NORTH EAST LINCOLNSHIRE SAFEGUARDING CHILDREN BOARD

CHILD DEATH REVIEW PROCESS AND CHILD DEATH OVERVIEW PANEL

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1. INTRODUCTION

Each death of a child is a tragedy and enquiries should keep the appropriate balance between forensic and medical requirements and the supporting the family at a difficult time. Professionals supporting parents and family members should assure them that the objective of the child death review process is not to allocate blame but to learn lessons. Families should be treated with sensitivity, discretion and respect at all times, and professionals should approach their enquiries with an open mind. The Review should help to prevent further such child deaths.

The responsibility for determining the cause of death rests with the coroner or the doctor who signs the medical certificate of the cause of death (and therefore is not the responsibility of the Child Death Overview Panel (CDOP)).

2. RESPONSIBILITIES OF THE LOCAL SAFEGUARDING CHILDREN BOARD (LSCB'S)

Where The LSCB is responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by the Child Death Overview Panel (CDOP). The Panel has a fixed core membership drawn from organisations represented on the LSCB and the flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate. The Panel is chaired by the Consultant within Public Health, who is a representative on the LSCB Operational Board.

In cases where organisations in more than one LSCB are have known about or have contact with the child, lead responsibility should sit with the LSCB for the area in which the child was normally resident at the time of death. Other LSCB's or local organisations which have had involvement in the case should cooperate jointly planning and undertaking the child death review. In the case of a looked after child, the LSCB for the area of the local authority

looking after the child should exercise lead responsibility for conducting the child death review, involving other LSCB's with an interest or whose lead agencies have had involvement as appropriate. North East Lincolnshire and North Lincolnshire LSCBs moved to a joint CDOP in April 2016.

3. THE REGULATIONS RELATING TO CHILD DEATHS

Regulation One of the LSCB functions, set out in regulation 6 of the Safeguarding Children Boards Regulations 2006, in relation to the deaths of any children normally resident in their area is as follows:

a) Collecting and analysing information about each death with a view to identifying:

- Any case giving rise to the need for a review mentioned in regulation

5(1)(e);

ii. Any matters of concern affecting the safety and welfare of children in the area of the Authority; and

iii. Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

b) Putting in place procedures for ensuring that there is a coordinated response by the Authority, their Board partners and other relevant persons to an unexpected death.

Every LSCB is required to supply anonymised information on child deaths to the Department for Education. This is so that the Department can commission research and publish nationally comparable analyses of these deaths.

The LSCB should ensure that appropriate single and multi-agency training is made available to ensure successful implementation of these procedures. LSCB partner agencies should ensure that relevant staff should have access to this training.

4. SPECIFIC RESPONSIBILITIES OF RELEVANT BODIES IN RELATION TO CHILD DEATHS

Registrars of Births and Deaths (Children and Young Persons Act 2008)	Requirement to supply LSCB with information which they have about the death of persons under 18 they have registered or re registered. Notify LSCB's if they issue a Certificate of No Liability to Register where it appears that the deceased was or may have been under the age of 18 at the time of death. Requirement to send the information to the appropriate LSCB (the one which covers the sub district in which the register is kept) no later than seven days from the date of registration.
Coroners and Duty to investigate and may require evidence and an inquest	Duty to investigate and may require evidence and an inquest Coroners duty to inform the LSCB for the area in which the child died or where the body was found within three working days Of deciding to investigate a death or commission a post mortem. Coroners duty to share information with relevant LSCB's.
Registrar General (section 32 of the Children and Young Persons Act 2008)	Power to share child death information with the Secretary of State, including about children who die abroad.
Medical Examiners (Coroners and Justice Act 2009)	It is anticipated that from 2014 Medical Examiners will be required to share information with LSCB's about child deaths that are not investigated by the Coroner.

Clinical Commissioning Groups (Health and Social Care Act 2012)	Employ, or have arrangements in place to secure the expertise of, consultant paediatricians whose designated responsibilities are to provide advice on commissioning paediatric services from: ➢ Paediatricians with expertise in undertaking enquiries into unexpected deaths in childhood; ➢ Medical investigative services; and ➢ The organisation of such services.
Designated Paediatrician for unexpected deaths in childhood	Ensure that relevant professionals (i.e. coroner, police and local authority social care) are informed of the death; coordinate the team of professionals (involved before and/ or after the death) which is convened when a child who dies unexpectedly (accessing professionals from specialist agencies as necessary to support the core team). Convene multi-agency discussions after the initial and final post mortem results are available.

5. PRINCIPLES

When dealing with an unexplained child death, all agencies need to follow five common principles:

a) Sensitivity and open minded balanced approach;
b) An inter-agency response;
c) Sharing of information;
d) Appropriate response to the circumstances;
e) Preservation of evidence.

Families should be treated with sensitivity, discretion and respect at all times, and professionals should approach their enquiries with an open mind.

Families should be offered support and advice following the death of their child, and a designated professional, should maintain contact at regular intervals with the family and other professionals to ensure that the family is kept informed regarding information about the child's death and to ensure that the family know where to get appropriate help and support.

6. THE DEFINITION OF AN UNEXPECTED CHILD DEATH

An unexpected death is defined as the death of an infant or child (less than 18 years old and excluding stillbirths) which:

- Was not anticipated as a significant possibility for example 24 hours before the death; or
- Where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

The designated paediatrician responsible for unexpected deaths in childhood should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt, these procedures should be followed until the available evidence enables a different decision to be made."

7. DEFINITION OF PREVENTABLE CHILD DEATHS

A preventable child death is defined as those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

In reviewing the death of each child the CDOP should consider modifiable factors for example in the family and environment, parenting capacity or service provision and consider what action could be taken locally and what action could be taken at a regional or national level.

8. IMMEDIATE ACTION BY PROFESSIONALS WHEN A CHILD DIES UNEXPECTEDLY

It is intended that those professionals involved (before and after the death) with a child who dies unexpectedly should come together to enquire into and evaluate the child's death. This means that some roles require an on call rota for responding to unexpected child deaths in their area. In North East Lincolnshire a Consultant of the Week model operates to cover the role of the local designated paediatrician responsible for unexpected child deaths in childhood.

The designated paediatrician responsible for unexpected deaths in childhood should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt the processes for unexpected deaths in childhood should be followed until the available evidence enables a different decision to be made.

When a child dies suddenly and unexpectedly, the consultant clinician (in a hospital setting) or the professional confirming the fact of death (if the child is not taken immediately to an Accident and Emergency Department) should inform the consultant clinician/ Consultant of the Week with responsibility for unexpected child deaths at the same time as informing the coroner and police. The police will begin an investigation into the sudden or unexpected death on behalf of the coroner. The Consultant of the week or paediatrician should initiate an immediate information sharing and planning discussion between the lead agencies (i.e. health, police and local authority children's social care).

The joint responsibilities of the professionals involved with the child include:

- Responding quickly to the unexpected death of a child;
- Maintaining a rapid response protocol with all agencies, consistent with the Kennedy principles and investigative practice from the National Police Chiefs' Council (formely known as Association of Chief Police Officers);
- Making immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the coroner;
- Liaising with the coroner and pathologist;
- Collecting information about the death;
- Providing support to the bereaved family and referring to specialist bereavement services where necessary and keeping them up to date with information about the child's death; and
- Gaining consent early from the family for the examination of their medical notes.

If the child dies suddenly or unexpectedly at home or in the community, the child should normally be taken to Accident and Emergency rather than the mortuary, unless it is deemed inappropriate to take the child to A&E. In some cases when a child dies at home or in the community, the police may decide that it is not appropriate to immediately move the child's body, for example because forensic examinations are needed.

As soon as possible after arrival at the hospital, the child should be examined by a consultant paediatrician and a detailed history should be taken from the parents or carers. The purpose of obtaining this information is to

understand the cause of death and identify anything suspicious about it. In all cases when a child dies in hospital, or is taken to hospital after dying, the hospital should allocate a member of staff to remain with the parents and support them through the process.

If a child has died at home or in the community, the lead investigator and senior health care professional should decide whether there should be a visit to the place where the child has died, ideally within 24 hours and who should attend. This should almost always take place for cases of sudden infant death. After this visit the senior investigator, visiting health care professional, GP, Health visitor or school nurse and local authority children's social care representative should consider whether there is any information to raise concerns that Neglect or Abuse contributed to the child's death.

Where a child dies unexpectedly, all registered providers of healthcare services must notify the Care Quality Commission (CQC) of the death of a service user- NHS providers may discharge this duty by notifying NHS England.

Where a young person dies at work the Health and Safety Executive should be informed. Youth Offending Teams review of safeguarding and public protection incidents (including the deaths of children under their supervision) should also feed into the CDOP process.

If there is a criminal investigation, the team of professionals must consult the lead police investigator and Crown Prosecution Service to ensure that their enquiries do not prejudice any criminal proceedings. If the child dies in custody, there will be an investigation by the Prisons and Probation Ombudsman (or by the Independent Police Complaints Commission in the case of police custody). Organisations who worked with the child will be required to cooperate with that investigation.

9. INVOLVEMENT OF THE CORONER OR PATHOLOGIST

If a doctor is not able to issue a medical certificate of the cause of death, the lead professional or investigator must report the child's death to the coroner in accordance with the protocol agreed with the coronial service. The coroner must investigate violence or unnatural death, or death of no known cause and all deaths where a person is in custody at the time of death. The coroner will then have jurisdiction over the child's body at all times. Unless the death is natural a public inquest will be held.

The Coroner will order a post mortem examination to be carried out as soon as possible by the most appropriate pathologist available (this may be a paediatric pathologist, forensic pathologist or both) who will perform the examination according to the guidelines and protocols laid down by the Royal College of Pathologists. The designated paediatrician will collate and share information about the circumstances of the child's death with the pathologist in order to inform this process.

If the death is unnatural or the cause of death cannot be confirmed, the coroner will hold an inquest. Professionals and organisations who are involved in the child review process must cooperate with the coroner and provide him/her with a joint report about the circumstances of the child's death. This report should include a review of all medical, local authority social care and educational records on the child. The report should be delivered to the coroner within 28 days of the death unless crucial information is not yet available.

10. NOTIFICATION OF A CHILD DEATH

It is the responsibility of the Designated Paediatrician to ensure that relevant professionals are informed of the death of a child. Once the Designated Paediatrician has informed the relevant agencies, those agencies should follow their own internal notification for informing the appropriate managers/ services.

The LSCB Chair is responsible for determining who should receive a child death notification as per national requirements on all child deaths using the Form A (Contact LSCB for a copy) and sending it to the person designated by the Independent Chair who is the LSCB Manager and CDOP Coordinator. Official notifications of an unexpected child death should be made as soon as possible or within 24 hours of the child's death (unless it is a weekend and then the notification must be made on the Monday morning). The notification timescale for expected child deaths to the designated person is 3 working days.

All notifications will be made using the nationally agreed notification Form A and must be emailed securely using encryption or via the government secure infrastructure (gcsx.gov.uk, pnn.police.uk). In addition agencies are asked to contact the LSCB Manager or CDOP Coordinator on 01472 325044 or 01472 323675 to inform them that a notification has been sent.

Individual agencies are responsible for ensuring that their staff are aware of the CDOP procedures and operate in compliance with these.

11. NOTIFICATION TO OFSTED

Where has been determined that it meets the notification criteria to Ofsted as set out in LAC 25 (2007), it is the responsibility of Children's social care to notify DfE and Ofsted.

12. RAPID RESPONSE MEETINGS FOLLOWING AN UNEXPECTED CHILD DEATH

Following the initial discussion /planning meeting coordinated by the Designated Paediatrician or Consultant of the Week, there will be a planned Rapid Response meeting held within 3 working days and following the initial post mortem results. This meeting will be chaired by the Designated Paediatrician and the meeting should also include:

- The coroner's office;
- The police;
- The council's Children's Social Care Service;
- The pathologist;
- Any other relevant healthcare professionals such as the school nursing or health visiting service;
- Any other relevant professional group that have had significant contact with the child/family;
- Any other relevant representative that is relevant based upon the individual circumstances of the death.

The purpose of this case discussion is to review any information that has come to light that may raise additional concerns about safeguarding issues and discuss the support to be offered to the family. The designated paediatrician should arrange for a record of the discussion to be sent to the coroner to inform the inquest and cause of death and to the relevant CDOP to inform the child death review. At the case discussion, it should be agreed how detailed information about the cause of the child's death will be shared, and by who, with the parents and who will offer the parents on-going support.

If there are concerns about surviving children living in the household the LSCB guidelines and procedures set out NELSCB child protection procedures should be followed with respect to these children.

At this stage the core data set should be collated/updated by sending out the Form B's to relevant agencies (supplied by the LSCB) and, if necessary, previous information corrected in a manner that enables this change to be audited. If the initial post-mortem findings or findings from the child's history suggest evidence of abuse or

neglect as a possible cause of death, the police child protection team and Children's Social Care Service should be informed immediately and the serious case review processes (see Serious Case Reviews) followed.

13. ACTION AFTER THE POST MORTEM RESULTS

Although the results of the post mortem belong to the coroner, it should be possible for the paediatrician, pathologist and lead police investigator to discuss the findings as soon as possible and the coroner should be informed immediately of the initial results. If these results suggest evidence of abuse or neglect as a possible cause of death, the paediatrician should inform the police and children's social care immediately. He or she should also inform the LSCB coordinator/ Chair of standing Serious Case Review subgroup so that they can consider whether the criteria for referral to serious case review. This notification can be made to the LSCB coordinator for the LSCB by contacting 01472 325044 or 01472 323675.

14. CASE DISCUSSION FOLLOWING THE FINAL RESULTS OF THE POST MORTEM EXAMINATION BECOMING AVAILABLE

A further case discussion meeting should be held, as soon as the final post mortem result is available. The timing of this discussion will vary according to the circumstances of the death. This may range from immediately after the post-mortem to eight to twelve weeks after the death. The type of professionals who will be involved in this meeting will depend on the age of the child. The meeting discussion should include those who knew the child and family, and those involved in investigating the death i.e. GP, health visitor or school nurse, paediatrician(s), pathologist, senior investigating police officers and where appropriate social workers.

This meeting should be convened and chaired by the designated paediatrician. At this stage the collection of the core data set should be completed and, if necessary, previous information corrected in a manner that enables this change to the information to be audited.

The main purpose of the case discussion is to share information to identify the cause of death and/or those factors that may have contributed to the death and then to plan future care for the family. Potential lessons to be learnt may also be identified by this process. Another purpose is to inform the Inquest.

There should be an explicit discussion of the possibility of abuse or neglect either causing or contributing to the death, and if no evidence is identified to suggest maltreatment this should be documented as part of the minutes of the meeting.

It should be agreed how detailed information about the cause of the child's death will be shared, and by whom, with the parents and who will offer them on-going support.

The results of the post mortem examination should be discussed with the parents at the earliest opportunity, except in those cases where abuse is suspected and/or the police are conducting a criminal investigation. In these situations the paediatrician should discuss with Children's Social Work Service, the police and pathologist what information should be shared with the parents and when. This discussion with the parents will usually be part of the role of the paediatrician responsible for the child's care and she or he will, therefore have responsibility for initiating and leading the meeting. A member of the primary health care team should usually attend this meeting.

A record of the case discussion and the record of the core data set will be made available to the local Child Death Overview Panel. This information will then be analysed and decisions made about what actions (if any) could be taken to prevent similar deaths in the future.

15. INTERFACE BETWEEN THE CHILD DEATH OVERVIEW PANEL PROCESS AND THE SERIOUS CASE REVIEW PROCESS

If it is thought at any time, that the criteria for a serious case review might apply, the LSCB coordinator/ Chair of standing Serious Case Review subgroup so that they can consider whether the criteria for referral to serious case review has been met.

Any case whereby it has been determined that the criteria for a Serious Case Review (SCR) has been met, will be managed as per the SCR process (see Serious Case Reviews). The findings from this review will be shared with the CDOP at the point where the Executive Summary for the SCR is to be made available, following agreement by the LSCB.

16. GENERAL INFORMATION FOR ALL PROFESSIONALS WHEN DEALING WITH THE FAMILY

This is a very difficult time for everyone. The time spent with the family may be brief but actions may greatly influence how the family deals with the bereavement for a long time afterwards.

A sympathetic, supportive and non-judgmental attitude whilst maintaining professionalism towards the investigation is essential.

Remember that people in the first stages of grief may be shocked, withdrawn, depressed, hostile, aggressive, or hysterical. Professionals should also be aware of how differing cultural beliefs may impact upon expressions of grief.

All professionals must record history and background information given by parents/carers in as much detail as possible. The initial accounts of the circumstances including timings must be recorded verbatim if possible. It is normally appropriate for the parent/carers to want physical contact with his/her dead child. This should be encouraged, albeit with observation and support by an appropriate professional.

The child should always be handled as if he/she were still alive, remembering to use his/her name at all times as a sign of respect.

In those child deaths where the cause of death is unknown, the coroner must be consulted. It is the coroner's decision to authorise a post mortem to establish the cause of death and to decide on the type of pathologist needed for the post mortem.

Staff from all agencies need to be aware that, on occasions, in suspicious circumstances, the early arrest of the parents/carers may be essential in order to secure and preserve evidence and thus effectively conduct the investigation. Agency professionals must be prepared to provide statements of evidence promptly in the above circumstances.

17. THE CHILD DEATH OVERVIEW PANEL

A review of all child deaths in the LSCB area covered by the child death overview panel will be undertaken. The functions of the CDOP include:

- Reviewing all child deaths up to the age of 18 years, excluding those babies who are still born and planned terminations of pregnancy carried out within the law;
- Collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;

- Discussing each child's case and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;
- Determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, is any actions could be taken to prevent future such deaths;
- Making recommendations to the LSCB or other relevant bodies promptly so that actions can be taken to prevent future similar deaths where possible;
- Identifying patterns or trends in local data and reporting these to the LSCB;
- Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required;
- Agreeing local procedures for responding to unexpected deaths of children; and
- Cooperating with regional and national initiatives for example with the National Clinical Outcome Review Programme - to identify lessons on the prevention of child deaths.

In reviewing the death of each child, the CDOP should consider modifiable factors, for example, in the family environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level.

The aggregated findings from all child deaths should inform local strategic planning, including the local Joint Strategic Needs Assessment, on how to best safeguard and promote the welfare of children in the area. Each CDOP should prepare an annual report of relevant information for the LSCB. This information should in turn inform the LSCB annual report.

Each CDOP should prepare an annual report of relevant information for the LSCB; this information should inform the LSCB annual review.

The CDOP panel will meet on a quarterly basis and will be chaired by the Director of Public Health, this is to ensure that the panel maintains a public health perspective and is more able to identify trends over time and develop preventative approaches to child deaths in the area.

The learning from reviewing child deaths will be incorporated into the LSCB Annual Review; they will be covered as appropriate in relevant training for multi-agency staff as part of the LSCB Learning and Improvement Framework.

18. INFORMATION SHARING

The legislative framework for sharing information throughout the CDOP process is set out within Statutory Guidance Working Together to Safeguard Children 2015 and the and Young Persons 2008 and Governments Information Sharing Practice Guidance.

Information within the CDOP is regarded as personal sensitive information about individuals and will be treated as such.

- All information sharing will comply with Caldecott guidelines;
- All information will be regarded as confidential and case discussion meetings and CDOP panel members will be required to sign a confidentiality agreement on each case;
- All information held on individuals will be stored as per the Protection Act and will be stored for a period of 6 years;

- Information sharing between the LSCB the Coroner, the Registrar and Independent Reviewing Team (child protection) will be as per the agreed protocols (see Appendix 3: Protocol for Working with H.M Coroner - Northern Lincolnshire);
- The executive summary of the CDOP annual review will be fully anonymised so that identifiable information is removed.

19. APPENDICES

Appendix 1: Flow Chart for Processes to be followed for an Unexpected Child Death

Appendix 2: Factors which may Indicate Concern

Appendix 3: Protocol for Working with H.M Coroner - Northern Lincolnshire

Appendix 4: Interface between the Child Death and Serious Case Review Processes

20. FURTHER INFORMATION

MBRRACE-UK (Mothers and babies: reducing risk through audits and confidential enquiries across the UK).