JOINT
COUNTY DURHAM AND DARLINGTON
CHILD DEATH REVIEW PROCESS

(These are for use in Darlington only)

Version as at: January, 2017

Title	**JOINT COUNTY DURHAM AND DARLINGTON CHILD DEATH REVIEW PROCESS**
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Update and Approval Process

Version	Group/Person	Date	Comments
	CDOP	January 2017	Finalised and signed off by Panel
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Reviewing Officer	

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Child Death Review Process

1. Introduction

1.1 Working Together to Safeguard Children 2015 defines an unexpected death "*as the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death*."

1.2 The Rapid Response Practitioner/Designated Doctor should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt, the processes for unexpected child deaths should be followed until the available evidence enables a different decision to be made.

1.3 The Local Safeguarding Children Boards Regulations 2006 require LSCBs to put in place the following functions:

- 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);
  - Any matters of concern affecting the safety and welfare of children in the area of the authority
  - Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area.
- Putting in place procedures for ensuring that there is a co-ordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

1.4 A partnership agreement is in place between Durham Safeguarding Children Board and Darlington Safeguarding Children Board and the Child Death Overview Panel will govern the:

- Sharing of data and information between the two Local Safeguarding Children Boards (LSCBs) and the CDOP.
- Financial support provided to the infrastructure and work of the CDOP by each of the two LSCBs and the Clinical Commissioning Groups of County Durham and Darlington.

1.5 The following procedures are meant to guide practice for all professionals working with children and families and for the members of the LSCB Child Death Overview Panel, (CDOP) which incorporates the Durham and Darlington LSCB areas.

1.6 The LSCBs of Durham and Darlington has a statutory responsibility to review the deaths of all children in the Durham and Darlington areas.

1.7 When a child dies in either of the above LSCB areas, there are two interrelated processes for reviewing child deaths (either of which can trigger a referral for consideration of a serious case review):

1. Rapid Response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child. This process is augmented by a Local Case Discussion.

2. An overview of all child deaths up to the age of 18 years (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) undertaken by the Child Death Overview Panel which is a sub-committee of the LSCB.

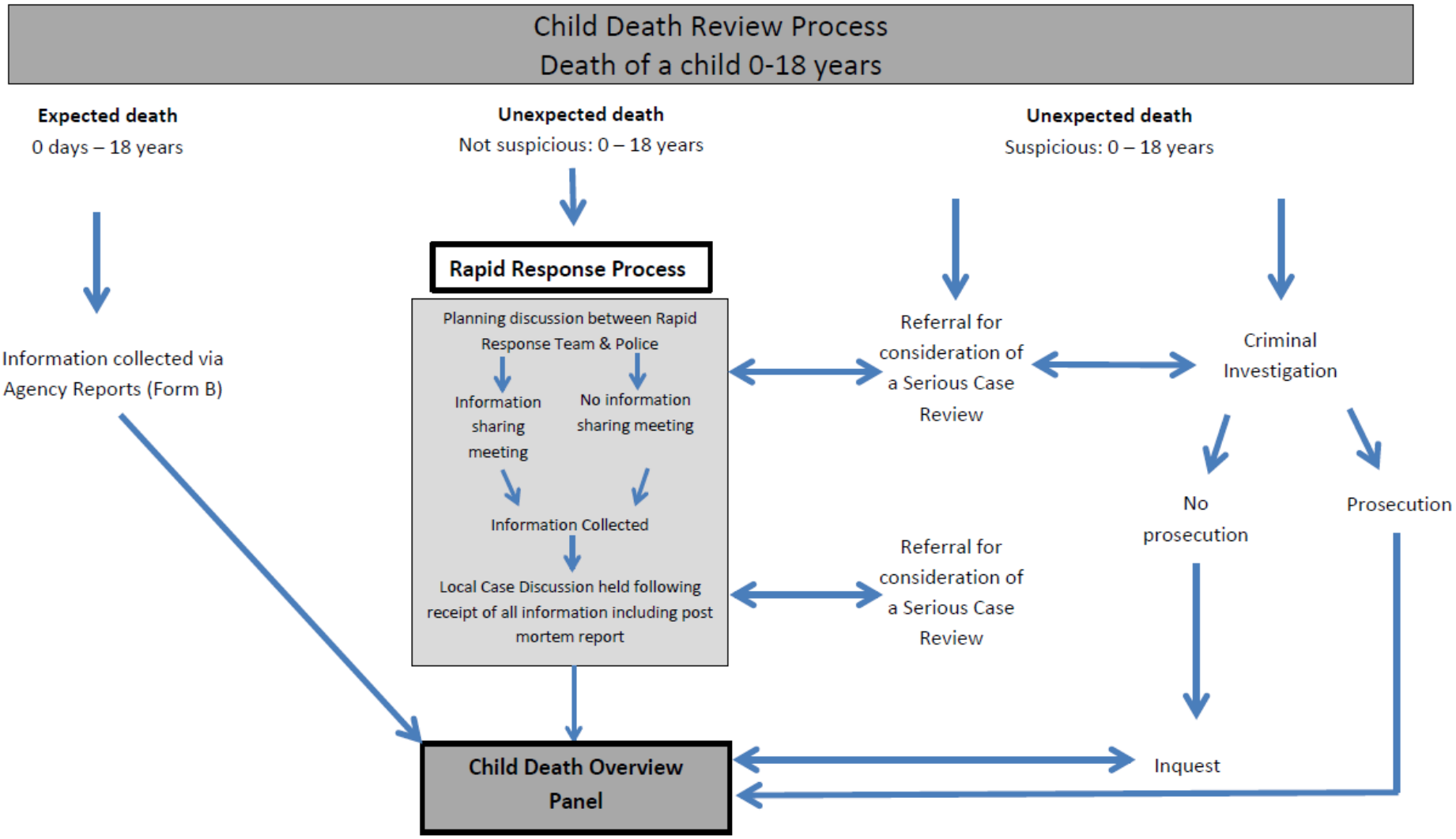
1.8 CDOP is responsible for reviewing the available information on all child deaths, and is accountable to the LSCB Chairs of the respective LSCB. The disclosure of information about a deceased child is to enable the LSCB to carry out its statutory functions relating to child deaths.

1.9 The Local Case Discussions and the CDOP examine the circumstances surrounding a child's death and make recommendations where appropriate. The LSCB use the findings from all child deaths, to identify patterns or themes and inform local strategic planning on how best to safeguard and promote the welfare of the children in their area.

1.10 The following terms are used in this document:

- An **unexpected death** is defined as the death of a child, in any setting, 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.

- Sudden Unexpected Death in Childhood **(SUDIC):** This is the sudden unexpected death of an apparently well child.


Child Death Review Process
Death of a child 0-18 years
Expected death
0 days – 18 years
Unexpected death
Not suspicious: 0 – 18 years
Unexpected death
Suspicious: 0 – 18 years
Rapid Response Process
Planning discussion between Rapid Response Team & Police
Information sharing meeting
No information sharing meeting
Information Collected
Local Case Discussion held following receipt of all information including post mortem report
Information collected via Agency Reports (Form B)
Referral for consideration of a Serious Case Review
Referral for consideration of a Serious Case Review
Criminal Investigation
No prosecution
Prosecution
Inquest
Child Death Overview Panel

2. Duty of All Agencies involved with the child

2.1 Any professional aware of a local child death should inform the LSCB Business Unit or alternatively complete the child death notification form (known as Form A).

2.2 Duty of the Registrar: Registrars must notify the appropriate LSCB about the deaths of children under the age of 18, within seven days from the date the death was registered.

2.3 Duty of the Coroner: The Coroner has a duty to inform the LSCB for the area in which the child died of the fact of an inquest or post mortem. Coroners are also given the powers to share other information with the LSCB for the purposes of reviewing child deaths and carrying out Serious Case Reviews.

3. Notification of a Child's Death

3.1 Deaths should be notified by the professional confirming the fact of the child's death. For unexpected deaths, this will be at the same time as they inform the Coroner and the CDOP Co-ordinator. If this is not the area in which the child is normally resident, the designated person should inform their opposite number in the area where the child normally resides.

3.2 In these situations, it should be decided on a case-by-case basis which LSCB should take responsibility for gathering the necessary information for a Panel's consideration. In some cases this may be done jointly.

3.3 Any person notifying the CDOP Co-ordinator of the death of a child should provide as much detail as is known to them in relation to the child and family and the circumstances of the death. They should inform the CDOP Co-ordinator of any professionals known to be involved with the child or family by completing Form A.

3.4 Following notification of the death of a child, the CDOP Co-ordinator should seek to establish which agencies and professionals have been involved with the child or family either prior to or at the time of death. A lead professional should be nominated in each agency to assist with this.

3.5 The professionals involved will be required to complete Form B

4. Professionals Responding to Information Requests

4.1 All professionals have a duty to provide the necessary information to the CDOP co-ordinator, to allow for a meaningful review. This may include providing reports and copy records. Agency reports should be completed and sent to the CDOP co-ordinator within three weeks of the request. Any non-compliance with a request for completion of an agency report form will be followed up in line with the CDOP escalation policy.

4.2 Professionals receiving an agency report form (Form B) should retrieve any relevant case records for the child or other family members to complete any information known to them or their organisation and return the form to the CDOP co-ordinator using a secure means of transfer.

5. Expected Deaths

5.1 Whilst it is to be expected that children with life-limiting or life-threatening conditions will die prematurely, it is not always easy to predict when, or in what manner they will die. Professionals responding to the death of a child with a life-limiting or life-threatening condition should ensure that their response to these families is appropriate and supportive, does not cause any unnecessary distress at a time when they are dealing with the tragic but anticipated, natural death of their child, and that their child's expected death can be dignified and peaceful. End of life care plans may be in place and therefore families, where appropriate, should be supported, to choose where their child's body is cared for after death, for example, in a children's hospice.

5.2 In all cases of expected deaths a note of opinion/referral of death is to be sent to the Coroner by the Clinician dealing with the case. A death certificate can only be issued following instruction by the Coroner.

5.3 Following notification of the expected death of a child, the CDOP Co-ordinator should notify the relevant agencies. The CDOP Co-ordinator should seek to establish which agencies and professionals have been involved with the child or family either prior to or at the time of death.

6. Unexpected Deaths

6.1 The Rapid Response Process: Each death of a child is a tragedy for his or her family, and subsequent enquiries/investigations should keep an appropriate balance between forensic and medical requirements and the family's need for support. A minority of unexpected deaths are the consequence of abuse or neglect or are found to have abuse or neglect as an associated factor. In all cases, enquiries should seek to understand the reasons for the child's death, address the possible needs of other children in the household, the needs of all family members, and also consider any lessons to be learnt about how best to safeguard and promote children's welfare in the future.

'Every child who dies deserves the right to have their sudden and unexplained death fully investigated in order that a cause of death can be identified, and homicide excluded.

Apart from anything else, this will help to support the grieving parents and relatives of the child. It is important to enable medical services to understand the cause of death and, if necessary, create interventions to prevent future deaths in children.

The Police have a key role in the investigation of infant and child deaths and their prime responsibility is to the child, as well as the siblings and any future children who may be born into the family concerned.'

SUDI Working Group Report 2004 (Appendix I, para 1.2, p66)

6.2 The role of the Rapid Response Team is to:

- Make immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the coroner;
- Undertake the types of enquiries/investigations that relate to the current responsibilities of their respective organisations when a child dies unexpectedly. This includes liaising with those who have ongoing responsibilities for other family members;
- Collect information in a standard, nationally agreed manner;
- Informed parents that their child's death will be reviewed and be provided with information outlining the Child Death Review process.
- Providing support to the bereaved family, and where appropriate referring on to specialist bereavement services; *and*
- Follow the death through and maintaining contact at regular intervals with family members and other professionals who have ongoing responsibilities for other family members, to ensure they are informed and kept up-to-date with information about the child's death.

6.3 The type of response to each child's unexpected death will depend on the individual circumstances of the case.

6.4 When a baby or older child dies unexpectedly in a non-hospital setting, the Investigating Officer and Rapid Response Practitioner should make a decision about

whether a visit to the place where the child died should be undertaken. This should almost always take place for infants who die unexpectedly. As well as deciding if the visit should take place, it should be decided how soon and who should attend. It is likely to be an Investigating Police Officer and a Rapid Response Practitioner who will visit and inspect the scene.

6.5 The purpose of a joint home visit is to identify all possible factors that may assist to determine why a child has died.

6.6 For children who die unexpectedly in a hospital setting, both the Rapid Response Service and Police should be contacted and a plan for next steps should be agreed in collaboration with the Paediatrician.

6.7 An Information Sharing Meeting may be convened dependent on the circumstances of the case and should include key professionals as required. The purpose of the meeting to gather background information, consider the circumstances of death and to agree a plan of action. Only nominated invitees are expected to attend; if you require a member of staff/supervisor for support contact should be made with the Rapid Response Practitioner arranging the meeting. Those attending are required to bring information that their service holds in respect of the child and family. If there are concerns about surviving children in the household, a Strategy Meeting should be held and a s47 assessment considered.

6.8 Specific guidance for Health and Police staff are detailed in their agency's policy for responding to sudden and unexpected deaths.

7. Multi-Agency Local Case Discussion

7.1 A Local Case Discussion may be convened by the Designated Paediatrician for Child Deaths dependent on the circumstances of the case when the results of the post-mortem tests are known. This will enable a discussion of all the issues and may give the best opportunity to identify the possible cause of death and any contributory factors. The meeting should include those professionals who knew the child and family, and those involved in investigating the death.

7.2 At this meeting all relevant information concerning the circumstances of the death, the child's history and subsequent investigations should be reviewed. Only nominated invitees are expected to attend the meeting any additions need to be discussed with the organiser of the meeting. Those attending are required to bring information that their service holds in respect of the child and family.

7.3 The main purpose of the meeting is for sharing information to identify the cause of death and/or those factors that may have contributed to the death which includes modifiable factors and then to plan the future care for the family. Potential lessons to be learned may also be identified by this process.

7.4 After the meeting, the Designated Doctor will prepare a summary of the issues discussed, including any factors thought to have contributed to the child's death, lessons to be learned and action points. This summary will be forwarded to relevant LSCB for consideration at the Child Death Overview Panel and the Coroner. An Analysis Pro forma (Form C) will usually be completed after discussion at the Child Death Overview Panel.

8. The Child Death Overview Panel

8.1 The CDOP should undertake an overview of all child deaths up to the age of 18 years (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) in the LSCB areas covered by Darlington and Durham CDOP. This overview will be based on information available from those who were involved in the care of the child, both before and immediately after the death, and other sources including, perhaps, the coroner. The panel will:

- Have a fixed core membership drawn from the key organisations represented on the LSCB to review these cases, with flexibility to co-opt other relevant professionals as and when appropriate;

- Hold meetings bi-monthly to enable each child's death to be discussed in a timely manner (the length of the discussion may vary depending on the nature of the death in question and the quantity of information available);

- Review the appropriateness of the professionals' responses to each death of a child, their involvement before and at the time of the death, and relevant environmental, social, health and cultural aspects of each death, to ensure a thorough consideration of how such deaths might be prevented in the future;

- Determine whether or not there were modifiable factors. The decision must be agreed by the CDOP and approved by the Chair of the CDOP. This decision cannot be finalised however until the outcome of other investigations (for example Serious Case Reviews, criminal proceedings, post mortem or Inquests) is known;

- Make recommendations to the LSCB or other relevant bodies as soon as these have been decided in order that prompt action can be taken to prevent such deaths in future where possible; and

- Identify any patterns or trends in the local data and report these to the LSCB. This includes the production of a Child Death Review Annual Report.

8.2 The CDOP has a clear relationship and agreed channels of communication with the local coronial service and the registrar superintendent.

8.3 The chair of the CDOP is responsible for ensuring that this process operates effectively.

8.4 Role of Designated Officer: The LSCB Business Manager is the Child Death Designated Officer that oversees child death notifications for their LSCB area. The LSCB Admin Co-ordinator is the CDOP co-ordinator whose role is to receive the notifications and to ensure that all information is received within the correct timescales and that this is available for the CDOP to consider.

9. OTHER RELATED PROCESSES

9.1 Criminal investigations: The Police are the lead agency for any criminal investigation. The Police must be informed immediately where there are any suspicious factors in the death, to ensure that the evidence is properly secured and

that any further interviews with family members and other relevant people accord with the requirements of the Police and Criminal Evidence Act 1984.

9.2 Where there is an ongoing criminal investigation, the Senior Investigating Officer and the Crown Prosecution Service must be consulted as to what it is appropriate for the professionals involved in reviewing a child's death to be doing, and what actions to take in order not to prejudice any criminal proceedings. Where a death of a young person occurs in custody, local agencies must co-operate with the Prisons and Probation Ombudsman.

9.3 Youth Offending Service: The Youth Justice Board for England and Wales (YJB) requires the Youth Offending Service to report and undertake Local Reviews of youth offending practice in cases where a child or young person has either died or attempted suicide whilst under supervision or within three months of the expiry of supervision. Where a child has died, the Local Management Review undertaken by the Youth Offending Service in relation to the death should feed into the child death processes initiated by the CDOP.

9.4 Serious Case Review: If it is thought, at any time, that the criteria for a Serious Case Review might apply, the chair of the LSCB should be contacted and the Serious Case Review Procedures should be followed known locally as the Learning and Improvement Framework. If a Serious Case Review is initiated, the CDOP will not be able to conclude the Child Death Review until after the Serious Case Review has been published. **This should not however prevent lessons from being learnt and from being acted upon.**

10. Local Documents

- Child Death Notification Form – Form A
- Child Death Agency Report – Form B
- Child Death Analysis Proforma – Form C

11. Local Contact Details

Darlington Safeguarding Children Board

Address: Town Hall, Darlington, DL1 5QT

Secure Email: LSCB@darlington.gcsx.gov.uk

Contact number: 01325 406452

Durham Safeguarding Children Board

Address: County Hall, Durham, DH1 5UJ

Secure Email: emaynard-gcsx@durham.gcsx.gov.uk

Contact number: 03000 265770