Child Death Reviews

The following information is based on the statutory guidance in Chapter 5, Working Together to Safeguard Children 2018 (HM Government, 2018) and Child Death Review Statutory and Operational Guidance (England) 2018 (HM Government, 2018)

1. Principles

The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths.
To improve the experience of bereaved families, as well as professionals, after the death of a child.
To ensure that information from the child death review process is systematically captured to enable local learning and, through the National Child Mortality Database, to identify learning at the national level, and inform changes in policy and practice.

2. Statutory requirements

The *Children and Social Work Act 2017*, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (July 2018)* and Child *Death Review Statutory and Operational Guidance (England) (October 2018*) provide the statutory guidance for reviewing child deaths in England.

The responsibility for ensuring child death reviews are carried out is held by 'child death review partners'(CDR) who in relation to a local authority area are defined as the local authority for that area and any clinical commissioning group in that area.
Child death review partners must make arrangements to review all deaths of children normally resident in the local area; and if they consider it appropriate the deaths in that area of non-resident children. This stage of the review is known as Child Death Overview Panel (CDOP).
In accordance with Child Death Review Statutory and Operational Guidance (England) 2018 and Working Together 2018 CDR partners across a South Yorkshire footprint (Barnsley, Doncaster, Rotherham and Sheffield) have agreed to align such that we cover a local child population whereby we will review greater than 60 deaths per year.

The responsibility for determining cause of death rests with the coroner or the doctor who signs the medical certificate.

This guidance is for use across a local level in Sheffield.

3. Definition

The Child Death Review process covers children; a child is defined as a person under 18 years of age. A child death review must be carried out for all children regardless of the cause of death.

This includes the death of any live-born baby where a death certificate has been issued. In the event that the birth is not attended by a healthcare professional, a Joint Agency Response should commence to carry out initial enquiries to determine whether or not the baby was born alive. If these enquiries determine that the baby was born alive the death must be reviewed.

For the avoidance of doubt, it does not include stillbirths, late foetal loss, or terminations of pregnancy (of any gestation) carried out within the law.

- Stillbirth: baby born without signs of life after 24 weeks gestation

- Late foetal loss: where a pregnancy ends before 24 weeks gestation

Cases where there is a live birth after a planned termination of pregnancy carried out within the law are not subject to a child death review.

Who does this apply to?

This statutory guidance applies to all organisations, (Chief Executives of clinical commissioning groups (CCGs) and local authorities, senior leaders within organisations who commission or provide services for children, as well as relevant regulatory bodies). All professionals who care for children, or who have a role in the child death review process, should read and follow this guidance so that they can respond to each child death appropriately. It should be complied with unless exceptional circumstances arise.

All local organisations or individual practitioners should have regard to any guidance on child death reviews issued by the government.

4. Local pathways to support the child death review process are as follows(further details on the following sections can be found in Child Death Review Statutory and Operational Guidance (England) 2018 (HM Government, 2018)

- **Immediate decision making and notifications.**

The attending healthcare team should notify the local child death review partners via: https://www.ecdop.co.uk/southyorkshire

Completing and submitting the Notification Form.

- **Investigation and information gathering.**

Whenever a child dies, practitioners should work together in responding to that death in a thorough, sensitive and supportive manner. After immediate decisions have been taken and notifications made, a number of investigations may then follow.

They will vary depending on the circumstances of the case, and may run in parallel. The timescales of investigations will vary greatly from case to case.

The aims of this response are to:

- establish, as far as is possible, the cause of the child's death

- identify any modifiable contributory factors

- provide ongoing support to the family

- learn lessons in order to reduce the risk of future child deaths and promote the health, safety and wellbeing of other children, the learning arising from investigations will inform the child death review meeting

- ensure that all statutory obligations are met

Child death review partners may request a person or organisation to provide information to enable or assist the reviewing and/or analysing of a child's death. The person or organisation to which a request is made should co-operate with this process; failure to do so can result in enforcement through legal action being instigated.

Where there has been agency involvement the practitioner will be requested to complete a Reporting Form via eCDOP.
Information may be requested verbally, through attendance at a meeting (in the case of Joint Agency Response after an unexpected child death), or through involvement in statutory reviews, serious untoward and patient safety incidents.

- **The Child Death Review Meeting**

This is the multi-professional meeting taking place prior to CDOP. At the meeting, all matters relating to an individual child's death are discussed by professionals involved with the case. The child death review meeting may be attended by professionals who were *directly involved in the care* of that child during his or her life and in the investigation into his or her death, and should not be limited to medical staff. This meeting already occurs in different formats and is called a variety of names across hospital and community settings (for example: mortality and morbidity meeting, perinatal mortality meeting, local case discussion, and in the SUDI Guidelines the final case discussion).
A draft analysis form and meeting minutes for each individual case should be sent from the child death review meeting to the CDOP administrator (via eCDOP if requested) to inform the independent review at a CDOP.

- **Child Death Overview Panel (CDOP)**

The review by the child death review partners (at CDOP), is intended to be the final, independent scrutiny of a child's death by professionals with no responsibility for the child during their life. The information gathered using all the standardised templates may help child death review partners to identify modifiable factors that could be altered to prevent future deaths.

This is a multi-agency panel, attended by senior professionals across agencies *who have had no involvement in* the case under discussion with all identifying information relating to the child redacted.

CDOP will have a permanent core membership (standing members) drawn from key organisations that provide services to children and their families. It is for child death review partners at a local level to determine what representation they have in any structure reviewing child deaths. Other members may be co-opted to contribute to discussion of individual cases where their expertise or area of work is relevant to the death.

Panel responsibilities

The functions of CDOP include:

- to collect and collate information on each child death, seeking relevant information from professionals and, where appropriate, family members;
- to analyse the information obtained, including the report from the child death review meeting, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths;
- to make recommendations to the Child Death Review Partners and other organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children;
- to notify the Child Safeguarding Practice Review Panel and Local Safeguarding Partners when it identifies that a child was abused or neglected;
- to notify the Medical Examiner (once introduced) and the doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death, for the purposes of improving death registration;
- to provide specified data to the Department of Health and then, once established, to the National Child Mortality Database;
- to produce an annual report for Child Death Review Partners on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process. This will form part of the Safeguarding Children’s Partnership Annual Report and the regional Annual Report.
- to contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.

5. Joint Agency Response

A Joint Agency Response is required if a child’s death:

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

This is a coordinated response involving police and health professionals.

Where a Joint Agency Response is required, practitioners should follow the process set out in *Sudden and Unexpected Death in Infancy and Childhood: multiagency guidelines for care and investigation (2016).*

The local area has the responsibility in co-ordinating the joint area response following the death of a child normally resident in their area. Where a death occurs involving a child/young person from a neighbouring area this will require some co-ordination with the area of residence.
The Lead Health Professional will be notified by either the hospital and/or police; the person assigned may be a doctor or nurse; this will vary according to who is on rota for that particular day. Local children's social care services should also be contacted to check if the child or family are known.
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 unexpectedly, 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 and the Crown Prosecution Service to ensure that their enquiries do not prejudice any criminal proceedings.
Where a child has died, and abuse or neglect is known or suspected, professionals at the initial information-sharing and planning meeting should notify the safeguarding partners whose responsibility it is to determine whether the case meets criteria for a child safeguarding practice review.

6. Family engagement and bereavement Support

Every family has the right to have their child's death sensitively reviewed in order to, where possible, identify the cause of death and to ensure that lessons are learnt that may prevent further children's deaths. Professionals have a duty to support and engage with families at all stages in the review process. Parents and carers should be informed about the review process, and given the opportunity to contribute to investigations and meetings, and be informed of their outcomes.

- all bereaved families should be given a single, named point of contact to whom they can turn for information on the child death review process, and who can signpost them to sources of support. ('Key worker'). This is the responsibility of the organisation where the child was certified dead.
- An appropriate consultant neonatologist or paediatrician should also be identified after every child's death to support the family. This is distinct from the key worker and might either be the doctor that the family had most involvement with while the child was alive or the designated professional on-duty at the time of death.

Other professionals may also provide vital support to the family; these include (but are not limited to) the GP, clinical psychologist, social worker, family support worker, midwife, health visitor or school nurse, palliative care team, chaplaincy and pastoral support team.

The leaflet When a Child Dies – A Guide for Parents and Carers should be given to *all* bereaved families or carers.

7. Deaths in specific situations

- ***Deaths overseas of children normally resident in England***

Any death overseas of a child normally resident in England requires comprehensive review. The default expectation is that all such deaths will be investigated by the coroner, and the primary responsibility for the child death review lies with the CDOP for the area where the child was normally resident. The Foreign and Commonwealth Office (FCO) is a vital source of information for professionals and families in such situations. They can be contacted on Coroner.LiaisonOfficer@fco.gov.uk, or in an emergency 0207 008 1500 (ask for Consular).

- ***Children with learning disabilities***

It is important to specifically recognise and record that a child or young person has learning disabilities, irrespective of any other diagnoses or syndromes that are recognised. This enables effective monitoring, auditing and evaluation of service provision; resource management and strategic planning; and assurance regarding equitable access to health services.

The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

The LeDeR programme team aims to support local areas to implement the LeDeR review process and to take forward the lessons learned from individual mortality reviews to make improvements to service provision. The LeDeR programme also collates and shares anonymised information from the review so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

Definition of learning disabilities

The LeDeR programme defines ‘learning disabilities’ to include the following:

- a significantly reduced ability to understand new or complex information and to learn new skills (impaired intelligence), with
- a reduced ability to cope independently (impaired social functioning), which
- started in childhood, with a lasting effect on development.

A child’s ability to understand and use information and to cope independently should be interpreted in relation to other children of a similar age.

Further information about the definition of learning disabilities used in the LeDeR programme can be found at: http://www.bristol.ac.uk/sps/leder/information-for-reviewers/briefing-papers/.

The interface between the Child deaths review and the LeDeR mortality review process

The child death review process will be the primary review process for children with learning disability and that it will not be necessary for the LeDeR programme to review each case separately.

When notified of the death of a child or young person aged 4-17 years who has learning disabilities, or is very likely to have learning disabilities but not yet had a formal assessment for this, the locality CDOP should report that death to the LeDeR programme at: http://www.bristol.ac.uk/sps/leder/notify-a-death/

or 0300 777 4774.

The LeDeR programme, in liaison with the National Child Mortality Database team and the Department of Health, will collate completed mortality reports relating to children and young people with learning disabilities, and identify common themes and patterns at regional and national levels.
These will be reported back to CDOPs on an annual basis.

- ***Deaths of children in adult healthcare settings***

A very small number of children (16 and 17 year olds) die in adult intensive care units (ICUs). The *Learning from Deaths* framework gives guidance to NHS trust for reviewing adult inpatient deaths, and this should remain the primary approach for reviewing the *quality of care* for children who die in adult ICU. However, in all other respects, children who die in adult settings should have the same rigour of review as all other children who die.
There should be close liaison with the designated doctor for child deaths from the outset, to ensure that this occurs. The designated doctor for child deaths should be notified when a child dies in adult ICU.

Immediate decision making and notifications applies. There should be notification of the child health system, GP, and local CDOP.
The Structured Judgement Review approach or other evidence based structured mortality review tool should be used to review the quality of clinical care. This report, Form C, and any other notes arising from the adult M&M meeting should be

forwarded to the relevant CDOP. The designated doctor for child deaths should help co-ordinate this.

- ***Suicide and self-harm***

Suicide is defined as a death where the conclusion of suicide is given at inquest where the coroner (or jury) is satisfied beyond reasonable doubt that the deceased did an act knowing and intending that their death would result.

The true rate of suicide is thought to be higher than that reported in national statistics and is one of the leading causes of death in young people.

The approach to reviewing suicides in children

Child suicide should be reviewed in the same manner as other child deaths, with the following expectations:

- All deaths related to suspected suicide and self-harm should be referred to the coroner for investigation;
- All deaths related to suspected suicide and self-harm will require a Joint Agency Response;
- The child death review meeting should be properly quorate and include experts in mental health and key professionals involved in the child's life across education, social services and health. Specific risk factors should be considered, including:
- family factors such as mental illness, alcohol or drug misuse, and domestic violence;
- abuse and neglect;
- bereavement and experience of suicide;
- bullying, including on-line bullying;
- suicide-related internet use, including searching for methods and posting suicidal messages;
- academic pressures, especially related to exams;
- social isolation, especially leading to withdrawal;
- physical health conditions that may have social impact, and their treatment
- alcohol and illicit drugs;
- mental ill health, self-harm, and suicidal ideation;
- The relevant CDOP should report to NCISH (ncish@nhs.net) all cases of child death that they believe might be due to suicide or self-harm, for as long as this national investigation of child suicide continues.
- Suspected child suicides should be discussed at a themed specialist CDOP review with attendant mental health specialists.

- ***Inpatient Mental Health settings***

This applies to all children in inpatient mental health settings whether they are treated ‘voluntarily’ as informal inpatients or detained under the Mental Health Act 1983 (MHA).

All deaths of children in inpatient mental health settings will trigger a Joint Agency Response.

All child deaths in inpatient mental health settings should be reported to the coroner. If the death was not due to natural causes, the coroner will open a formal investigation that may lead to an inquest.

When a child dies while detained under the MHA, there should also be a safeguarding practice review.

- ***Deaths in custody***

The primary responsibility for the investigation of the death of a child in custody lies with the coroner and Prisons and Probation Ombudsman (PPO). The coroner’s duty to investigate deaths in custody and state detention also includes patients detained under the Mental Health Act 1983. The same processes also apply to the death of a child accommodated in a secure welfare placement. While the CDR partners for the area where the child was normally resident are responsible for ensuring a review of the death at CDOP takes place, it is the CDOP for the area where the most learning can be captured that would normally conduct the CDOP review

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