Child Deaths and be proportionate to the agency response required.

Key Worker/ support for the family

Supporting and engaging the family who have lost a child is of prime importance throughout the whole Child Death Overview Process. Recognising the complexity of the process, and the state of total shock that bereavement can bring, families should be given a single, named point of contact (**Key Worker**) who they can turn to for information on the processes following their child's death, and who can signpost them to sources of support. In addition, they should be provided with a leaflet for parents, families and carers to help understand and navigate the Child Death Overview Process.

Immediate support should be provided by the clinical team looking after the child and family. In all cases, there should then be an early case discussion to identify the Key worker **(See Appendix A)**.

Child Death Review Meeting

Although investigations following the death of a child will vary, **every** child's death should be discussed at a Child Death Review Meeting. This is the final **multi-professional meeting** involving the individuals *who were directly involved* in the case. The nature of this meeting will vary according to the circumstances of the child's death and the practitioner involved, but has common aims and principles in all cases. **It is the responsibility of the organisation responsible for the declaration of death to arrange the CDRM.** The exception to this is when a Joint Agency Response has occurred, in which case responsibility defaults to the lead health professional. Each child's death requires unique consideration and where possible, should engage professionals across the pathway of care.

The results of the meeting should be captured on a draft 'child death analysis form' (formally Form C) and uploaded to the eCDOP system.

3. Child Death Overview Panel (CDOP)

The CDOP panel is a sub group of the OSCB that has an overview of all deaths of children under 18 years occurring in Oxfordshire and is responsible for reviewing all children whose home address is Oxfordshire.

The Panel will provide independent scrutiny of each child's death from a multi-agency perspective and includes lay members and senior professionals *who have had no involvement* in the cases under discussion, who have been delegated to the panel.

For specialist advice, additional professionals may be co-opted to join the Panel.

The CDOP meets quarterly to:

- Classify cause of death
- Identify modifiable factors* (All classification and modifiable factors are determined by the DoH)
- Decide on preventability of death
- Consider whether to make recommendations and to whom they should be addressed
- On concluding each review, the Panel makes recommendations which can include matters affecting the safety and welfare of children in Oxfordshire and wider public health concerns. These are referred back to the OSCB and national offices, as appropriate, for further action. This learning is also incorporated in the OSCB Annual Report.

*These are defined as factors which may have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future deaths

Joint/ whole panel themed meeting.

Oxfordshire and Buckinghamshire CDOP, in collaboration with Berkshire CDOPconvene themed panels three times a year. These meetings will involve senior professionals *who have had no involvement* in the cases under discussion and who can identify thematic system changes, in order to learn lessons for the prevention of future child deaths.

4. How can I find out more about Child Death Review Processes?

The following links provide further information and guidance on the processes:

- **Working Together to Safeguard Children, 2018 (Chapter 5)**
- **Child Death Review Guidelines 2018**
- **Sudden Unexpected Death In Infancy and Childhood Multi-agency guidelines for care and investigation**
- **When a child dies A guide for parents and carers**

Appendices

Appendix A – Information on the Key Worker's Role in the CDOP Process
Appendix B – Form B Flowchart
Appendix C – Form B Manager's Flowchart
Appendix D – Child Death Review Meeting Guidelines
Appendix E – Coroners Investigations: A Short Guide

Appendix A: Information on the Key Worker's Role in the CDOP Process
(Appendix 5 of Child Death Review Guidelines 2018)

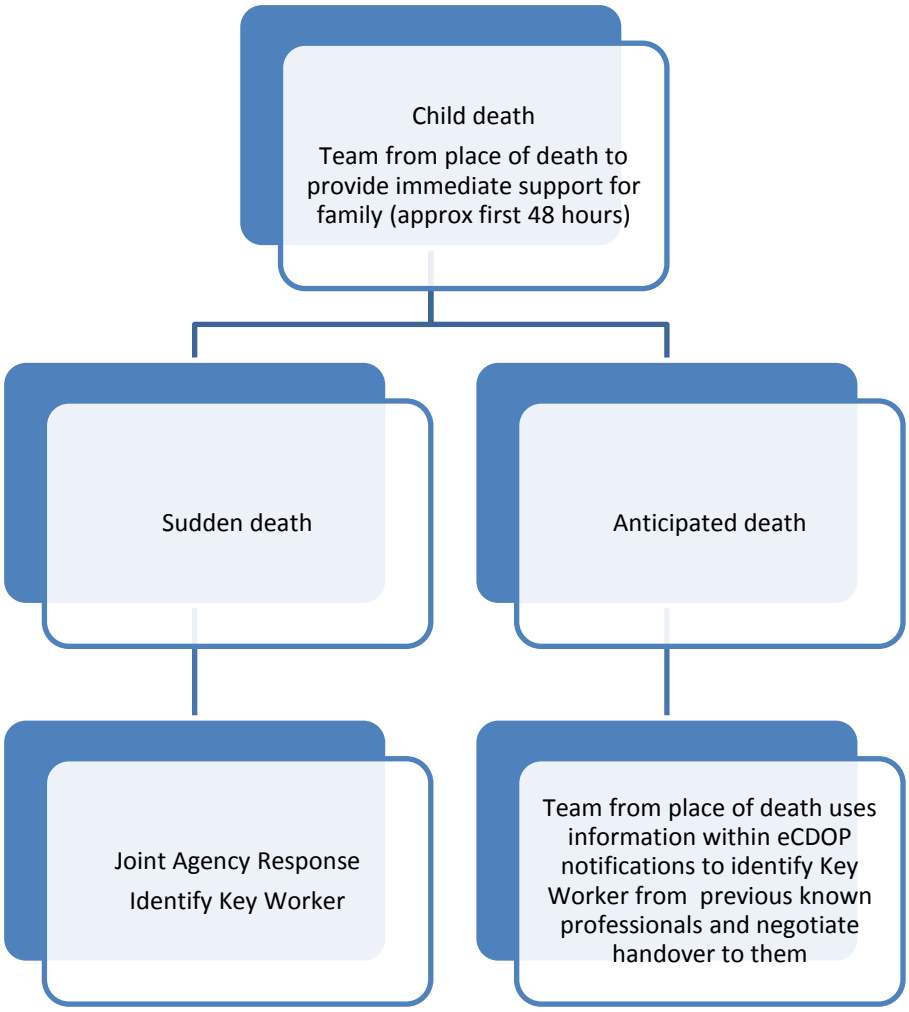
All bereaved families should be given a single, named point of contact, who can provide information on the Child Death Overview Process, and who can signpost them to sources of support. This role is referred to as the "Key Worker".

This role could be taken by a range of practitioners, for example a nurse or a member of a bereavement support team. The qualities and competencies of the individual are more important than their professional background. Given shift patterns and annual leave, organisations should ensure that the Key Worker is supported by a team who can step in to cover absences. Families should expect to be able to contact the Key Worker or a team member during normal working hours.

It is anticipated that in most cases there is a professional known to the family, who is well placed to support the family and already has this as part of their role. The most significant additional work will be representing the family voice to the rest of the MDT, and ensuring that, in line with the NHS Long Term Plan, Primary Care are informed at all times.

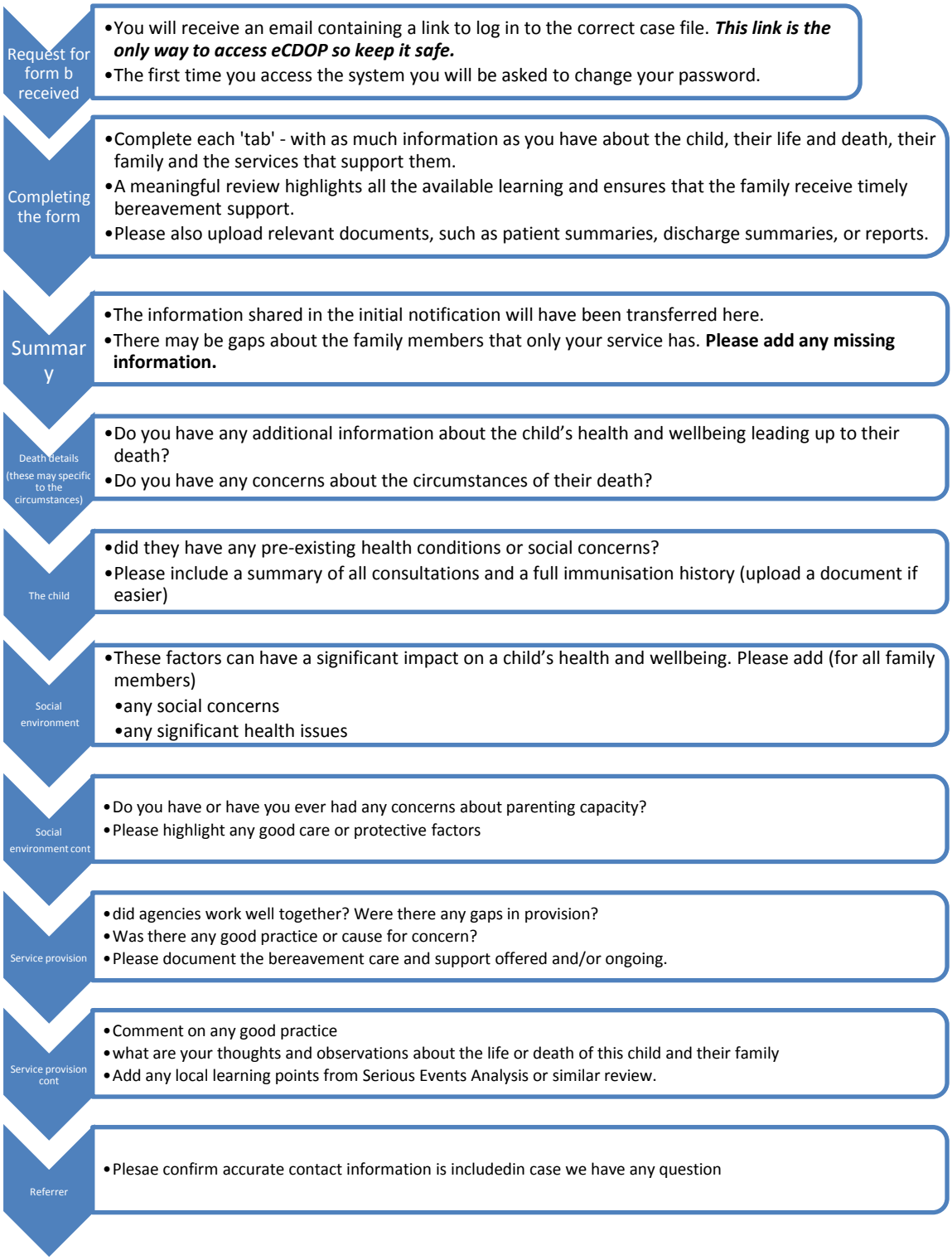
Examples of how to identify a key worker

Situation	Who	Rationale
Unexpected: suspicious	Coroner's Officer or Family Liaison Officer, Social Worker	Coronial and/or criminal investigations take precedence. Consider a second professional who is known to the family
Unexpected: not suspicious	GP, Health Visitor, Head Teacher, Faith Minister	Professional already known to the family
Expected: neonate	GP, Midwife, Health Visitor, Neonatal Bereavement Officer	Professional already known to the family
Expected: child with a life limiting illness	Palliative Care professional, Community Children's Nurse, Special School Nurse	Professional already known to the family
Expected: previous health issues, defined period of illness leading to death	Community Children's Nurse, Special School Nurse, GP, Social Worker	Professional already known to the family

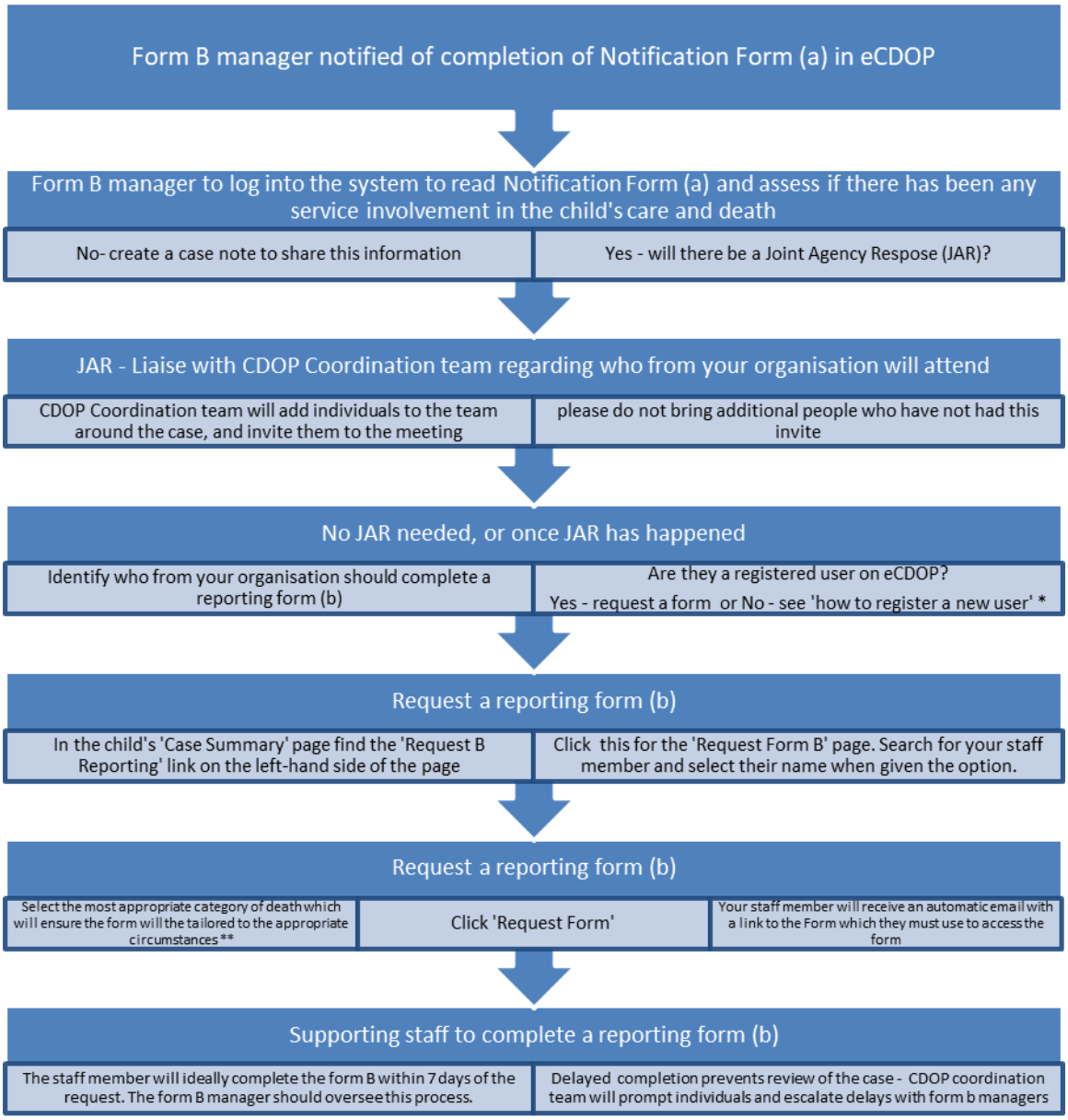

Child death
Team from place of death to provide immediate support for family (approx first 48 hours)
Sudden death
Anticipated death
Joint Agency Response
Identify Key Worker
Team from place of death uses information within eCDOP notifications to identify Key Worker from previous known professionals and negotiate handover to them

Appendix B: How to complete a form B (eCDOP information gathering following a child death)

It is a statutory requirement that all child deaths are reviewed (Working Together to Safeguard Children 2018). In Oxfordshire this process is managed by the Oxfordshire Clinical Commissioning Group Safeguarding team using a system called eCDOP.
The form has several sections split by a tab bar at the side of the screen for different types of information:

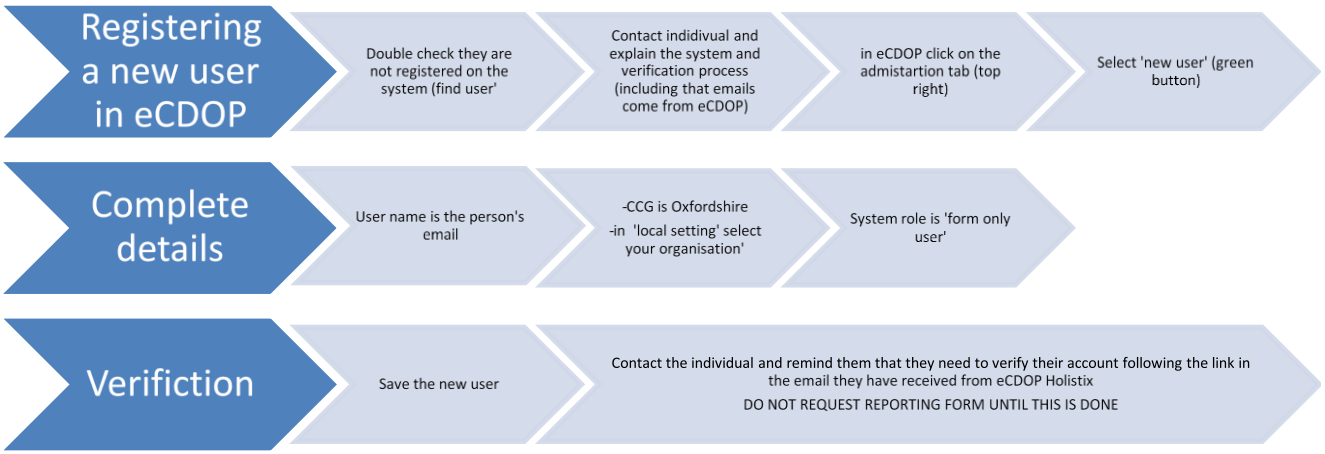


Appendix C – Process Map for Form B Managers



Additional questions**
Please speak to CDOP Coordination team for clarification if the choice isn't obvious
Violent of maltreatment related death
Suicide or Self harm including alcohol or substance misuse
Trauma or other external event
Death of a child with a life limiting condition
Acute asthma or anaphylaxis
Cardiac: congenital or acquired
Other chromosomal, genetic or congenital anomaly (not including cardiac)
Infection (after first week of life)
SUDI/SUDIC
Acute metabolic/ diabetic ketoacidosis
Perinatal or neonatal event
Oncology condition
No

Registering a new user*



Appendix D – Child Death Review Meeting Guidelines

The CDRM is a multi-professional meeting where all matters relating to an individual child's death are discussed by the professionals **directly involved** in the care of that child during life and their investigation after death. The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved. For example, it could take the form of a final case discussion following a Joint Agency Response; a perinatal mortality review group meeting in the case of a baby who dies in a neonatal unit; a hospital-based mortality meeting following the death of a child in a paediatric intensive care unit; or similar case discussion. The review meeting should be flexible and proportionate, and focused on local learning. It is important that all deaths are reviewed. However, in certain circumstances it may be appropriate for the review to be quite brief or for the meeting to discuss one child or several children. In every case, the Analysis Form should be drafted at the CDRM and then sent to the relevant CDOP.

For deaths of babies in a midwifery unit, on delivery suite, and in a neonatal intensive care unit, the child death review meeting will often be known as a perinatal mortality review group meeting.

In all cases, the aims of the CDRM are:

- to review the background history, treatment, and outcomes of investigations, to determine, as far as is possible, the likely cause of death;
- to ascertain contributory and modifiable factors across domains specific to the child, the social and physical environment, and service delivery;
- to describe any learning arising from the death and, where appropriate, to identify any actions that should be taken by any of the organisations involved to improve the safety or welfare of children or the child death review process;
- to review the support provided to the family and to ensure that the family are provided with:
    - the outcomes of any investigation into their child's death;
    - a plain English explanation of why their child died (accepting that sometimes this is not possible even after investigations have been undertaken) and any learning from the review meeting;
- to ensure that CDOP and, where appropriate, the coroner is informed of the outcomes of any investigation into the child's death; and
- to review the support provided to staff involved in the care of the child.

Notes of the meeting should be taken to help with completion of the draft analysis form sent to CDOP.

It is the responsibility of the organisation responsible for the declaration of death to arrange the CDRM. The exception to this is when a Joint Agency Response has occurred, in which case responsibility defaults to the lead health professional. Each child's death requires unique consideration and where possible, should engage professionals across the pathway of care.

The CDRM should be chaired by a lead professional for the child death review process within the organisation where death was declared, or the lead health professional in a Joint Agency Response. In general, children who die in hospital should be discussed within the department where the child

died and considered an integral part of wider clinical governance processes. Children who die in the community might be discussed at the local GP surgery, and children who die in a hospice discussed in that centre. However, the location of the meeting might also be informed by practical considerations relating to where the majority of the child's treatment took place.

The 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. In order to best capture the views of those directly involved, it may be beneficial to start the process as soon as possible, prior to the formal CDRM. The CDRM should occur before any coroner's inquest, and before the CDOP meets. The CDRM is a meeting for professionals. In order to allow full candour among those attending, and so that any difficult issues relating to the care of the child can be discussed without fear of misunderstanding, parents should not attend this meeting. However, parents should be informed of the meeting by their key worker and have an opportunity to contribute information and questions through their key worker or another professional. At the meeting's conclusion, there should be a clear description of what follow up meetings have already occurred with the parents, and who is responsible for reporting the meeting's conclusions to the family. This would generally be the child's paediatrician, or in the case of a neonatal death, obstetrician and neonatologist. In a coroner's investigation, such liaison should take place in conjunction with the coroner's office, bearing in mind that the conclusion on the cause of death in such cases is the responsibility of the coroner at inquest.

Template for CDRM Minutes

Date of meeting
Introductions & Apologies
Background information
Agency Reports
Risks to other children / Need for formal risk assessment
Support for Family
Staffing Debrief
Any Other Business
Actions

CDRM Flow chart

Death of a child

- Notification by all practitioners/ professionals
- JAR if sudden death, or where no ACP and end of life planning is in place
- Appointing of key worker - professionals discussion or at JAR

First 4 weeks

- Provider organisation from place of death or Lead Clinician (if a JAR was held) decide format of meeting - Mortality &Morbidity, Neonatal Mortality &Morbidity, individual CDRM
- Type of meeting confirmed in case note on eCDOP, including Coordinator
- Identify date for meeting (within 3/12 of death)

CDRM

- Agreed Coordinator from provider books a room
- eCDOP Form B Manager for organsiation leading, sets up meeting and sends out invites via eCDOP
- Key worker liaises with family, including asking whether they have any outstanding questions or concerns
- Minutes from meeting uploaded to eCDOP by agreed Coordinator or Form B Manager
- Key worker feeds back to family
- Learning to be shared through agencies

Appendix E – Coroners Investigations: A Short Guide

Ministry of Justice

Coroner investigations

A short guide

This leaflet aims to help you if someone close to you has died and their death has been reported to the coroner. It doesn't go into detail, but explains where you can get more information.

This leaflet is a brief summary and does not cover every circumstance.

The Guide to Coroner Services is a more detailed booklet and has more information on everything in this leaflet. It is available from:

- www.gov.uk
- your local coroner's office, or
- the Ministry of Justice by emailing coroners@justice.gsi.gov.uk or calling 020 3334 3555 and asking for the coroner team.

What does a coroner do?

A coroner is an independent judicial office holder, appointed by a local council. Coroners usually have a legal background but will also be familiar with medical terminology.

Coroners investigate deaths that have been reported to them if it appears that:

- the death was violent or unnatural
- the cause of death is unknown, or
- the person died in prison, police custody, or another type of state detention.

In these cases coroners must investigate to find out, for the benefit of bereaved people and for official records, who has died and how, when, and where they died.

More information on what to expect is at:
www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner

Post-mortem examination

If a coroner decides that an investigation is necessary, a pathologist will normally carry out a post-mortem examination of the body.

The coroner must release the body as soon as possible, after which you can arrange the funeral.

You should let the coroner know in writing if you wish to take the body abroad (including to Scotland and Northern Ireland).

If the post-mortem examination shows the cause of death, the coroner will send a form to the Registrar of Births and Deaths stating the cause of death. You can then make an appointment to register the death.

Inquest

If it was not possible to find out the cause of death from the post-mortem examination, or the death is found to be unnatural, the coroner has to hold an inquest. An inquest is a public court hearing held by the coroner in order to establish who died and how, when and where the death occurred.

The inquest will be held as soon as possible and normally within 6 months of the death if at all possible. The coroner will let you know if more time is needed and what to expect in your case.

If the death occurred in prison or custody, or if it resulted from an accident at work, there will usually be a jury at the inquest.

At the end of the inquest

The coroner (or jury where there is one) comes to a conclusion at the end of an inquest. This includes the legal 'determination', which states who died, and where, when and how they died. The coroner or jury also makes 'findings' to allow the cause of death to be registered. When recording the cause the coroner or jury may use one of the following terms:

- accident or misadventure
- alcohol/drug related
- industrial disease
- lawful killing
- unlawful killing
- natural causes

- open
- road traffic collision
- stillbirth
- suicide

The coroner or jury may also make a brief 'narrative' conclusion setting out the facts surrounding the death in more detail and explaining the reasons for the decision.

Legal advice

Instructing a solicitor to represent you at an inquest is not necessary in most cases, although you may do so if you wish. An inquest is a fact-finding process and the coroner will ensure that the process is fair and thorough, and that your questions about the facts of the death are answered.

Challenging a coroner's conclusion or making a complaint about the service

You may challenge a coroner's decision or an inquest conclusion. You should do this as soon as possible as for some challenges there is a three month limit. If you are thinking about doing this you should first seek advice from a lawyer with expertise in this area.

If you are unhappy with a coroner's personal conduct you should complain to the Judicial Conduct Investigations Office.

If you wish to complain about the standard of service you have received you should first do so to the coroner.

The Law Society website may help you find a solicitor at http://www.lawsociety.org.uk/

The Judicial Conduct Investigations Office can be contacted by calling 020 7073 4719 or online at: https://ojc.judiciary.gov.uk/OJC/complaintlink.do

Getting copies of documents

You may request copies of reports of any post mortem examination, and of documents that are relevant to the investigation. The coroner's office will not charge a fee for copies of documents provided before or during the inquest, but may charge after the inquest.

You may also request a recording of the inquest hearing, for which there will be a charge.

Getting more information and bereavement support

The Guide to Coroner Services outlines what to expect regarding particular types of deaths – for instance the death of a child, a death abroad, a service personnel death or where there may be a criminal investigation into the death.

There are many local and national bodies, support groups and faith groups which help people who have been bereaved. The coroner's office will be able to provide further information.

The NHS Choices website has details of support organisations:
www.nhs.uk/livewell/bereavement/Pages/bereavement.aspx

The Department for Work and Pensions publishes:

- general information on what to do after a death: www.gov.uk/after-a-death
- specific information on Bereavement Payment and Allowance:
  www.gov.uk/bereavement-allowance

Another source of information is the pre-recorded Metropolitan Police Bereavement Information Line on 0800 032 9996 and its website:
http://content.met.police.uk/Site/bereavementfamilyliaison