

# **Royal College of Paediatrics and Child Health guidance on Child Death Review Processes**

**March 2008**

## 1. Introduction

From 1st April 2008 Child Death Review (CDR) processes will become mandatory for Local Safeguarding Children Boards (LSCBs) in England, but Scotland, Wales and Northern Ireland will be using different processes. The processes to be followed when a child dies were outlined within *Working Together to Safeguard Children* (2006), which took the principles set out in the Baroness Kennedy report on Sudden and Unexpected Death in Infants (RCPATH and RCPCH, 2004) and extended them to **all** child deaths.

The overall purpose of the child death review process is to understand why children die and put in place interventions to protect other children and prevent future deaths. It is intended that these processes will:

- Document and try to understand the cause of death so that parents can come to terms with the death of their child, and then take steps to prevent the deaths of any other children.
- Identify patterns of deaths in a community so that preventable or avoidable hazards that may contribute to deaths can be recognised and reduced.
- Contribute to the improved collection of forensic evidence in the very small proportion of deaths where there might be concerns of maltreatment or some other criminal act.

There are two interrelated processes outlined in *Working Together* (2006). Paediatricians will be involved in one or both:

- A rapid response team (RRT) is a group of key professionals who come together for the purpose of enquiring into and evaluating the cause of death where the death of an individual child is unexpected<sup>1</sup>.
- A Child Death Overview Panel (CDOP) undertakes an overview of all child deaths (under 18 years) in the LSCB area(s). The panels are responsible for reviewing information on all child deaths (expected and unexpected), and are accountable to the LSCB Chair.

The aim of this guidance is to provide recommendations for paediatricians on how they can best contribute to this process. The capacity of paediatricians is finite, and therefore this guidance will signal where paediatric skills can best be utilised.

## 2. Implications for paediatricians

In order for the Child Death Review (CDR) process to be effective, paediatricians must play a number of key roles, as set out in *Working Together* (2006) (paragraph 7.18 page 158).

For the rapid response component:

- Lead and co-ordinate the multi-agency investigative process following an unexpected childhood death, where this is not the role of another statutory agency.

---

<sup>1</sup> An unexpected death is defined as *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* (Fleming et al., 2000; RCPATH and RCPCH, 2004).

- Contribute to the gathering of information in relation to the unexpected childhood death, bringing specific paediatric skills through history taking, examination and medical investigations.
- Involvement as part of the rapid response team, following an unexpected child death, to confirm the death, to start the process of investigation and to gather and appraise health information relating to the child and family.
- Contribute to the support offered to bereaved parents, through providing information, answering questions, and either providing or appropriately referring on to others for practical or emotional bereavement support.
- Feedback to parents regarding the cause of death following the final case discussion.

For the Child Death Overview Panel component:

- Provide health information on individual children to the Child Death Overview Panel.
- Provide paediatric expertise to the Child Death Overview Panels, contributing to understanding, evaluating and responding to lessons learned from patterns of child deaths.
- Advise on commissioning and organisation of paediatric services to undertake enquiries into unexpected deaths in childhood, as part of the designated paediatrician for unexpected death in childhood.

### **3. Competences required for the Child Death Review Process**

The competences required by health professionals flow from the key aims to investigate the possible causes of death and to provide ongoing support to the bereaved family. The health professional competences should be seen in conjunction with the complementary competences of other professional groups including the police. It would be unusual for any one health professional to possess all the competences outlined below, but rather these should be seen as competences required within the team. Where a health professional lacks one or more of these competences, this should not preclude their involvement in the processes of information gathering and family support, but they should acknowledge those areas and seek appropriate input, support or guidance from other professionals in the multi-agency team.

For the rapid response team the key competences required from the health professionals are to be able to:

- Take a medical history, confirm the child's death, examine the child and organise appropriate investigations.
- Initiate the multi-agency rapid response process and share with other professionals any information gained about the circumstances of the child's death or their background. The health professional may lead the investigation, or may be part of the team with other professionals taking the lead.
- Inform the family of their child's death; explain the rapid response process, the purpose and process of the autopsy, common causes of sudden unexpected death and any interventions carried out; listen to the family's concerns and answer questions; be aware of the needs of other family members; provide the family with or direct the family to sources of support.
- Observe and comment on the environment where the child died and work with other involved professionals to interpret the information gathered.

- Provide a written summary, utilising information gained from all appropriate sources.
- Contribute to a final case discussion to review the factors surrounding the child's death.
- Share information on the child and family with the Child Death Overview Panel.

For the Child Death Overview Panel the key competences required from the health professionals are to be able to:

- Contribute to the process of reviewing all childhood deaths through the Child Death Overview Panel, providing relevant knowledge and skills to interpret the information gained, and advise of appropriate learning and action arising from the process.
- Actively contribute to the implementation of programmes to prevent future deaths.

In addition *Working Together* (paragraph 7.11) specifies that each PCT should have access to a paediatrician with responsibilities for advising on child death review processes (hereafter the "designated paediatrician for unexpected deaths in childhood"). This paediatrician, who will contribute to the Child Death Overview Panel, should:

- Have an understanding of the causes and patterns of deaths in infancy and childhood and know where to access information about local numbers and patterns of child deaths.
- Be able to offer support and advice to other health professionals involved in responding to child deaths.
- Advise the PCTs and acute trusts on the provision of paediatric and other health services required for the rapid response and the Child Death Overview Panel.
- Liaise with the Local Safeguarding Children Board, local coroner and other professionals in establishing local procedures for responding to unexpected child deaths and reviewing all child deaths.
- Work with colleagues from within health and in other agencies to improve the processes of responding to unexpected child deaths.
- Contribute to local training in responding to and learning from child deaths.
- Actively contribute to the implementation of programmes to prevent future deaths.

#### **4. Issues for consideration - implementation challenges**

##### *Resources*

The Department of Health (DH) and the Department for Children, Schools and Families (DCSF) have both announced specific funding streams (£10m and £7.4m per year for 3 years respectively) allocated to PCTs and LSCBs to support the implementation of child death review processes. Paediatricians will need to work with their LSCBs and PCTs to determine how this money is appropriately and effectively used. The designated doctor role for unexpected death is separate to the role of the designated doctor for child protection, although the same doctor may undertake both roles. Co-ordination of a review, in particular ensuring input from the relevant organisations will be time consuming. A model of the likely time implications of these processes is being developed as a guide to assist paediatricians and

commissioners in drawing up job plans to encompass the paediatric role in responding to and reviewing child deaths.

Early estimates would suggest that for a total population of 500,000, approximately one day a week of paediatrician time would be required to cover both the paediatric roles within the rapid response team and the paediatric roles of the Child Death Overview Panel. This assumes that the paediatrician undertakes the majority of the health roles themselves rather than using a delegated model using other health professionals for some of the roles required. The *Operating Framework* (DH, 2007) and *Public Service Agreements* (HM Treasury, 2007), together with *Staying Safe: Action Plan* (DCFS, 2008) make it clear that there is a requirement placed upon contributory agencies to the LSCB to ensure a CDR process is implemented, lessons learned, interventions to prevent future deaths implemented and the overall impact evaluated.

#### *Home visits*

Following each unexpected child death, there should be a careful discussion between all the professionals involved, including the paediatrician, to determine if, when and how any home visit should be carried out, and who should be present. It is likely that in reality different areas will utilise different approaches, such as the use of specially trained and supported health visitors. *Working Together* (paragraph 7.38) suggests that home visits are undertaken jointly, usually by the senior investigating police officer and a health care professional.

A central part of the management of any unexpected death is an early visit to the family home and where this is different, the scene of death. This is not so much a crime scene investigation, but a holistic evaluation of the circumstances of death and an opportunity to provide support to the family. These visits should take place as soon as possible after the death and within 24 hours, and should involve the police, an experienced health professional, who may be a paediatrician, or another health professional (e.g. a specially trained health visitor or nurse). There may be situations where, for pragmatic reasons, or because of the nature of the death, a joint visit is neither possible nor appropriate, or where the police need to visit the scene of death early to gather forensic evidence. However, even where that is the case, consideration should be given as to whether a subsequent joint visit may add further useful information or contribute to family support.

#### *A proportionate response*

The CDR process is based on the Baroness Kennedy report (RCPATH and RCPCH, 2004) recommendations, which focused on sudden and unexpected deaths in infancy (SUDI). The CDR process will need to consider both expected and unexpected deaths both of which can be either explained or unexplained. Hence it should not be assumed that the process of investigation of all deaths should necessarily follow that of a SUDI. It is a good model for sudden unexpected infant deaths, but does not translate in its entirety to deaths in older children, or to expected deaths, deaths in hospital and indeed some unexpected deaths in the community.

The level of detail of an investigation needs to be proportionate to the potential learning about future preventability of deaths, the need for gathering information in order to understand the cause and circumstances of death, the support needs of the family, and any forensic requirements to secure a conviction. A consideration of

these factors should help determine the nature and course of any response. For example, following the death of a child with complex health needs or a life-limiting condition, the most appropriate team to be involved will be those professionals already known to the family; the police would not need to be involved if there is a natural or expected cause of death, but may need to be involved if any concerns come to light. Conversely, in an unexpected death, if there are clearly suspicious circumstances, the police may take a lead role, with a more restricted role for the paediatrician and other health professionals.

#### *Relationship with parents and families*

The CDR process and in particular the home visit is an important opportunity for parents to share information and seek support. Unlike normal medical confidentiality it is important that parents are aware that information obtained during a medical interview will be shared with the police. The paediatrician's role is to gather information and to contribute to the interpretation of that information within the context of their medical knowledge and skills; it is not the role of a paediatrician to apportion blame or culpability, or to challenge parental accounts of events. Paediatricians should inform parents that in the circumstances of an unexpected death in childhood, the normal expectation of medical confidentiality is overruled by the need to share information with the multi-agency team that has the statutory responsibility to investigate the cause of death.

#### *Post death sampling and pathology*

Under the Human Tissue Act, it is illegal to take samples from a dead person anywhere other than in licensed premises. Discussions need to take place with the local Coroner to extend licences to cover local emergency departments and to agree protocols for appropriate immediate investigations to be taken prior to the autopsy. A protocol for immediate investigations following a sudden unexpected death in infancy is provided in the Baroness Kennedy report (RCPPath and RCPCH, 2004). This may need to be adapted in the light of further research, but should form the basis for local discussions to agree a standard set of investigations for different circumstances of death. Furthermore with the increased rigour associated with the investigation of unexpected deaths, there will be larger numbers of cases requiring forensic paediatric post-mortems as opposed to paediatric pathology post-mortems. Access to these services is currently limited.

#### *Litigation*

Whilst there is no evidence to date from the pilot studies, there are some concerns that the process of CDR and investigation may give rise to litigation if health service failings or deficiencies are identified. Further, the process may increase the concerns that parents are possibly culpable in the death of their child. This must be avoided and it should be made clear to all involved that the process of investigation is focussed on learning and not on blame. If specific failings or concerns are identified through the child death review process, these should be investigated and addressed through the appropriate channels.

#### *Duplication of effort*

There are likely to be multiple services and organisations involved with the CDR. LSCBs will need to produce a clear guidance to inform decision-making within the rapid response team and all other agencies to reduce any unnecessary duplication between investigative agencies.

## **5. Access to training and resources**

In order to support health professionals and ensure that the full range of competences outlined in section 4 are developed within a team, there are several possible training opportunities and resources available. Clearly decisions will need to be made about what is most appropriate at a local level.

### *Why Jason Died*

A familiarisation DVD and accompanying document with FAQs published by DCSF, provides an introduction for health professionals to the processes to be followed when a child dies.

<http://www.everychildmatters.gov.uk/socialcare/safeguarding/childdeathreview/dvd/>

### *Study of early starter child death overview panels*

A multi-agency research team has evaluated the introduction of child death review processes in 9 sites across England. Emerging findings from this study, together with planning resources are available and a final report is expected in May 2008.

<http://www.everychildmatters.gov.uk/socialcare/safeguarding/childdeathreview/warwickstudy/>

### *Training materials to support child death review processes*

DH commissioned Warwick University to produce and pilot multi-agency training materials for members of LSCBs and key professionals on the CDR processes. These will be available from April 2008 and will be available on CD and via a website for local trainers to both train themselves and provide training. There are three components:

- Basic multi-agency awareness training
- Half day awayday session for Child Death Overview Panels
- 1 day in depth session for rapid response frontline staff

<http://www.everychildmatters.gov.uk/socialcare/safeguarding/childdeathreview/trainingmaterials/>

### *The Warwick Advanced Course in the Management of Unexpected Childhood Deaths*

A 3 day advanced course for senior professionals in all agencies involved in responding to unexpected childhood deaths. The overall aim of the course is to facilitate improved management of unexpected childhood death across the UK in line with recognised best practice and with the statutory guidance from DCSF.

<http://www.warwick.ac.uk/go/sudc>

## **6. Examples of rapid response teams**

The exact approach each team takes, particularly regarding the rapid response home visits will be dependent on several factors including the capacity and existing skills of the health professionals involved. High level details of some solutions are outlined below.

### *Example 1*

The paediatrician on-call is involved in the immediate responses in the hospital, including initial history taking, examination of the child, early investigations and discussions with the family. The paediatrician liaises with colleagues in other agencies to plan the rapid response. Home visits with a paediatrician are offered in normal working hours, at a pre-arranged time in conjunction with the police. This

approach will be able to utilise well developed skills of history taking and communication. The approach does require sufficient paediatric time to support follow-up phone calls, meetings and report writing. Out of hours, acute paediatricians covering a hospital will be involved in the immediate responses in hospital and participate in information sharing and planning discussions, but would not normally be able to attend an early home visit out of hours. The paediatrician first involved participates in the final case discussion, chairing this if appropriate, and in any further action or feedback to the family.

### *Example 2*

The paediatrician on-call is involved in the immediate responses in the hospital, including initial history taking, examination of the child, early investigations and discussions with the family. The use of the acute paediatrician on-call for the hospital to cover rapid response visits can be challenging, particularly at weekends. A separate paediatric rota is therefore established to enable paediatricians to participate in home visits both during working hours and out of hours. This may be through having a “second on-call” arrangement, with another paediatrician covering the wards; or through involving community paediatricians where there is a separate community paediatric rota to cover both child protection and unexpected childhood deaths; or through regional or subregional collaboration between specialist paediatricians with responsibility for unexpected childhood deaths. The paediatricians involved agree who is best placed to participate in the final case discussion and in any further follow up or feedback to the family. The service uses an information gathering proforma in conjunction with pathways and protocols for collecting clinical specimens and post mortem examinations. This ensures continuity of approach within the team.

### *Example 3*

A team of trained specialist health visitors or nurses is established at a regional or subregional level to support the rapid response process. The paediatrician on-call works closely with the specialist health visitor or nurse in the immediate response in the hospital, including initial history taking, examination of the child, early investigations and discussions with the family. The specialist health visitor or nurse liaises with colleagues in other agencies to plan the rapid response. Home visits are undertaken by either the specialist health visitor or nurse or the paediatrician depending on the nature of the case and any practical arrangements. The paediatrician and the specialist health visitor or nurse agree who is best placed to participate in the final case discussion, and in any further follow up or feedback to the family. The advantages of this system are that it draws on the strengths of health visitors and nurses in their knowledge of families and communities, providing support and care to families, experience in multi-agency working. Such a system would be supported by the use of agreed proformas for information gathering and sharing. The specialist health visitors or nurses would be supported by the designated paediatrician and would need to liaise closely with the acute paediatricians over individual cases. The rapid response service could be delivered by health visitors and nurses or a mixed rota between nurses and paediatricians.

## **7. Outstanding issues**

There remain some issues that still need to be addressed:

- Training. The community and general paediatric CSACs will need to consider how to further develop and assess the competences required. The college

training committee should review the training materials provided through the DCSF resource and the Warwick course and advise on any outstanding training needs for paediatricians and how these can be met.

- The importance of public health input on child death overview panels. A robust public health approach to the investigation of deaths at a population level is clearly important to the success of this programme.
- Ensuring lessons learned are incorporated into health service risk management and improvement processes of acute Trusts.
- Pathology services including perinatal pathology and licensing of emergency departments under the Human Tissue Act.

## **8. Recommendations**

In terms of the rapid response teams, RCPCH recommends that:

1. Paediatricians are part of the process to support parents following the death of their child. Part of this support is to give parents an understanding of why their child died. This is particularly important where the child died suddenly and unexpectedly.
2. There is flexibility when considering the appropriate response to a particular death. There will be circumstances (such as road traffic accident or other trauma) when a home visit may not be appropriate or required, although a home visit may be beneficial for the family involved in some of these situations.
3. Paediatricians ensure that parents and families understand the aims and process of the CDR and in particular parents should understand the difference between usual medical confidentiality prior to death, and the situation when investigating unexpected deaths.
4. Multidisciplinary meetings are a key component of the rapid response process, at which paediatricians should be fully involved. They provide an opportunity to communicate, minimise duplication of effort and agree on future actions.

In terms of the Child Death Overview Panels, RCPCH recommends that:

1. Paediatricians should contribute to the process of understanding patterns of death in the communities in which they work. This understanding should inform strategies to prevent future deaths.
2. There is careful consideration of which categories of child death will require full investigation, such as all unexpected and unexplained deaths. A priority setting process may be appropriate to determine which categories of death will offer the most informative investigations and subsequent learning. LSCBs may need to find ways of collaborating with other LSCBs to create a critical mass to ensure both efficiency and effectiveness. This is an opportunity to engage others with the wider Children's Public Health agenda including the Strategic Health Authorities and the regional Government Offices.
3. That a cycle of learning from child deaths is completed. It is important that LSCBs have an explicit mechanism to input into commissioning and service improvement plans so that the lessons learnt can be implemented and future deaths reduced.
4. Paediatricians should be actively involved in programmes that reduce hazards to health, especially those that may result in death in the child population.

## 9. References

DCFS (2008) *Staying Safe: Action Plan*. Available online at:

<http://www.everychildmatters.gov.uk/files/E311A3DE50297A05E31F401F17DC67EB.pdf>

DH (2007) *The NHS in England: The operating framework for 2008/9*. Available online at:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_081094](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094)

Fleming, P. J., Blair, P. S., Bacon, C. and Berry, P. J. (2000). *Sudden Unexpected Death in Infancy. The CESDI SUDI Studies 1993-1996*. London: The Stationery Office.

HM Government (2006) *Working Together to Safeguard Children*. London: The Stationery Office. Available online at:

<http://www.everychildmatters.gov.uk/files/AE53C8F9D7AEB1B23E403514A6C1B17D.pdf>

HM Treasury (2007) *Public Service Agreements*. Available online at:

[http://www.hm-treasury.gov.uk/pbr\\_csr/psa/pbr\\_csr07\\_psaindex.cfm](http://www.hm-treasury.gov.uk/pbr_csr/psa/pbr_csr07_psaindex.cfm). See PSAs 12 and 13.

Royal College of Pathologists and the Royal College of Paediatrics and Child Health (2004). *Sudden unexpected death in infancy. A multi-agency protocol for care and investigation*. London: Royal College of Pathologists and the Royal College of Paediatrics and Child Health. Available online at:

<http://www.rcpath.org/resources/pdf/SUDI%20report%20for%20web.pdf>