ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PROCEDURE FOR UNEXPECTED CHILD DEATH AND NATIONAL LEARNING DISABILITIES MORTALITY REVIEW PROCESSES

1.0 INTRODUCTION

This procedure sets out the roles and responsibilities of Trust staff in responding to the death of a child and complies with *Working Together 2018 and* the Local Safeguarding Partnership Procedures for responding to deaths in childhood. This Procedure outlines staff roles in responding to the death of a child and should be read in conjunction with the local area Safeguarding procedures.

1.1 Child Death Review Partners are required to be notified of the death of any child 0- 18 years whether from natural, unnatural, known or unknown causes, at home, in hospital or in the community

1.2 It is important to specifically recognise and record if a child or young person has learning disabilities, irrespective of any other diagnoses or syndromes that are recognised. The Learning Disabilities Mortality Review (LeDeR) programme describes a review process for the deaths of people aged 4 years and over with Learning Disabilities in England.

1.3 There are two inter-related processes for reviewing child deaths. Either process can trigger a Child Practice Safeguarding Review formally known as a Serious Case Review (SCR). The processes are:

- Rapid response by a group of key professionals coming together for the purpose of enquiring into and evaluating each unexpected death of a child;

  and

- 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 Local Safeguarding Partnership area/s, undertaken by a panel.

2.0 PURPOSE

2.1 The purpose of the procedure for unexpected child death review is to collect and analyse information about all local childhood deaths with a view to identifying:

- Cases requiring serious case review.
- Concerns affecting the safety and welfare of children.
- Wider public health or safety concerns arising from a particular death or from a pattern of deaths.
- A coordinated agency response to all unexpected deaths of children.

2.2 There is a process to be followed when responding to, investigating, and reviewing the death of any child, from any cause. This is for two main reasons:

- to improve the experience of bereaved families, as well as professionals, after the death of a child; and
- to ensure that information from the child death review process is systematically captured to enable local learning and, through the planned National Child Mortality Database, to identify learning at the national level, and inform changes in policy and practice

2.3 Minorities 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 and also consider any lessons to be learnt about how best to safeguard and promote children's welfare in the future.

2.4 The purpose of the local reviews of deaths of a child with learning disabilities is to identify any potentially avoidable factors that may have contributed to the person's death and to develop plans of action that individually or in combination will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities.

2.5 Child suicide should be reviewed in the same manner as other child deaths, with the following expectations:

- Deaths related to suspected suicide and self-harm should be referred to the coroner for investigation;
- Deaths related to suspected suicide and self-harm will require a Joint Agency Response;
- The Child Death Review Meeting should include experts in mental health and key professionals involved in the child's life across education, social services and health.

2.6 All child deaths in an inpatient mental health setting (general and secure) whether they are treated 'voluntarily' as informal inpatients or detained under the Mental Health Act 1983 (MHA) will be subject to the child death review process and reported to the coroner. When a child dies while detained under the MHA, there should also be a Child Safeguarding Practice Review. The Child Death Review Meeting should involve the care coordinator for the community mental health team as well as other professionals from children and young people's mental health services.

2.7 An unexpected death of a child will be subject to an investigative process by the Rapid Response Team which is made up of a;

- Consultant Paediatrician (responsible for ensuring the process is correctly carried out).
- Police officer.
- On call health professional.
- Children's social worker if there has been prior involvement or abuse or neglect is suspected to be a factor in the death.

2.8 This procedure will primarily apply to staff working directly with children and young people and on call managers. However there may be occasions where information on a parent is required from adult services. Therefore all staff working with children and adults should be aware of this procedure which outlines roles and responsibilities in responding to the death of a child or young person and consideration of the possible needs of other children in the household and other family members.

3.0 DEFINITION

3.1 An 'unexpected death' of a child occurs where;

- Death was not anticipated as a significant possibility 24 hours before it occurred

  or

- There was a similarly unexpected collapse leading to or precipitating the events which led to the death.

3.2 A Designated paediatrician will be notified of **all** unexpected deaths in childhood. When staff are uncertain about whether the death is unexpected the Designated Paediatrician should be contacted.

3.3 Each area may have a Local Child Death Review Panel (LCDRP) whose functions are to collect and analyse information relating to the death of any child in their area. The panel will identify any matters of concern giving rise to the safety and welfare of children in their area along with any wider public health or safety concerns.

3.4 A Child Death Overview Panel (CDOP) will be responsible for reviewing information on all child deaths in order to enable the Local Safeguarding Partnership to carry out its statutory functions relating to child deaths. The CDOP Panel has a permanent core membership drawn from the key organisations represented on the Local Safeguarding Partnership. Trust Community Health staff may become members of a CDR and should refer to specific Local Safeguarding area guidance.

3.5 The Learning Disabilities Mortality Review (LeDeR) programme defines 'learning disabilities' to include the following:

- Significantly reduced ability to understand new or complex information and to learn new skills (impaired intelligence), with
- Reduced ability to cope independently (impaired social functioning), which
- Started in childhood with a lasting effect on development.

3.6 The child death review process will be the primary review process for children with learning disability and it will not be necessary for the LeDeR programme to review each case separately. When notified of the death of a child or young person aged 4-17 years who has learning disabilities, or is very likely to have learning disabilities but not yet had a formal assessment for this, the local CDR Partners should report that death to the LeDeR programme

4.0 PROCESS

4.1 Death should not be assumed and if a child appears to have died or collapses, an ambulance should be called and resuscitation attempted until the arrival of the ambulance.

4.2 A child should be immediately transferred to A&E where the designated paediatrician declaring the death or clinical specialist for child death will be responsible for initiating the rapid response (if the death is unexpected) / child death review process.

4.3 The Rapid Response Team will be identified within 4 hours of the death being notified.
The Rapid Response Team will decide on action to be taken for example:

- Visit to scene of death (within 24hrs and prior to post mortem).
- Notification to relevant professionals.
- Obtaining information from relevant professionals.

4.4 If declared dead at the scene the health professional is responsible for identifying anything about the child's death which gives rise for concern or cause for suspicion and for passing these concerns on to the appropriate authority. The professional is also responsible for initiating the rapid response / child death review process by notifying the death in the usual way using the **Notification Form**. It is the responsibility of the General Practitioner (GP) or health professional present to record information about the sense of death that would normally have been collected via this process and to make this available to child death panel manager/administrator.

4.5 Trust staff may be contacted by other NHS professionals to identify if a child has been known to Trust services. Staff should co-operate with sharing information.

4.6 If a death is identified as suspicious the Police are the lead investigating agency. If criminal proceedings are necessary the Child Death Review Process will cease until notified otherwise by police.

4.7 Trust Staff should inform the Trust Safeguarding Team and record all information as soon as possible in the child/Young person's records. Trust Incident Forms should be completed as per Trust policy.

4.8 Trust staff directly involved with a case will be expected to complete a copy of the data set or a written report for the child Death Review Team within ten working days using the **Reporting form B** and the relevant **sub B. Forms** will be sent to staff from the Child Death Review Administrator.

4.9. All staff that have had contact with a child who has died will be asked to share information on the child for the purposes of informing the professional response and work of the Child Death Review Panels.

4.10 Where a health care practitioner becomes aware of a death, they should check that the relevant Child Health Information Department have been notified.

4.11 Records should be retained for all child deaths until discussion of the case at the child death review panel and then stored in accordance to Trust record keeping and storage policy.

4.12 Copies of all forms and reports should be sent to the Trust Safeguarding Team.

4.13 The Child Death Review Team will continue to meet to discuss the case and identify findings or additional input required by professionals.

4.14 A visit to the scene of the death will be undertaken by the Police Officer and Clinical Specialist for Child Death forming the rapid response team. A health visitor, GP or other similar professional who has had previous contact with the family may also participate in the home visit to provide support.

4.15 Ongoing bereavement support for the family may be identified by Community Healthcare and CAMHS teams who may be asked to offer services to siblings where appropriate.

4.16 If concerns are raised at any stage about the possibility of surviving children in the household being abused or neglected, the Trust Safeguarding policies & procedures should be followed and Children's Social Care notified.

4.17 Where a case is transferred for a Local Safeguarding Child Practice Review formally known as Serious Case Review Panel the Trust will comply with the Child Safeguarding Practice Review procedures and complete an Individual Management Review where required. This may be in addition to an internal Serious Incident Investigations which may be required.

5.0 LESSONS LEARNED

5.1 The Child Death Review Partners will aggregate the findings from all child deaths, collected according to a nationally agreed minimum data set, to inform local strategic planning on how best to safeguard and promote the welfare of the children in the local authority area.

5.2 The Child Death Review Partners are responsible for disseminating lessons in order to improve policy, professional practice and interagency working.

5.3 All relevant recommendations will be placed on the Trust Mental Health Act and Safeguarding Sub-Committee action plan.

5.4 Where appropriate cases will be placed on the 'Lessons Learned' section of the Trust Safeguarding link on the Intranet.

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