

SECTION 31

CHILD DEATHS

This section sets out the actions to be taken in response to all child deaths in the city, and particular actions to be taken in response to an unexpected child death.

1. GUIDANCE

Working Together to Safeguard Children [2010] Chapter 7.

The West Midlands SUDC Protocol.

2. SCOPE OF THIS SECTION

- 2.1 Guidance in this Section relates to all deaths of children and young people up to age 18, excluding stillbirths and planned terminations of pregnancy carried out within the law. However, implementation of parts of the Section may need to be adapted to take into account the age of the child.

3. RESPONSIBILITY OF THE SAFEGUARDING CHILDREN BOARD

- 3.1 Each local safeguarding children board has the following duties in relation to the deaths of children normally resident in their area –

- To collect and analyse information about each death with a view to identifying:
 - Any case giving rise to the need for a serious case review
 - Any matters of concern affecting the safety and welfare of children in the area of the authority; and
 - Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
- To put in place procedures for ensuring that there is a co-ordinated response by the Board partners and other relevant persons to an unexpected death.

- 3.2 Each safeguarding children board should use the aggregated findings from all child deaths to inform local strategic planning on how best to safeguard and promote the welfare of children in the area.

Working Together

4. PRINCIPLES

- 4.1 In all cases enquiries following a child's death should seek to –
- Understand the reasons for the child's death;
 - Address the needs of other children in the household;
 - Address the needs of all family members; and
 - Consider any lessons to be learned about how best to safeguard and promote the welfare of children in the future.
- 4.2 All professionals should approach their enquiries with an open mind and should at all times treat families with sensitivity, discretion and respect.

5. DEFINITIONS

Unexpected death of a child

- 5.1 An unexpected death is the death of a child that was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death.
- 5.2 There will be some situations in which it is not immediately clear whether to regard the death of a child as unexpected - for example where a child has a life limiting illness but the manner or time of the death is unexpected. If there is uncertainty about whether a death should be regarded as unexpected, practitioners should consult the SUDIC Paediatrician. The process for unexpected deaths should be followed until enough evidence is available to make a clear decision.

Preventable child death

- 5.3 For the purpose of this Section, preventable child deaths are those in which modifiable factors may have contributed to the death. Modifiable factors are those which could be modified by achievable local or national intervention.

The designated person for child death overview

- 5.4 Each local safeguarding children board is required to nominate a designated person for child death overview, to whom child death notifications should be sent. The Registrar of Births and Deaths is required to notify the designated person of the registration of the death of any person aged under 18.
- 5.5 The child death overview panel (CDOP) coordinator is the designated person for child death overview for Birmingham Safeguarding Children Board.

The SUDIC paediatrician for unexpected deaths in childhood

5.6 The SUDIC (Sudden Unexplained Deaths in Childhood) Paediatrician is a consultant paediatrician whose role is to provide advice to one or more primary care trusts and to the safeguarding children board on:

- The commissioning of paediatric services from paediatricians with expertise in undertaking enquiries into unexpected deaths in childhood and the medical investigative services; and
- The organisation of such services.

In *Working Together to Safeguard Children* this role is referred to as the designated paediatrician for unexpected deaths in childhood.

6. THE CHILD DEATH OVERVIEW PANEL (CDOP)

6.1 Each local safeguarding children board is required to maintain a sub-committee called the child death overview panel. This panel is responsible for reviewing the available information on all child deaths. The core membership of the panel is drawn from the key agencies represented on the Board, but it may co-opt other relevant practitioners as and when appropriate.

6.2 The child death overview panel should hold meetings at regular intervals to:

- Determine whether or not each death should be deemed preventable; The panel should consider the modifiable factors in the family, environment, service provision etc and determine whether any action taken locally or at a regional or national level might reduce the risk of future child deaths. This decision cannot be finalised until the outcome of other investigations is known, for example post-mortem, inquest, serious case review or criminal proceedings. The decision should always be approved by the Chair of the panel;
- Collect and collate an agreed minimum data set on each child who has died;
- Identify any patterns or trends in the local data and report these to the safeguarding children board;
- Review and evaluate the data on all child deaths, identifying lessons to be learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children;

Working Together

- Identify any public health issues and consider how best to address them;
- Make recommendations to the safeguarding children board or to other relevant bodies about action to prevent further deaths where possible;
- Monitor the support and assessment services offered to families of children who have died;
- Advise the safeguarding children board on the resources and training required locally to ensure an effective inter-agency response to child deaths;
- Review the appropriateness of the professional response to each death of a child, the involvement of practitioners before and at the time of death, and the relevant environmental, social, health and cultural aspects of each death;
- Inform the Chair of the safeguarding children board where specific new information should be passed to the coroner or other appropriate authorities;
- Refer to the Chair of the safeguarding children board any deaths where there may be grounds to undertake further enquiries;
- Provide relevant information to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family;
- Monitor the appropriateness of the professional response to each unexpected death of a child;
 - This will include:
 - Reviewing the reports produced by the rapid response team;
 - Considering the extent to which the team has brought together any recorded wishes and feelings of the child;
 - Making a full record of this discussion; and
 - Providing the professionals with feedback on their work.
 - Where there is an ongoing criminal investigation, the panel must consult the Crown Prosecution Service as to what it is appropriate for it to consider and what actions it might take, in order to avoid prejudicing any criminal proceedings.
- Evaluate the effectiveness of the procedures set out in this Section; and
- Co-operate with regional and national initiatives to identify lessons on the prevention of child deaths.

7. ALL CHILD DEATHS

- 7.1 The professional who confirms the death of a child in the city will notify the CDOP coordinator. The notification should include as much information as possible about the child and family and the circumstances of the death, and should list all professionals known to be involved with the child and family. A template for making this notification (Form A) is available at www.education.gov.uk/childrenandyoungpeople/safeguarding/safeguardingchildren/childdeathreview/a0068866/national-templates-for-lscbs-to-use-when-collecting-information-about-child-deaths
- 7.2 On receiving notification of a child death, the designated person will establish which agencies and professionals have been involved with the child prior to or at the time of death. All deaths will be considered at the next CDOP meeting. Following the CDOP meeting the CDOP coordinator will send a copy of Form B (this is also available from the website above) to identified professionals.
- 7.3 Within three weeks of receiving Form B, each identified professional should retrieve any relevant case records, record the information known to their agency and return the completed form to the CDOP coordinator and the SUDIC nurse coordinator. There will be times when complete information is not available at this stage because of ongoing medical or police investigations.
- 7.4 The CDOP coordinator will collate the information received on to a single Form B and store it on a secure database until the case is reviewed by CDOP.

Involvement of more than one LSCB

- 7.5 Safeguarding children boards will need to communicate with each other when -
- A child who is normally resident in the area of one local safeguarding children board dies while in the area of another; or
 - Partner agencies in more than one LSCB area have known about, or had contact with, the child

In these situations, when the designated person for the area in which the child died is notified of the death, they will notify the designated person for the other safeguarding children board.

Working Together

- 7.6 One child death overview panel must take lead responsibility for gathering information – usually this will be the panel for the area where the child was normally resident at the time of death. In the case of a looked after child, lead responsibility will lie with the safeguarding children board for the area of the local authority responsible for the child's care.

Meetings of the panel

- 7.7 Before each meeting of the child death overview panel the CDOP coordinator will circulate anonymised copies of the collated Form Bs to all panel members. If any panel member feels that supplementary material relating to a particular death should be considered by the panel, they should send this to the designated person for circulation to panel members. However, before this material is circulated, the designated person and panel chair will consider carefully whether it is appropriate for the meeting and whether there are any issues of confidentiality.

- 7.8 The child death overview panel will:

- Review each case brought before it;
- Consider any factors contributing to the death;
- Classify the cause of death;
If the panel is unable to classify the death, or to carry out an adequate review, from the available information it may reschedule the case for a later meeting and specify the further information to be obtained.
- Make a decision as to the preventability of the death;
- Identify any modifiable factors; and
- Consider whether to make any recommendations about actions to prevent such deaths in the future.
Recommendations should be directed at interventions that could help improve the future safety and welfare of children in the local area or beyond it. The panel will not normally make recommendations in relation to individual case management.

- 7.9 Form C may be used to facilitate the panel discussion and to make an anonymous record of its conclusions. This template is available from <http://www.education.gov.uk/childrenandyoungpeople/safeguarding/safeguardingchildren/childdeathreview/a0068866/national-templates-for-lscbs-to-use-when-collecting-information-about-child-deaths>

7.10 The panel may decide that it should consider a group of similar deaths (for example road traffic accidents, sudden unexpected death in infancy or deaths of children with life limiting conditions) at a specific designated meeting. Specialists in the particular type of death may then be invited to attend that meeting.

8. EXPECTED DEATHS

8.1 When a child's death is not regarded as unexpected, the team looking after the child may choose to organise a discussion of the case to identify good practice and any lessons that may be learned to improve the care of other children. Information on these discussions should be provided to the child death overview panel - a template for recording this (Form C) is available at the website above.

9. UNEXPECTED DEATHS

9.1 Detailed local guidance on responding to an unexpected child death will be found in the *West Midlands SUDC Protocol*. - The West Midlands Best Practice Multi-agency Protocol for the Management of Sudden Unexpected Deaths in Infants and Children under 18. This will be made available on the BSCB website. This protocol includes guidance on the roles and responsibilities of each agency.

Immediate response

9.2 When a child dies unexpectedly at home or in the community, the child will normally be taken to an A&E department. As soon as practicable after arrival at a hospital the child should be examined by the consultant paediatrician on call – in the case of a young person over 16 years of age a consultant in emergency medicine may be more appropriate – who will take a detailed history of the events leading up to and following the discovery of the child's collapse. They will follow the West Midlands SUDC Protocol.

9.3 When the child is pronounced dead, the consultant clinician should review all the available information and inform the parents, explaining the future involvement of the police and coroner.

9.4 The consultant clinician will inform the coroner and the SUDIC paediatrician. An on-call paediatrician for sudden deaths is available via BCH switchboard 24 hours a day, 365 days a year. If the child was not taken to A&E this will be done by the professional confirming the fact of death.

9.5 In most circumstances following the unexpected death of a child it will be appropriate to allow the parents to spend some time with, and to hold, their child. Hospital staff and the rapid response team will arrange for this to be supervised by a nurse or other professional.

Working Together

- 9.6 Before the parents leave the hospital or, if the child was not transferred to hospital, before the professionals leave the home, the parents should be informed about the sudden unexpected deaths procedure and details of who they should contact for information.

The rapid response team

- 9.7 When a child dies unexpectedly the SUDIC paediatrician and the SUDIC Nurse Co-ordinator for unexpected deaths in childhood will bring together a team made up of the practitioners who will be involved in the immediate professional response - the rapid response team. (This will usually include the Police, a Paediatrician, Social Care and SUDIC Nurse Co-ordinator). The responsibilities of the rapid response team will include:

- Responding quickly to the unexpected death of a child;
- Making immediate enquiries into and evaluating the reasons for and circumstances of the death;
The means by which this will be carried out must be agreed with the coroner.
- Undertaking enquiries relating to the current responsibilities of their respective organisations;
This includes liaising with those who have ongoing responsibilities for other family members.
- Providing support to the bereaved family, and where appropriate referring them on to specialist bereavement services;
- Maintaining contact at regular intervals with family members, and with other professionals who have ongoing responsibilities for family members, to ensure they are informed and kept up-to-date with information about the child's death; and
- Collecting information in a standard, nationally agreed manner.

Planning

- 9.8 The SUDIC paediatrician and the SUDIC Nurse Co-ordinator for unexpected deaths will ensure that relevant professionals (the coroner, the police, local authority children's social care, the health visitor or school nurse and the GP) are informed of the death. Children's social care and health agencies will quickly identify any information they hold which may be relevant to the circumstances of the death, and share it with the police and the SUDIC paediatrician.

- 9.9 The SUDIC paediatrician, the SUDIC Nurse Coordinator and the police will agree whether any immediate action is necessary and which professional or agency will take the lead. The agreed plan should include a commitment to close collaboration and communication between agencies. It should establish which agencies have known or been involved with the child (including CAMHS, school or early years provider) and agree who should make contact with them to inform them of the child's death and obtain information about the history of the child, the family and other members of the household.
- 9.10 Consideration should be given to any need for action in respect of other children in the family/household.

Home or scene visit

- 9.11 A home visit and/or a visit to the scene of the death may be necessary – for any sudden death of a child aged less than two years a home visit will be undertaken within 24 hours: decisions regarding older children will be made on a case by case basis. The visit will normally be conducted by the senior investigating officer, the SUDIC paediatrician and the SUDIC Nurse Co-ordinator. The purpose of the home or scene visit is to:

- Review the initial history and obtain further details about the circumstances of the death;
- Evaluate the environment where the child died;
- Provide support to the family; and
- Inform the family about the investigation process.

Post mortem

- 9.12 The SUDIC paediatrician and the SUDIC Nurse Co-ordinator will collate the information collected by those who were involved in responding to the child's death and share it with the pathologist conducting the post mortem examination.

Initial multi-agency meeting

- 9.13 When the initial post mortem results are available, the SUDIC Nurse Co-ordinator and the SUDIC paediatrician will usually convene a multi-agency discussion involving the police, local authority children's social care and any other relevant professionals. This discussion will review whether the available information raises any concerns about safeguarding issues. If the initial post mortem findings or findings from the child's history suggest abuse or neglect as a possible cause of death, the procedure for initiating a serious case review will be followed as set out in Section 32 of these procedures [Serious Case Reviews].

Working Together

- 9.14 The meeting will share information about the family between agencies and arrange for the family support needs to be met
- 9.15 If there are concerns about the needs of surviving children in the family the SUDIC Paediatrician and or the SUDIC Nurse Co-ordinator should discuss these with the relevant services, such as Bereavement Services.
- 9.16 If safeguarding concerns are identified during the meeting, it will become a strategy meeting under the interagency child protection procedures, and the chair of the meeting will notify the chair of the safeguarding children board. Any death of a child in which abuse or neglect is known or suspected to be a factor will be dealt with as set out Section 32 of these procedures [Serious Case Reviews].
- 9.17 At this stage the SUDIC Paediatrician and SUDIC Nurse Co-ordinator will update the core data set, and pass this information to the CDOP Coordinator, who will collate the child death core data set on the child death database.

Final multi-agency case review meeting

- 9.18 As soon as the final post mortem result is available the SUDIC Nurse Co-ordinator will initiate and invite agencies to a case review meeting chaired by the SUDIC paediatrician. The professionals involved in this meeting will depend on the age of the child; they should include those who knew the child and family and those involved in investigating the death, for example the GP, health visitor or school nurse, paediatrician, pathologist, senior investigating police officer and, where appropriate, social workers.
- 9.19 The purpose of this meeting is to –
- Share information from the history, scene examination, autopsy and other investigations;
 - Identify the cause of death and/or the factors that may have contributed to the death;
 These may be factors intrinsic to the child, or related to parental care, to family and environmental factors, or to service provision.
 - Agree how detailed information about the cause of the child's death will be shared with the parents, and by whom;
 - Identify the continuing needs of the family and agree who will offer the parents ongoing support;
 - Identify potential lessons for future practice; and

- Inform the inquest.
- 9.20 The meeting should explicitly discuss the possibility that neglect or abuse may have caused or contributed to the death. If no evidence is identified to suggest maltreatment, this should be recorded in the minutes of the meeting.
- 9.21 At this stage the SUDIC Paediatrician and the SUDIC Nurse Co-ordinator will update the child death core data set, making any necessary corrections to the previous information.

Report to coroner

- 9.22 The SUDIC Paediatrician will deliver to the coroner a report which includes all information collected relating to the circumstances of the death and a review of all relevant medical, social and educational records.
- 9.23 The paediatrician will send a copy of the record of the case review meeting and all reports to the coroner. The SUDIC Nurse Co-ordinator will send a copy of the minutes to the review meeting members and also to the Child Death Review Co-ordinator

Informing the parents

- 9.24 The SUDIC paediatrician will seek the permission of the coroner to discuss the results of the post mortem examination with the parents. However, this would not be appropriate if abuse or neglect are suspected and/or the police conducting a criminal investigation. In this situation the paediatrician will discuss with the police, children's social care and the pathologist what information should be shared with the parents and when. A home visit will then be conducted by the SUDIC paediatrician and the SUDIC Nurse Co-ordinator.

10. COORDINATION WITH OTHER PROCESSES

- 10.1 If there is an ongoing criminal investigation, the rapid response team must consult the Senior Investigating Officer and the Crown Prosecution Service about any actions they should not take in reviewing the death in order to avoid prejudicing any criminal proceedings.
- 10.2 Where a death of a young person occurs in custody, local agencies must cooperate with the Prisons and Probation Ombudsman.
- 10.3 When a child dies unexpectedly whilst healthcare services are being provided, or as a consequence of a regulated activity, the registered person for the provider must notify the Care Quality Commission or the National Patient Safety Agency, giving details of the circumstances of the death.

Working Together

- 10.4 When a young person dies or commits suicide whilst under the supervision of a youth offending team, or within 3 months of the expiry of such supervision, the youth offending service must undertake a local review of practice. A copy of this review should be sent to the child death overview panel coordinator for consideration by the panel.
- 10.5 If it appears at any time that the criteria for a serious case review might apply, the Chair of the Child Death Overview Panel will notify the serious cases sub-group, who will make recommendations to the Chair of BSCB as set out in Section 32 of these procedures [Serious Case Reviews].

11. SUPPORT FOR FAMILY MEMBERS

- 11.1 The SUDIC paediatrician and the SUDIC Nurse Co-ordinator will be responsible for ensuring parents/carers are kept up to date with information about the child's death and about the involvement of professionals, unless this information sharing would jeopardise police investigations or other criminal justice processes. This will include information about the whereabouts of their child and any planned moves.

12. ANNUAL REPORT

- 12.1 The child death overview panel should prepare an annual report of relevant information for the Safeguarding Children Board. This information should include:

- The total number of deaths reviewed;
- Any description of the deaths that the panel deems appropriate;
- The panel's recommendations about future actions to prevent child deaths;
- A review of the actions taken to implement the recommendations of the previous year's report; and
- A note of any previous recommendations which have not been fully implemented and are carried forward.

Information which could lead to the identification of individual children or family members should not be included in this report.