Guernsey Child Death Review Processes

Working Together 2018 states that all areas should form Child Death Review Partnerships that establish processes to ensure all deaths of children under 18 are reviewed and a Child Death Overview Panel (CDOP) is convened to provide an overview and to ensure that actions are taken to remediate any modifiable factors identified that may have contributed to the death or care of the child prior to death.

The child death review process covers children; a child is defined in the Act as a person under 18 years of age.

A child death review must be carried out for all children regardless of the cause of death. This includes the death of any live-born baby where a death certificate has been issued. In the event that the birth is not attended by a healthcare professional, child death review partners may carry out initial enquiries to determine whether or not the baby was born alive. If these enquiries determine that the baby was born alive the death must be reviewed.

For the avoidance of doubt, it does not include stillbirths (baby born without signs of life after 24 weeks gestation, late foetal loss (where a pregnancy ends without signs of life before 24 weeks), or terminations of pregnancy (of any gestation) carried out within the law (cases where there is a live birth after a planned termination of pregnancy carried out within the law are not subject to a child death review).

The following process has been outlined to meet the WT 2018 requirements and align with the key principles and objectives of the Child Death Review Statutory and Operational Guidance (England) 2018 whilst taking account of the Guernsey law and context.

The Named Nurse Child Safeguarding will undertake the role of Designated Health Professional for Child Deaths (DHPCD) and should be notified of each child death and sent all relevant information. The DHPCD will work closely with the Designated Doctor Child Safeguarding in undertaking the following:

- Responsibility for and taking an oversight of the child death review process, including ensuring that appropriate processes are followed if a child dies in an adult facility
- Advising the Islands CDOP regarding necessary experts required to inform ordinary and themed panels
- Advising the Islands CDOP on the identification of modifiable contributory factors
- Liaising, as appropriate, with the HIPS CDOP to ensure that themed panels are properly coordinated
- Assisting the Islands CDOP in the development and implementation of appropriate preventative strategies to reduce the child deaths
- Preparing an annual report with the Chair summarising the activities of the Islands CDOP

Cover for absence of the DHPCD will be provided by a Quality Improvement Manager from the Quality and Safety Team.

<u>Neonatal Deaths (Birth to 28 days)</u>

The following process will be applied to neonatal deaths that are not considered to require a Joint Agency Response (for which see under Unexpected Deaths)

1. A completed CDR Notification Form to be sent to the CDOP Coordinator as soon as possible after the death and always within 24 hours
2. The CDOP coordinator will notify the DHPCD immediately

3. The Lead Clinician for the case, under consultation with the DHPCD, will consider who will be asked to complete a Reporting Form to be returned to the CDOP Coordinator
4. As part of the discussion, it will be agreed who needs to be present at the Child Death Review meeting
5. There will also be consideration by the Lead Clinician for the case, under consultation with the DHPCD, as to who should be identified as the Key Worker for the family during the child death review process.
6. A multidisciplinary review of the case, including consideration of completed CDR Reporting Forms and any other reviews/investigations, will be held at the next ***perinatal/neonatal mortality and morbidity review meeting*** after the death, at which the discussion of the death will be chaired by the DHPCD.
7. Feedback arrangements to the family will be agreed at the meeting.
8. The CDR analysis form will be completed at the meeting.
9. The CDR Analysis Form and all CDR Reporting Forms to be returned to the CDOP Coordinator.

Expected Postneonatal Deaths (29 days onwards)

The process to be followed for deaths of children from chronic, life-limiting conditions and for whom the attending medical practitioner is able to issue a medical certificate of cause of death, is as follows:

1. A completed CDR Notification Form to be sent to the CDOP Coordinator as soon as possible after the death and always within 24 hours.
2. The CDOP coordinator will notify the DHCPD immediately.
3. The Lead Clinician for the case, under consultation with the DHPCD, will consider who will be asked to complete CDR Reporting Forms to be returned to the CDOP Coordinator.
4. The Lead Clinician for the case, under consultation with the DHPCD, will consider who should be identified as the Key Worker for the family during the child death review process.
5. A multidisciplinary Child Death Review Meeting to be arranged within three months of the child's death:
    a. Chaired by the DHPCD.
    b. Attended by the Designated Doctor Child Safeguarding
    c. Attended by professionals involved in the child's care in Guernsey.
    d. Consideration of all CDR Reporting Forms and the outcomes of any other reviews/investigations.
    e. Completion of the CDR Analysis Form
    f. Feedback arrangements to the family to be agreed at the meeting.
6. The CDR Analysis Form and all CDR Reporting Forms to be returned to the CDOP Coordinator.

Unexpected Deaths (at any age)

An unexpected death is that of an infant or child whose death 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 which led to the death

Deaths that occur unexpectedly and for which a medical certificate of cause of death cannot be issued are under the jurisdiction of HM Procureur and a detailed protocol for managing the cases as agreed with HM Procureur is appended. These deaths will trigger a Joint Agency Review (JAR):

1. Death to be notified immediately to HM Procureur (as per protocol)
2. SUDI protocol as agreed with HM Procureur to be followed in respect of immediate history taking, examination of the body, specimen taking and arrangements for post-mortem examination
3. Death to be notified by the police as soon as possible to the DHPCD to arrange a joint interview with parents/carers and visit to the scene of death, ideally within 24 hours
4. Completion of a CDR Notification Form to be sent to the CDOP Coordinator as soon as possible after the death and always within 24 hours (as per protocol).

5. Liaison with the police and social care services as appropriate when the initial post-mortem examination findings are available to plan the next stages of the CDR, including who will be acting as the Key Worker for the family.
6. If no further statutory action is required, the DHPCD to plan a multidisciplinary Child Death Review Meeting (CDRM).
7. The CDRM will ideally be held within 3 months of the child's death but **must** be informed by the full post-mortem results:
    - Chaired by the DHPCD
    - Attended by the Designated Doctor Child Safeguarding
    - Attended by health professionals involved in the child's care at the time of the death, including primary care, and other agencies as appropriate (it is expected that Children's Social Care services will always be invited)
    - Consideration of all CDR Reporting Forms and outcomes of any other reviews/investigations
    - Completion of the CDR Analysis Form
    - Feedback arrangements to the family to be agreed at the meeting (normally by the DHPCD)

    The CDR Analysis Form and all CDR Reporting Forms to be returned to the CDOP Coordinator.

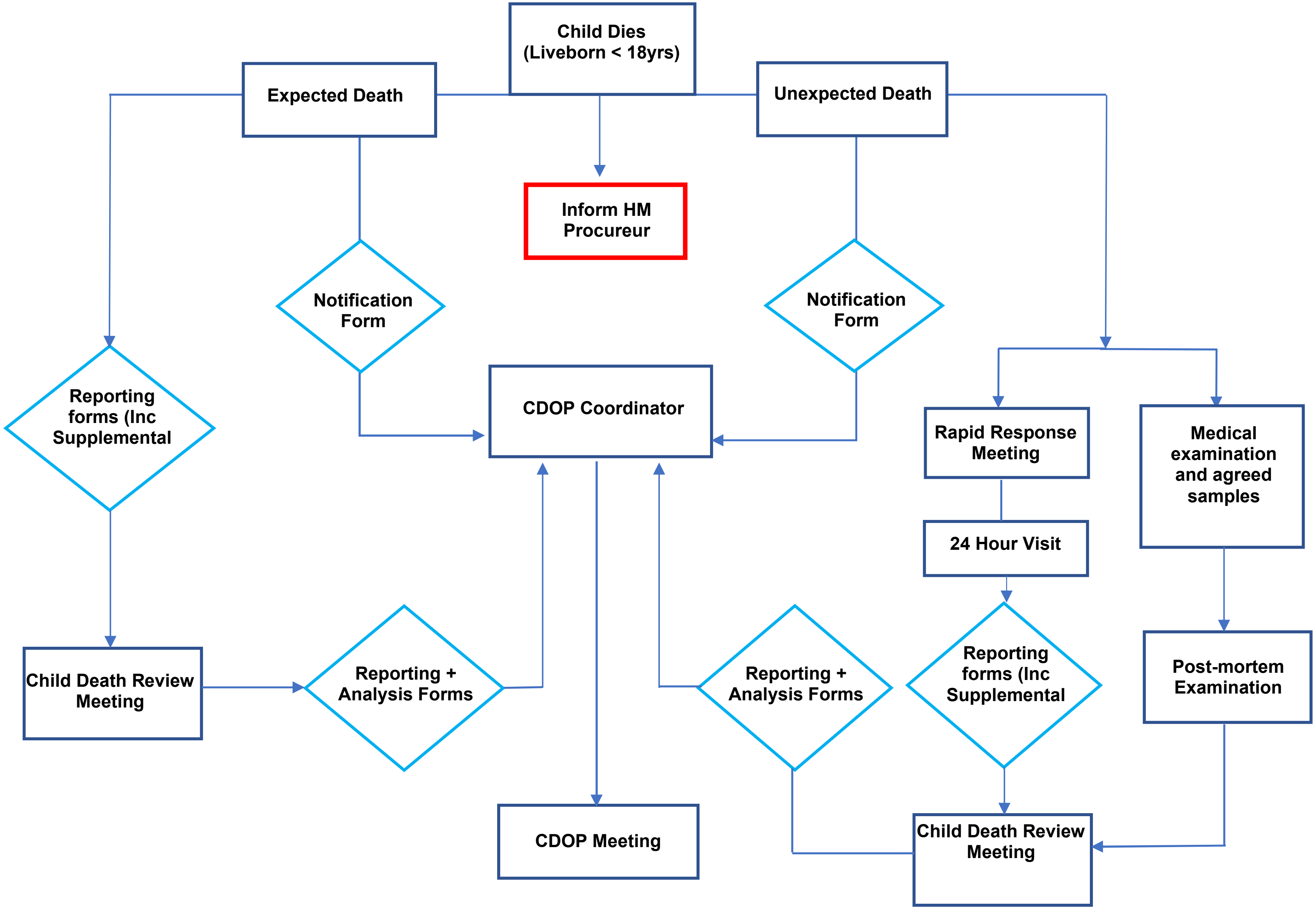
Deaths in special situations

Rarely, deaths in children occur in other situations than those outlined above. Such cases will always require individual multiagency consideration of the appropriate process to follow to enable as full and appropriate a review as possible. The process will normally include a Child Death Review Meeting involving relevant practitioners and completion and return to the CDOP Coordinator of the CDR Notification, Reporting and Analysis Forms.

Chapter 7 of the *Child Death Review Statutory and Operational Guidance (England) October 2018* identifies six special situations and provides guidance on processes to follow that may be helpful in informing discussions on the process to follow in the Bailiwick of Guernsey:

1. Deaths overseas of children normally resident in the country
2. Deaths in children with learning disabilities
3. Deaths of children in adult healthcare settings
4. Suicide and self-harm
5. Deaths of children in inpatient mental health settings
6. Deaths in custody

Chapter 7 is attached as an appendix.


Child Dies
(Liveborn < 18yrs)
Expected Death
Unexpected Death
Inform HM Procureur
Notification Form
Notification Form
Reporting forms (Inc Supplemental
CDOP Coordinator
Rapid Response Meeting
Medical examination and agreed samples
24 Hour Visit
Child Death Review Meeting
Reporting + Analysis Forms
Reporting + Analysis Forms
Reporting forms (Inc Supplemental
Post-mortem Examination
CDOP Meeting
Child Death Review Meeting

Appendices

Chapter 7

Specific situations

7.1 Deaths overseas of children normally resident in England

7.1.1 Introduction and Principles

7.1.1.1 The CDR partners must make arrangements for the review of each death of a child normally resident in the area, including if they die overseas. They and CDR partners may learn about such a death from a variety of sources (e.g. Foreign and Commonwealth Office (FCO), media, coroner, public).

7.1.1.2 Because the duties of the coroner are engaged by the body of the deceased person lying within their area, these duties will only arise in respect of children who die abroad and whose bodies are returned to England. The duties of the coroner do not arise if the child is buried or cremated abroad. The coroner taking responsibility will usually be the coroner covering the area to which the child's body is brought for funeral arrangements.

7.1.1.3 The investigation of deaths that occur abroad by the coroner is often difficult due to problems securing evidence. The FCO usually assists by making contact with foreign authorities on behalf of the coroner, as the coroner has no power to summon evidence or witnesses outside England and Wales.

7.1.1.4 When the death has taken place abroad, the local CDR partners are advised to seek advice from the local senior coroner first; the CDR partners may also need assistance from agencies abroad, including police involved in the investigation of the death in question. Such reviews require careful coordination to ensure that relevant information from the FCO, international funeral directors, coroner, and local services (health, education, social services) is presented to the panel.

7.1.2 Foreign and Commonwealth Office

7.1.2.1 The FCO can provide support to British nationals in difficulties overseas and provides useful resources for what should happen in the event of a death overseas. In the event that a child who is a British national, dies abroad, the child's family should notify the local authorities and the UK Embassy, High Commission, or Consulate in the country where the child has died. The family can also contact the FCO directly. Diplomatic officials in these offices will, when notified of a death, advise relatives how to register the death (abroad and/or in the UK); advise on how to repatriate the body using local or international funeral directors, and give guidance relating to bereavement support. Their staff will also notify the coronial liaison officer at the FCO. The FCO collects routine information about each death such as name, date of birth, address, known cause of death, and the welfare of other siblings. It is customary practice for the FCO to also notify the relevant CDR partners and CDOP where the child was normally resident, if a UK address is provided to them. The FCO will only be aware of a death if the family, local authorities or other interested party notifies them. The FCO can be contacted on Coroner.LiaisonOfficer@fco.gov.uk, or in an emergency 0207 008 1500 (ask for Consular).

7.2 Children with learning disabilities

7.2.1 Introduction and principles

7.2.1.1 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. This enables effective monitoring, auditing and evaluation of service provision; resource management and strategic planning; and assurance regarding equitable access to health services.

7.2.1.2 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[17]. Within the four NHS England regions, a LeDeR Regional Coordinator supports and provides a governance structure to local multi-agency Steering Groups to deliver the LeDeR mortality reviews. LeDeR recommends that CDOP Chairs are represented at the regional LeDeR Steering Group. The LeDeR programme team aims to support local areas to implement the LeDeR review process and to take forward the lessons learned from individual mortality reviews to make improvements to service provision. The LeDeR programme also collates and shares anonymised information from the review so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

7.2.2 Definition of learning disabilities

7.2.2.1 The LeDeR programme defines ‘learning disabilities’ to include the following:

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

7.2.2.2 A child’s ability to understand and use information and to cope independently should be interpreted in relation to other children of a similar age.

7.2.2.3 This definition encompasses children and adults with a broad range of disabilities; IQ alone is not sufficient to identify this population. For example, it includes those with autism who also have learning disabilities but not those on a higher level of the autistic spectrum, such as some with Asperger’s Syndrome, who may be of average or above average intelligence. The definition does not include those who only have a specific ‘learning difficulty’ (such as dyspraxia or dyslexia). The fact that a child has physical disabilities does not mean that they have learning disabilities. Further information about the definition of learning disabilities used in the LeDeR programme can be found at: http://www.bristol.ac.uk/sps/leder/information-for-reviewers/briefing-papers/.

7.2.2.4 When it is obvious that a child has learning disabilities (e.g. because they have a specific syndrome that is associated with learning disabilities) this should be recorded even if a formal identification process for learning disabilities is yet to take place. In addition, even if a child has a specific condition associated with learning

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[17] Before the age of 4 years it can be difficult to ascertain if a child has learning disabilities, unless they have a specific syndrome always associated with learning disabilities. The LeDeR programme therefore starts reviewing deaths of people with learning disabilities from age 4 years onwards.

disabilities (e.g. Fragile X syndrome, Down's syndrome) they should still have their learning disabilities recorded as a separate and specific issue.

7.2.3 The interface between the child deaths review and the LeDeR mortality review process

7.2.3.1 The LeDeR mortality review process is described on the LeDeR website (http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/). The LeDeR programme adheres to key principles of communication, cooperation, and independence when liaising with other investigation or review processes. It is expected that the child death review process will be the primary review process for children with learning disability and that it will not be necessary for the LeDeR programme to review each case separately.

7.2.3.2 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 at http://www.bristol.ac.uk/sps/leder/notify-a-death/ or 0300 777 4774. The person notifying the death to LeDeR should provide core information about the child and the relevant CDR partners. The CDR partners should then ensure that the LeDeR programme is represented at the meeting at which the death is reviewed. In addition, the Local Area Contact for the LeDeR programme and the CDOP or its equivalent chair should discuss the potential input from a LeDeR reviewer to offer expertise about learning disabilities (if appropriate) and to ensure the collection of core data for the LeDeR programme. Any completed notes and/or Analysis Form arising from the discussion should be submitted to the Local Area Contact for the LeDeR programme by the CDR partners. If the Local Area Contact is not known, contact the LeDeR team on 0300 777 4774.

7.2.3.3 Some panels may find benefit in having additional 'learning disability themed meetings' at which common contributory factors leading to deaths, and frequently made learning points and recommendations, can be reviewed together through an equalities lens. The Regional Coordinator or Local Area Contact from the LeDeR programme should attend such meetings. The LeDeR programme, in liaison with the National Child Mortality Database team (once operational) and NHS Digital, on behalf of the Department of Health and Social Care, will collate completed mortality reports relating to children and young people with learning disabilities, and identify common themes and patterns at regional and national levels. These will be reported back to CDR partners and CDOPs on an annual basis.

7.3 Deaths of children in adult healthcare settings

7.3.1 Introduction and principles

7.3.1.1 A very small number of children (nearly always 16 and 17 year olds) die in adult intensive care units (ICUs), the deaths of these children are still subject to the child death review process.

7.3.1.2 The *Learning from Deaths* framework gives guidance to NHS trusts for reviewing adult inpatient deaths, and this should remain the primary approach for reviewing the *quality of care* for children who die in adult ICU. However, in all other respects, children who die in adult settings should have the same rigour of review as all other children who die. There should be close liaison with the designated doctor for child deaths from the outset, to ensure that this occurs.

7.3.2 Royal College of Physicians (RCP) National Mortality Case Record Review programme

7.3.2.1 *Learning from Deaths* requires NHS Trusts to review the deaths of patients in NHS care. For *adult* deaths, NHS providers are required to use a methodology for reviewing the *quality of care*, such as the Structured Judgment Review (SJR) approach advocated by the RCP National Mortality Case Record Review Programme. This methodology has not been validated for use in relation to children. More information on Learning from Deaths.

7.3.3 The approach to reviewing deaths of 16 and 17 year olds in adult ICU

7.3.3.1 The majority of hospital deaths in children and young people occur in regional paediatric and neonatal intensive care units. However, some age-admission policies across networks of care may stipulate that critically ill 16 and 17 year olds are cared for on an adult ICU. In order to avoid confusion for families and clinical staff, the general expectations arising from *Learning from Deaths* apply to children who die on adult ICUs, with the following essential caveats:

- There should be notification of the child health system, GP, and local CDR partners and CDOP office;
- The designated doctor for child deaths should be notified when a child dies in adult ICU. This individual can provide a central role in terms of:
  - advice regarding the need for a Joint Agency Response;
  - identifying whether the child is known to paediatric health professionals who should be represented at the adult mortality and morbidity (M&M) meeting; and
  - attending the adult M&M meeting and completing a standardised Analysis Form for the purposes of the relevant CDOP.
- The Structured Judgement Review approach, or other evidence based structured mortality review tool, should be used to review the quality of clinical care. This, the standardised CDR Analysis Form, and any other notes arising from the adult M&M meeting should be forwarded to the relevant CDOP. The designated doctor for child deaths should help co-ordinate this.

7.4 Suicide and self-harm

7.4.1 Introduction and principles

7.4.1.1 Suicide is defined as a death where the conclusion of suicide is given at inquest where the coroner (or jury) is satisfied that the deceased did an act knowing and intending that their death would result. The High Court has recently handed down a judgment (R(Maughan) v Senior Coroner for Oxfordshire [2018] EWHC 1955 (Admin)) in which stated that its clear view was that a conclusion of suicide, whether expressed as a narrative statement or in short-form, is required to be proved to the civil, and not the criminal, standard of proof. This is a significant change to the previously understood position. It is likely that this case will be appealed to the Court of Appeal and therefore the legal position may be further clarified in due course.

7.4.2 National Confidential Inquiry into Suicide and Homicide by people with Mental illness (NCISH)

7.4.2.1 NCISH examined deaths of all children by suicide and published annual reports in 2016 and 2017. This review has now been suspended although further work may be undertaken using the same methodology in the future.

7.4.3 The approach to reviewing suicides in children

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

- all deaths related to suspected suicide and self-harm should be referred to the coroner for investigation;
- all deaths related to suspected suicide and self-harm will require a Joint Agency Response;
- the CDRM should include experts in mental health and key professionals involved in the child’s life across education, social services and health. Specific risk factors should be considered, including:
    - family factors such as mental illness, alcohol or drug misuse, and domestic violence;
    - abuse and neglect;
    - bereavement and experience of suicide;
    - bullying, including on-line bullying;
    - suicide-related internet use, including searching for methods and posting suicidal messages;
    - academic pressures, especially related to exams;
    - social isolation, especially leading to withdrawal;
    - physical health conditions that may have social impact, and their treatment
    - alcohol and illicit drugs;
    - mental ill health, self-harm, and suicidal ideation;
    - Issues relating to self-identity, including gender identity; or
    - exploitation, including child sexual exploitation, radicalisation, and gang-related exploitation.

7.4.3.2 Suspected child suicides should, where possible, be discussed at a themed specialist CDOP review with attendant mental health specialists.

7.5 Inpatient Mental Health settings

7.5.1 Introduction and principles

7.5.1.1 The principles set out in this section apply to all children in inpatient mental health settings whether they are treated 'voluntarily' as informal inpatients or detained under the Mental Health Act 1983 (MHA).

7.5.1.2 All deaths of children in inpatient mental health settings will trigger a Joint Agency Response (see Chapter 3.2).

7.5.1.3 All child deaths in an inpatient mental health setting (general and secure) should be reported to the coroner. If the death was not due to natural causes, the coroner is likely to open a formal investigation that may lead to an inquest.

7.5.1.4 When a child dies while detained under the MHA, there should also be a safeguarding practice review.

7.5.2 Child death review process

7.5.2.1 The professional confirming the death should inform the local designated doctor for child deaths at the same time as informing the coroner and the police. NHS and independent providers of inpatient mental health settings must notify the Care Quality Commission (CQC) or they can notify NHS England of the death of a patient through a local manager, or by reporting on the risk management system where information is uploaded to the national reporting and learning system. Where a child was detained under the Mental Health Act 1983, the death must be reported to the CQC.

7.5.2.2 Immediate decision making should take place as set out in Chapter 2 of this guidance. Following necessary investigations (see Chapter 3), a CDRM should take place (see Chapter 4). The CDRM 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. Other necessary attendees might be: GP, education/school representative, and social worker. This should be followed by a CDOP review (see Chapter 5).

7.5.3 Child Safeguarding Practice Reviews

7.5.3.1 When a child dies while detained under the Mental Health Act 1983 or while deprived of their liberty by the state, the death must be notified to Ofsted and the local safeguarding partners. These deaths, along with the death of any child in custody or secure accommodation, may trigger a local or national child safeguarding practice review.

7.5.4 Involvement and Support to Parents, Carers and Staff

7.5.4.1 As in any child death review process, there should be meaningful involvement of families (see Chapter 6). Effective co-ordination is vital when parallel investigations take place. A "key worker" should be assigned to every bereaved family to act as a single point of contact.

7.5.4.2 The inpatient manager might act as the case manager in providing progress updates on the separate investigations.

7.5.4.3 Bereavement support should be provided for families and consideration given to providing psychological support for staff involved in the care of the child.

7.6 Deaths in custody

7.6.1 Introduction and principles

7.6.1.1 The primary responsibility for the investigation of the death of a child in custody lies with the coroner and Prisons and Probation Ombudsman (PPO). The coroner's duty to investigate deaths in custody and state detention also includes patients detained under the Mental Health Act 1983. The same processes also apply to the death of a child accommodated in a secure welfare placement[18]. While the CDR partners for the area where the child was normally resident are responsible for ensuring a review of the death at CDOP takes place, it is the CDOP for the area where the most learning can be captured that would normally conduct the CDOP review (as described in Chapter 5.5).

7.6.2 The Prisons and Probation Ombudsman

7.6.2.1 The PPO investigates all deaths of children in prisons, secure children's homes, secure training centres, young offender institutions, immigration removal centres and approved premises (formerly known as probation hostels). This also generally includes children and young people temporarily absent from such establishments but still subject to detention (for example, where a young person is under escort or attending hospital). Deaths of children in police custody are not investigated by the PPO, but are instead investigated by the Independent Police Complaints Commission.

7.6.2.2 Following a child death in custody, the police will begin an investigation and submit a report to the coroner. In tandem, the police may be involved in relation to investigating criminal matters related to the death, and not solely as the coroner's agent. The PPO will then further investigate the death to establish the circumstances surrounding the death and provide a written report with recommendations to the relevant organisations. The PPO investigation is separate to the coroner's inquest. However, a copy of the PPO report is sent to the coroner to assist their investigation. The PPO also publishes its investigation reports on its website after the inquest. HM Prison and Probation Service has its own internal guidance for staff following a death in custody which includes processes for providing support to family and carers.

7.6.3 The PPO and NHS England

7.6.3.1 NHS England's Health and Justice commissioners are responsible for commissioning health services for children and young people in detained settings. When a child dies in custody the PPO will contact the lead within the local NHS England Health and Justice commissioning team, with details of the PPO Lead Investigator for the case, and will request the appointment of a clinical reviewer. This will occur within one working day of the PPO being notified of the death. The aim of the clinical review is to examine the health services and treatment provided to the deceased individual while in custody, identify any areas of service delivery failure, identify any causes, contributory factors and learning opportunities, and make clear recommendations for the improvement of health service provision as appropriate.

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[18] The Children and Young People Secure Estate includes three types of residential placements for 10 to 17 year olds sentenced or remanded to custody. These are secure children's homes (SCHs), secure training centres and young offender institutions. SCHs may also provide care and accommodation for young people referred by local authorities for a secure welfare placement, in accordance with s.25 Children Act 1989, for the protection of themselves and/or others.

7.6.3.2 The Children and Young People Secure Estate is a national resource, and children can be placed anywhere within the estate and may not be placed within their local area. Learning from child deaths in custody is important not just in terms of the health commissioner and secure setting, but also in terms of how placement decisions are made in the future.

7.6.4 Local NHS England response

7.6.4.1 Where it is suspected that problems with care or service delivery in relation to NHS-commissioned healthcare have contributed to or caused the death of a child in custody, a serious incident should be declared and an investigation managed according to the Serious Incident Framework. The NHS England commissioner should simultaneously notify the NHS England central team via the Director of Health and Justice.

7.6.4.2 Usually the serious incident investigation will meet the needs of a clinical review for PPO purposes, so long as it is carried out by a clinician who is not involved in, or responsible for, the commissioning or provision of the healthcare service where the death occurred.

7.6.5 Deaths in custody and the child death review process

7.6.5.1 NHS providers should inform the CDOP where the child was normally resident of the death of any child in custody. Whilst it is acknowledged that such events will always be investigated by the PPO and the coroner, the CDOP where the death occurs should receive the outcomes of those investigations and conduct a comprehensive review of the case.

7.6.5.2 Pregnant women in custody should be transferred to hospital for the delivery of their baby. If the baby delivers in the place of custody, that baby should be transferred to hospital. In both circumstance, should the baby then die in a neonatal unit, the standard child death review process should be follow