Islands Child Protection Committee

Working Together for the Children of Guernsey and Alderney

CHILD DEATH REVIEWS

Contents

Purpose

This document sets out procedures to follow in relation to all child deaths in order to:

1) establish how the ICPC will collect and analyse information about each child 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 islands
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths

2) clarify roles and responsibilities for the coordinated response to an unexpected death

Each death of a child is a tragedy and enquiries should keep an appropriate balance between forensic and medical requirements and 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 with the aim of preventing further such child deaths.

The responsibility for determining the cause of death rests with the Law Officers or the doctor who signs the medical certificate of cause of death. It is not the responsibility of the Child Death Overview Panel.

Responsibilities of the Islands Child Protection Committee (ICPC)

The ICPC is responsible for ensuring that a review of each death of a child, normally resident in the islands, is undertaken by a Child Death Overview Panel (CDOP). The CDOP will have a fixed core membership drawn from organisations represented on the ICPC. Other relevant professionals may also be co-opted onto the panel to discuss certain types of death as and when appropriate. The CDOP should include a professional from public health as well as child health. It should be chaired by the ICPC Chair's representative. That individual should not be involved directly in providing services to children and families in the islands.

The ICPC should be informed of the deaths of all children normally resident in the islands. Notification of all child deaths should be sent to a designated person in the ICPC, to be decided by the ICPC Chair. The designated person in the ICPC will be responsible for gathering information from all relevant agencies, collating the information, recording anonymised data and sending collated information to CDOP members.

Responsibilities of Child Death Overview Panels

The functions of the CDOP include:

- reviewing all child deaths up to the age of 18, excluding those babies who are stillborn 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 the professionals directly involved – so they can then convey this to the family in a sensitive manner;
- determining whether the death was deemed preventable (i.e. those deaths in which modifiable factors may have contributed to the death) and decide what, if any, actions could be taken to prevent future such deaths;
- making recommendations to the ICPC promptly, so that action can be taken to prevent future such deaths where possible;
- identifying patterns or trends in local data and reporting these to the ICPC;
- referring back to the ICPC for consideration of a SCR where a suspicion arises that abuse or neglect may have been a factor in a child's death.

The aggregated findings from all child death should inform local strategic planning on how best to safeguard and promote the welfare of children. The CDOP should prepare an annual report of relevant information for the ICPC.

Definition of preventable child deaths

Preventable child deaths are those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of 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 at a local, regional or national level.

Definition of an unexpected death of a child

An unexpected death is defined as the death of an infant or child (less than 18 years old) 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 death.

The relevant 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 child deaths should be followed until the available evidence enables a different decision to be made.

Action by professionals when a child dies unexpectedly

The Islands Child Protection Committee Regulations 2010 require the ICPC to provide interagency guidance and promote effective cooperation between all those involved in safeguarding and promoting the welfare of children in the islands. This guidance is intended to ensure a coordinated response by partner agencies, and other relevant persons, when a child dies unexpectedly.

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 duty paediatrician at the same time as informing the Law Officers and the police. The police will begin an investigation into the sudden or unexpected death on behalf of the Law Officers. The paediatrician should initiate an immediate information sharing and planning discussion between the lead agencies (i.e. health, police and children's social care) to decide what should happen next and who will do it. The joint responsibilities of the professionals involved with the child include:

- responding quickly to the child's death in accordance with agreed procedures;
- maintaining a rapid response protocol with all agencies, consistent with the Kennedy principles and current investigative practice from the association of chief police officers;
- making immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the Law Officers;
- liaising with the Law Officers and the pathologist;
- undertaking the types of enquiries/investigations that relate to the current responsibilities of their respective organisations;
- collecting information about the death;
- providing support to the bereaved family, referring to specialist bereavement services where necessary and keeping them up to date with information about the child's death; and
- gaining early consent 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 an Accident and Emergency Department. In some cases, the police may decide that it is not appropriate to immediately move the child's body, e.g. because forensic examinations are needed.

As soon as possible after arrival at 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 police investigator and senior health care professional should decide whether there should be a visit to the place where the child died, how soon (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 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 Health and Social Services Department Governance and Assurance Team of the death of a service user. Where a young person dies at work the Health and Safety Executive should be informed.

If there is a criminal investigation, the team of professionals must consult the lead police investigator and the Law Officers 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 that worked with the child would be required to cooperate with that investigation.

Involvement of Law Officers and 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 Law Officers, in accordance with agreed protocols. The Law Officers must investigate violent or unnatural death, death of no known cause and all deaths of a person in custody. The Law Officers will have jurisdiction over the child's body. If the death is not considered to be of natural causes a public inquest will be held.

The Law Officers will order a post mortem examination to be carried out as soon as possible by the most appropriate pathologist available who will perform the examination according to the guidelines and protocols laid down by the Royal College of Pathologists. The relevant 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 of a child is considered to be through unnatural causes or the actual cause of death cannot be confirmed, the Law Officers will hold an inquest into the death. Professionals and organisations involved in the investigation into the death of the child will be expected to provide evidence for the Police in order to compile a comprehensive report for the Law Officers. This will cover all the circumstances that have been identified concerning the child's death, including reference to all medical, social care and educational records.

A full report will be sent to the Law Officers by the Police to enable an inquest into the death (usually within 6 months); although an initial report will be made available to ensure timely release of the body.

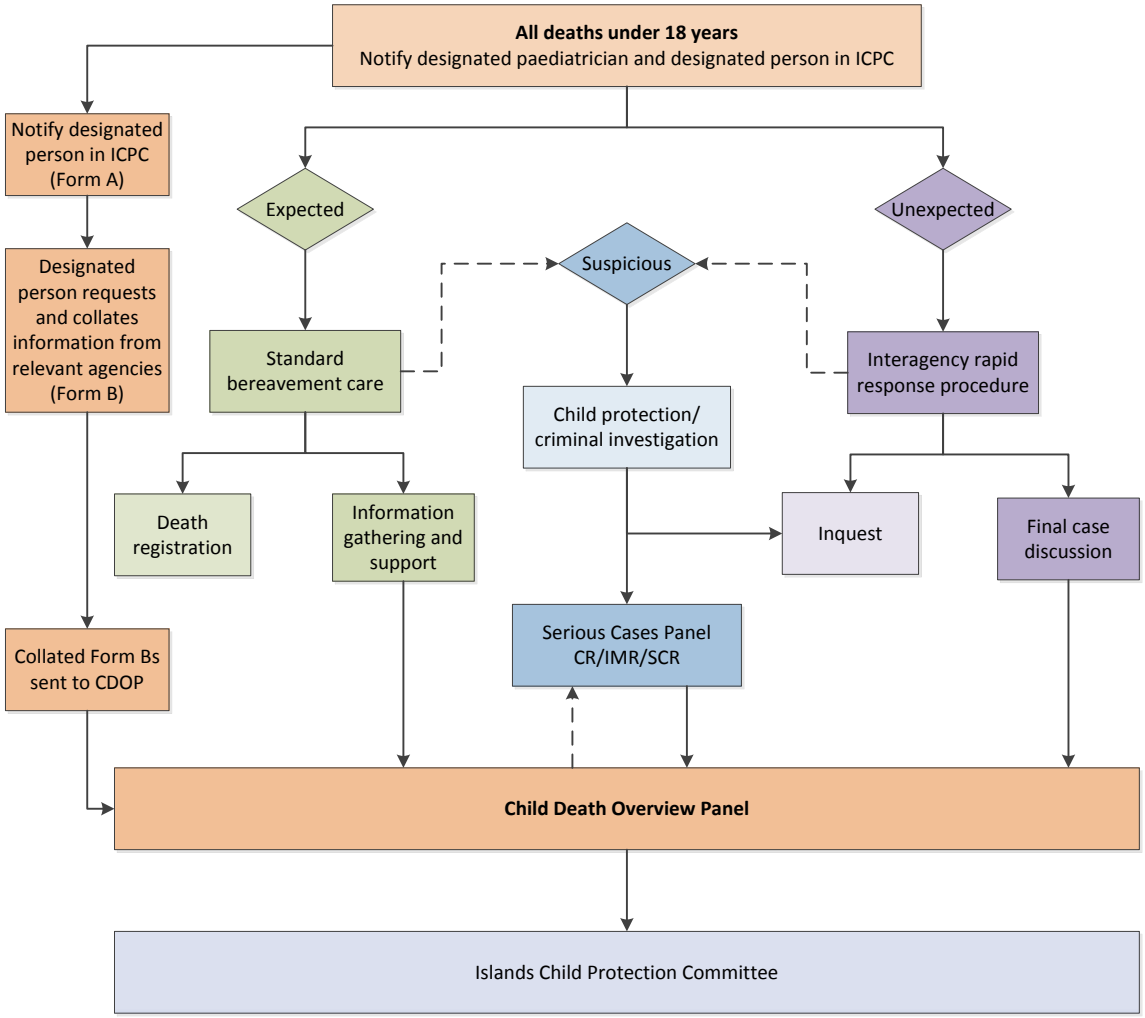
Action after the post mortem

Although the results of the post mortem belong to the Law Officers, the paediatrician, pathologist and lead police investigator should be able to discuss the findings as soon as possible and the Law Officers should be informed immediately of the initial results. If the 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. At this point the ICPC Chair should also be informed so they can consider whether the criteria are met for initiating a SCR.

Shortly after the initial post mortem results become available the relevant paediatrician for unexpected child deaths should convene a multi-agency case discussion, including all those who knew the family and were involved in investigating the child's death. The professionals should review any further available information, including any that may raise concerns about safeguarding issues. A further multi-agency case discussion should be convened by the relevant paediatrician (or a deputy) as soon as the final post mortem result is available. This is in order to share information about the cause of death or factors that may have contributed to the death and to plan future care of the family. The relevant paediatrician should arrange for a record of the discussion to be sent to the Law Officers, to inform the inquest and cause of death, and to the relevant CDOP(Form B4), to inform the child death review. At the case discussion it should be agreed how detailed information about the cause of death will be shared with the parents and by whom, and who will offer the parents on-going support.

Appendix 1

Child Death Review Process



The Child Death Overview Panel (CDOP), which reports to the Islands Child Protection Committee (ICPC), is responsible for reviewing all child deaths. The purpose of reviewing all child deaths is to determine the extent to which they were avoidable or potentially avoidable and to identify any trends, patterns or lessons that might be learnt. There are two interrelated processes for reviewing child deaths; **a)** for those that were **expected**; and, **b)** for those that were **unexpected**. Either process can trigger a serious case review at any stage if there is suspicion of abuse or neglect.

Appendix 2

Unexpected Death Process