Royal College of Anaesthetists

When a child dies

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The child death process
All anaesthetists may at some point be involved as part of a multi-professional team managing the death of a child or young person. This chapter is to give anaesthetists an understanding of the framework that has been developed and how agencies respond when a child dies. This is a summary only and further information can be gained by opening the links.

Reasons for a process
The death of an infant or child is a tragedy not only for their family but also for professionals involved in the care of that child.

Following three high profile criminal cases involving prosecution of mothers for the death of their child(ren) an intercollegiate (RCPath/RCPCH) working party produced a protocol for handling sudden unexpected death in infants (SUDI) in 2003. This has recently been revised (November 2016). **It has been extended to include all deaths in infancy and childhood.** Please click here for information. (Please note that this protocol is for England and does not describe the process for Scotland and Wales).

The protocol acknowledges that whilst in the majority of cases the death will have been from natural causes, in some case infants and children are fatally harmed by those caring for them.

The legal position and statutory guidance in England
A statutory duty to undertake investigation of any death in childhood exists in England. The process applies to the death of any child **under 18 years** whether from natural, unnatural, known or unknown causes, at home, in hospital or in the community. Still births and deaths resulting from planned termination of pregnancy carried out within the law are excluded from this process.

England
Children Acts 1989 and 2004 (England), Working Together to Safeguard Children 2018. Click here for information.

Key issues for Child Death Overview Process (CDOP) as a result of proposed changes to Working Together published October 2018

Please note that these changes apply to England only

Overarching changes
Political responsibility for child death review will move from DfE to DH

Local responsibility for review rests with the local authority and CCGs

A National child death mortality database to be established to collate national data has begun work. Expected implementation 2020

Revised guidelines (WT 2018) published autumn 2018 set out the responsibility of child death review partners

Revised forms for information gathering and analysis issued in autumn 2018. These are now called:
- notification form (previously known as form A)
- reporting form (previously known as Form B)
- analysis form (previously known as Form c). From 2020 this information will be shared with the national child mortality database. Currently data is sent to NHS digital.

Revised guide for families is also due to be published.

Joint agency response
This is a co-ordinated multi-agency response which will be triggered if the death:
- is or could be due to external causes
- is sudden and no apparent cause (including SUDI/C)
- occurs in custody, or where child detained under Mental Health Act
- initial circumstances raise suspicions that death may not have been natural
- still birth where no health care professional in attendance.

Aim of child death review is to:
- identify cause of death
- provide support to families
- identify modifiable/contributory factors
- ensure statutory obligations are met
- learn lessons. Promote health and wellbeing of other children.

Changes to process of child death review
All deaths in children should follow a similar path to include:
- immediate decision making and notifications to include decision as to whether needs joint agency response (involve Rapid response team to aid information gathering for unexpected death)
- investigation and information gathering.

Child death review meeting needs to be flexible and proportionate but be held for all child deaths not just unexpected deaths
- CDOP (Child Death Overview Process).
- National child mortality database.
- Support for families – families should have an identified key worker to act as named point of contact throughout the process of the child death review.

The process is slightly different in Scotland, Wales and Northern Ireland but based on the same principles and will be briefly described.

The principles

Is the death expected or unexpected?

Expected death
The death of an infant or child which was anticipated following on from a period of illness that has been identified as terminal, and where no active intervention to prolong life is ongoing.

If the death is expected the child will be declared dead and the death will be notified to the Co-ordinator of the Child Death Review panel (England) who records all the child deaths in the county. Local policies may vary but notification is cascaded out to ensure that the death is reported to all relevant providers of health, education and social care. All child deaths are discussed at at the Child Death Overview Panel (CDOP). No further investigation is required unless there is any evidence that the death was suspicious in which case the process for un-expected death would be followed.

On occasion it may be necessary for an anaesthetist or intensivist to provide information to the overview panel or review information provided by colleagues e.g. in the case of a peri-operative death or death in Paediatric Critical Care (PCC)

Unexpected death
The death of an infant or child (defined as anyone who had not yet reached their 18th birthday) 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 led to the death (relevant when there is a significant time delay between the collapse of the child and their eventual death).

In England when there is an unexpected death of a child there should be a multiagency co-ordinated response a 'Child death rapid response' from health, the police and children's social care. The exact details may vary between areas and each area's local safeguarding children board (LSCB) should have a local policy that describes this is more detail.

The response to unexpected child death (England)
This can be divided into the initial, early and late response. Peterborough LSCB produced a dramatic reconstruction 'Why Jason died' in a short film format to help professionals familiarise themselves with the process which may be of further help in describing this. Please click here for further information.

Immediate/initial response:
If a death occurs outside of hospital the child will be taken to their nearest A&E department and the on call paediatrician will be notified. The police will decide if the scene needs to be secured. The coroner must be informed and will take initial legal possession of the body and open an investigation into their death. Any decisions about the child need to be taken with the coroner's agreement.

Health staff will follow their local protocol to undertake the initial assessment and management including a detailed history, examination and preliminary medical and forensic investigations. It is important that the immediate care of the family and siblings is considered.

Early response
There should be a home visit to gather further information. This is done jointly by health staff and Police officers who have been specifically trained to undertake these visits to gather as much information in a sensitive way to help identify possible factors that may have contributed to the child's death. This visit is important and was developed to help investigate cases of sudden unexpected death in infancy to try to balance parental support with any necessary forensic investigation.

An initial informal information sharing meeting should be held within the first 24 hours to consider all aspects of the child's death from relevant sources particularly health (both primary and secondary care), children's services, police and education depending on the age of the child and the needs of the family. If there are safeguarding concerns that emerge the meeting may become a section 47 (safeguarding investigation) strategy meeting led by children's social care.

All cases of unexpected death will require a post-mortem which will be carried out by a specially trained pathologist under the direction of the coroners service. This may be a paediatric pathologist unless there are concerns the death was due to abuse in which case a forensic pathologist is required to do the examination.

When the findings of the post mortem are available they will be shared with the coroner who will give permission for them to be shared with the lead health and police professionals. If the results suggest abuse and or neglect then social services will be informed which will result in further enquiries and a further local case discussion should take place.

The coroner's officer will be the main point of contact for the family unless it is clear that the death was from natural causes. The family should be informed once the post mortem results are available.

At this stage the body can be released by the coroner for burial.

Late response (England): multiagency meeting, Inquest, Serious case review and child death review
As soon as all the results of relevant investigations have been obtained a further local multiagency case discussion should take place. This should happen before the coroner's inquest and a report from that meeting should be available to the coroner. Not all unexpected deaths will result in an inquest. If it is clear that the death is from natural causes then the coroner will sign the case off to the registrar of births and deaths. If this is not possible the inquest will aim to ascertain the medical cause of death if possible.

Hospitals, community trusts and General practitioners will review any deaths of their patients within their own governance structures to consider the case to clarify whether any lessons can be learnt. The report from this review will be made available to the Child death overview panel in England.

Child death over view panels

All deaths will be notified and will be subject to review by a Child Death Overview Panel (CDOP)/Child death review panel (CDR), a subcommittee of the Local safeguarding children board (LSCB) which has a statutory function to investigate all child deaths. This is in order to:

- establish as far as is possible the cause or causes of the death
- identify any potential contributory or modifiable factors
- provide ongoing support to the family
- ensure all statutory obligations are met
- learn lessons in order to reduce the risk of future infant/child deaths.

This is the final part of the child death process and can only be completed once all the other proceedings have taken place including any criminal proceedings. For the majority of child deaths this would be done between 6 and 12 months after the death but may be delayed beyond this in complex cases where both criminal proceedings and serious case reviews must be completed so that all reports are available to the panel. This information goes to a nationally held database. Any lessons to be learned will be disseminated via the panel.

Anaesthetists maintaining level 3 competences in Safeguarding may wish to arrange to attend as an observer to a CDOP

Serious case reviews

A serious case review is done if a child has died and there is evidence that abuse or neglect is involved. The reviews were set up to identify why a child has been seriously harmed and to improve systems and services for children and their families. Serious case reviews are subject to a triennial analysis, the most recent report was published in 2016.

It is recognised that important lessons and information on trends in child maltreatment can be ascertained from this ongoing analysis and surveillance.

Please click here for further information.

The Child Death overview process in other parts of the UK

Scotland
There is not as yet a *statutory* child death review process for in Scotland. However the Scottish Government commissioned a Child Death Review in 2014, and following this report, a review about implementation in 2016.

There will be a pilot of the formal system in Scotland in early 2018.

At present the process followed after a sudden unexpected death in infancy (SUDI) is described in www.sudiscotland.org.uk and bears many similarities to the process elsewhere in the UK with emphasis on multi-agency working.

The Procurator Fiscal (PF) plays a key role, similar to the Coroner, in deciding whether a post mortem examination should be carried out and what happens following this. Details for families on the role of the PF can be found at www.copfs.gov.uk/publications/deaths and the Crown Council can action a Fatal Accident Inquiry if there are still unanswered questions around the death

Children are certified dead under the legislation laid out in the Certification of Death (Scotland) Act 2011. The significant change to the previous legislation is that a Death Certification Review Service has been created which, under the auspices of a Senior Reviewer, looks at the accuracy of a sample of Medical Certificates of Cause of Death (MCCD). The death certificates of children are not exempt from this process, so in practical terms parents need to be informed that the death certificate of their child may be randomly chosen to be scrutinised further and could significantly delay the funeral.

Wales
Wales Child Death Review Programme
The Child Death Review programme in Wales aims to identify and describe patterns and causes of child death including any trends, and to recommend actions to reduce the risk of avoidable factors contributing to child deaths in Wales.

The Procedural response to unexpected death in childhood (PRUDIC) revised 2014 sets out a minimum standard for the multi-agency response to the unexpected death of a child or young person. The aim of the PRUDIC is to ensure that this response is safe, consistent and sensitive to those concerned, and that there is uniformity in the approach taken across Wales. The procedure will be implemented in all unexpected child deaths and followed to completion at the Case Review Meeting.

Northern Ireland
For more information - Children (N Ireland) order 1995, Contact Health & Social Care board: http://www.hscboard.hscni.net/

October 2018