Infant and child deaths

Good practice recommendations

1. Paediatricians should follow national multiagency processes following the death of child.

2. A paediatrician should always attend the multiagency meetings following the death of a child.

15.1 Introduction

15.1.1 There are a range of review and audits that can take place to enable professionals and organisations to reflect on individual cases. The statutory guidance entitles this a *learning and improvement framework*[559], and this is a document that should be maintained by the LSCB.

15.1.2 Some reviews, SCRs and child death reviews, are required by legislation. However, the statutory guidance encourages LSCBs to consider conducting reviews in other cases too.

15.1.3 The different types of review include:

- Serious Case Review: for every case where abuse or neglect is known or suspected and either; a child dies or a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child;
- Child death review: a review of all child deaths up to the age of 18;
- Review of a child protection incident which falls below the threshold for an SCR; and
- Review or audit of practice in one or more agencies.

15.2 Serious Case Reviews

15.2.1 In England, LSCBs are required to undertake a Serious Case Review (SCR) in specified circumstances.

15.2.2 A SCR must always be held where:
a) Abuse or neglect of a child is known or suspected; and
b) Either —
i. The child has died; or
ii. The child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

15.2.3 With regard to b ii) above, unless it is clear that there are no concerns about interagency working, the LSCB must commission an SCR.

15.2.4 In addition, an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a young offender institution, in a secure training centre or a secure children's home, or where the child was detained under the Mental Health Act 2005.

15.2.5 LSCBs should also consider conducting reviews on cases which do not meet the SCR criteria; for example, to ensure good practice is shared and embedded. LSCB may also hold a SCR in other situations where a child is seriously but non-fatally harmed as a consequence of abuse or neglect[560].

15.2.6 From 2013 there will be a national panel of independent experts to advise LSCBs about the initiation and publication of SCRs.

15.2.7 From January 2013, Wales replaced the SCR with Multiagency Child Practice Reviews (concise or extended) which involves agencies, staff and families reflecting and learning from what has happened in order to improve practice in the future[561].

15.2.8 Similar arrangements are in place in Northern Ireland, but without the requirement to hold a SCR after every fatal case.

15.2.9 In Scotland, child death reviews are part of SCRs and are held at the discretion of the Child Protection Committee.

15.2.10 A SCR is a more in-depth and focused review than that involved in the child death overview process. It is specifically focused on learning lessons to improve the way agencies and individuals work, both individually and collectively, to safeguard and promote the welfare of children.

15.2.11 Paediatricians may be called upon to contribute to the learning of a SCR. They may be required to make their clinical notes available to the review team, and may be interviewed by members of the review team, or participate in a focus group or other learning process.

15.2.12 It is important that paediatricians are open and frank in their responses to the gathering of information for the review. The process can be threatening, but should be seen as an important learning opportunity. A reflective attitude helps in identifying learning points from the review.

15.2.13 Paediatricians, particularly named and designated safeguarding professionals, may be called upon to compile a health Individual Management Review (IMR) or health overview report, or to sit on a SCR panel and contribute to assessing the information gathered. The final overview report of the SCR will be written by an independent author and the panel has an independent chair. These professionals are reliant on the individual expertise of other panel members in appropriately assessing and interpreting the information gathered.

15.2.14 Any paediatrician taking on the role of health IMR author should, on notification of the decision to undertake a SCR, secure all health records relating to the child. They should attend all briefing events, and should pay close attention to the tight timescales for completing the review. Depending on the scope and terms of reference of the review, they should arrange to interview those health professionals who have been involved with the child and family. They should carefully review all the relevant health records. The IMR author should compile a chronology of health events in the life of the child and family within set timescales. They should analyse the information provided, identifying any learning arising from the case. They should identify any relevant recommendations and consider how these can be translated into an action plan.

15.2.15 However, IMRs are now not required automatically following the publication of Working Together to Safeguard Children 2013[562]. LSCBs are not prescribed to use any particular one model for undertaking SCRs. This is likely to lead to local variation about the methodology that is used so paediatricians should refer to their LSCB guidance.

15.2.16 Any learning from the SCR should not be delayed until completion of the review; action should be taken straight away to address any learning or recommendations identified. Paediatricians may contribute to disseminating any learning from the SCR and for implementing any action plan within their organisation.

Further reading

- Brandon M, Sidebotham P, Bailey S, Belderson P, Hawley C, Ellis C, Megson M (2012) New learning from serious case reviews: A two year report for 2009-2011. Department for Education research brief. https://www.education.gov.uk/publications/eOrderingDownload/DFE-RB226%20Research%20Brief.pdf
- Vincent S, Petch A (2012) Audit and analysis of significant case reviews. http://www.scotland.gov.uk/Resource/0040/00404517.pdf
- National Policing Improvement Agency (2009) Guidance on investigating child abuse and safeguarding children, http://www.ceop.police.uk/Documents/ACPOGuidance2009.pdf

15.3 Child deaths

15.3.1 Each year around 4,000-4,500 children die in England[563]. The majority of these deaths will be from natural, medical causes, particularly from perinatal causes and congenital abnormalities. A large proportion of child deaths will be in the context of known life-limiting or life-threatening disorders.

15.3.2 However, as many as 20% of child deaths will be from external causes (accidents, homicides and suicides, or deaths that remain unexplained or cannot be classified). The proportion of deaths from external causes rises to over 50% in adolescents.

15.3.3 4,012 child death reviews were completed by Child Death Overview Panels (CDOP) in the year ending 31 March 2012. Of these, 20% were identified as having modifiable factors; defined as factors which may have contributed to the death and, if modified, could reduce the risk of future child deaths. Of this 20%, 24% were due to 'sudden unexpected, unexplained deaths' and an additional 18% were due to 'trauma and other external factors'[564].

15.3.4 Confidential enquiries into child mortality have shown that, even in deaths from natural causes, modifiable factors can be identified in as many as 26% of cases[565]. These may be factors in relation to parental care, the environment, or issues around provision of or access to healthcare.

15.3.5 Child death review processes in the UK are based on principles of:

a) Respect for every child and family; both before and after their death;
b) The needs of children and families for support and information;
c) The 'rights' of children and families to have their deaths thoroughly and sensitively investigated; and
d) The public health imperative to take informed and evidence-based action to prevent future child deaths.

15.3.6 The Children Act 2004[566] placed responsibilities on Local Authorities to put in place procedures both to respond rapidly to individual unexpected childhood deaths (Rapid Response), and to review all child deaths systematically (CDOPs). The Child Death Review process is established in England and similar processes are developing in Wales, Scotland and Northern Ireland. Guidance on these processes is provided in *Working Together to Safeguard Children*[567 568]. These processes

work in conjunction with, and do not replace, the statutory requirements for all deaths to be registered through the registrars of births, deaths and marriages; and the remit of the coroner (procurator fiscal in Scotland) to investigate and certify certain categories of death, including all suspected accidents, homicides and suicides.

15.4 Definitions

15.4.1 An unexpected child death is defined as one 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 events which led to, the death'[569]. This term, and the related terms SUDI (Sudden Unexpected Death in Infancy) and SUDC (Sudden Unexpected Death in Childhood) are descriptive terms used at the point of presentation. Within this description there will be deaths for which a cause is ultimately found ('explained SUDI/SUDC') which may be a medical cause or external cause, and others for which no cause is found ('SIDS' or 'unexplained child death').

15.4.2 Sudden Infant Death Syndrome (SIDS) is a descriptive term which is used at the conclusion of an investigation when no cause of the death is found. SIDS is defined as 'the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history'[570]. The term SIDS should be used for any unexplained infant death which meets these criteria, even in situations where contributory factors (such as co-sleeping or parental drug use) are identified, or other findings (such as co-incidental congenital anomalies, pathology or injuries) are present, but cannot be shown to have caused the death.

15.4.3 In Wales, the process which sets out the minimum standards expected is called PRUDIC – Procedural Response to Unexpected Deaths in Childhood[571].

15.4.4 In Scotland, there are certain criteria for holding a review when a child dies[572].

15.5 Responding to the unexpected death of a child: general principles

15.5.1 When a child dies suddenly or unexpectedly, a coordinated and timely multiagency response provides the opportunity to support the family through their bereavement, and to investigate that child's death thoroughly and sensitively[573].

15.5.2 The responses to an unexpected death have the following aims:

a) Supporting the family;
b) Gathering information to help establish the cause of death and to identify possible contributory factors; and
c) Ensuring a coordinated joint agency response that meets statutory requirements.

15.5.3 Appropriate responses are facilitated by having:

a) Clear local joint agency protocols;
b) Readily accessible information (including for example an ED SUDI/SUDC pack); and
c) An identified professional lead for unexpected child deaths (the SUDI/SUDC paediatrician).

15.5.4 Prior liaison with the local coroner/procurator fiscal, police child protection team, children's social care, and the pathology department helps to ensure that appropriate processes are in place and that staff know clearly what their roles are.

15.6 The role of the paediatrician

15.6.1 Paediatricians bring their own unique skills to the joint agency process. By working in a joint agency manner, they are not expected to carry out a forensic investigation, or to take on roles that are more appropriately carried out by other professionals. In the same way, police officers, social workers or other professionals are not expected to undertake tasks for which they do not have the relevant skills or training, such as taking a medical history, examining a child's body, or carrying out medical investigations.

15.6.2 If, at any stage of the response to an unexpected death, concerns arise that the death may be unnatural, or that abuse or neglect may have contributed, the police should take the lead in all further investigations. Paediatricians and other health professionals will continue to play an important part, working alongside the police and children's social care professionals to gather and interpret health information, to support the family, and to consider the needs of any surviving siblings or other children.

15.6.3 These processes would not normally apply to children dying in hospital from known causes, or those with known life-limiting or life-threatening conditions. However, it is important to recognise that not all deaths in this group of children will be as a result of the underlying condition. These children deserve the same respect and rights as every other child. In these situations, it is helpful to have an early discussion with the palliative care, community or primary care team who know the child and family; to ensure that appropriate decisions are made, and that the family are not subject to inappropriate and intrusive investigations.

15.6.4 It is important throughout the process to treat the child and the family with respect. Always refer to the child by name. As far as possible respect the family's wishes in relation to how the process should be managed and give the family time. Consider any cultural or religious needs of the family, and use interpreters where English is not the first language.

15.7 Responding to the unexpected death of a child: immediate response

15.7.1 Following the unexpected death of a child in the community, the child and parents/carer will normally be brought to the nearest hospital with paediatric facilities.

15.7.2 Appropriate measures should be taken to resuscitate the child according to Resuscitation UK Council guidelines[574]. Once it is clear that resuscitation is no longer appropriate, the decision to stop resuscitation should be made by a senior paediatrician, in discussion with the whole team and the family. The paediatrician should confirm that the child is dead and inform the family.

15.7.3 A named nurse should be allocated to support the family throughout their time in hospital.

15.7.4 Unless the child's death is an expected death in a child with a recognised cause of death, the doctor will not be able to issue a medical certificate of the cause of death, and the death must therefore be referred to the coroner/procurator fiscal.

16 Records and reports

Good practice recommendations

1. Clear contemporaneous documentation should be written in the child's medical record, to include telephone conversations and discussions with the multiagency team.
2. A safeguarding proforma assists the initial assessment *(see Appendix 1)*.
3. Document reasons for any deviations or difficulties.
4. Document positive and negative findings.
5. When summarising your findings, discuss differential diagnoses, base your opinions on the balance of probability supported with the evidence base.
6. There should be no discrepancies between notes, reports and police statements.

16.1 General

16.1.1 Following the death of Victoria Climbié from child abuse and neglect in 2000, Lord Laming conducted an inquiry and reported on his findings in 2003[583], making a number of recommendations for health. Recommendations 65-80 in particular refer to record keeping, reports and management. These are the cornerstone for best practice for paediatricians and have been included in this chapter.

16.1.2 Paediatricians play an important role in the assessment and management of children where there are suspicions of abuse and neglect. Any record, report and/or statement made following an assessment must be full, fair and accurate.

> *'When concerns about the deliberate harm of a child have been raised, doctors must ensure that comprehensive and contemporaneous notes are made of these concerns. If doctors are unable to make their own notes, they must be clear about what it is they wish to have recorded on their behalf.'*
>
> Recommendation 68, The Victoria Climbié Inquiry 2003

16.1.3 The use of a medical proforma *(see Appendix 1)* is recommended practice and prompts the practitioner to structure the consultation (including the history, examination, investigations, opinion and action plan), capture and record the detail, act as an 'aide memoire' and develop a report and/or police statement. Body maps facilitate drawings of visible lesions and injuries, including genital and anal findings, which should be corroborated by photo-documentation. *see Chapter 17.*