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child death review project

Tees Child Death Review Project, hosted by Redcar & Cleveland Safeguarding Children Board and in statutory partnership with Hartlepool, Middlesbrough and Stockton-on-Tees Local Safeguarding Children Boards.

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When a Child Dies

An Introduction to Child Death Review Processes

From April 2008 responsibility given to LSCBs to review all child deaths . There are 2 main strands

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Working Together (2010)

Chapter 7 – Child Death Review Processes

- A **Rapid Response** by a group of key professionals who come together for the purpose of enquiring into and evaluating each **Unexpected** Death of a Child
- An **Overview** of **ALL** Child Deaths in the area, undertaken by a **Panel (CDOP)** to assess preventability
- Preventability= those in which modifiable factors may have contributed to the death…defined as those by which means of nationally or locally achievable interventions could be modified to reduce the risk of future child deaths.

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Expected Child Deaths

- Notification of death sent to RMSO (by Health) and CDR Project (by any involved agency)
- All involved agencies and professionals to react in accordance with their organisational procedures (i.e. Referral for Bereavement Support, Life Celebrations in School)
- Information gathered to present to LCD
- Case analysis and recommendations to CDOP

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What is an Unexpected Death?

The death of a child which was not anticipated as a significant possibility for example 24 hours before the death

or

Where there was a similarly unexpected collapse or incidence leading to or precipitating the events which led to the death

(Fleming et al, 2000: *Sudden Unexpected Deaths in Infancy. The CESDI SUDI Studies 1993-1996,* London, The Stationery Office)

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Rapid Response: Purpose

- To establish, where possible, a cause or causes of death (in conjunction with the Coroner)
- To identify any contributory factors
- To provide ongoing support to the family

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Principles Underlying the Rapid Response

1. Family centred
2. Joint agency
3. Systematic, yet sensitive
4. “Golden Hour” Principle

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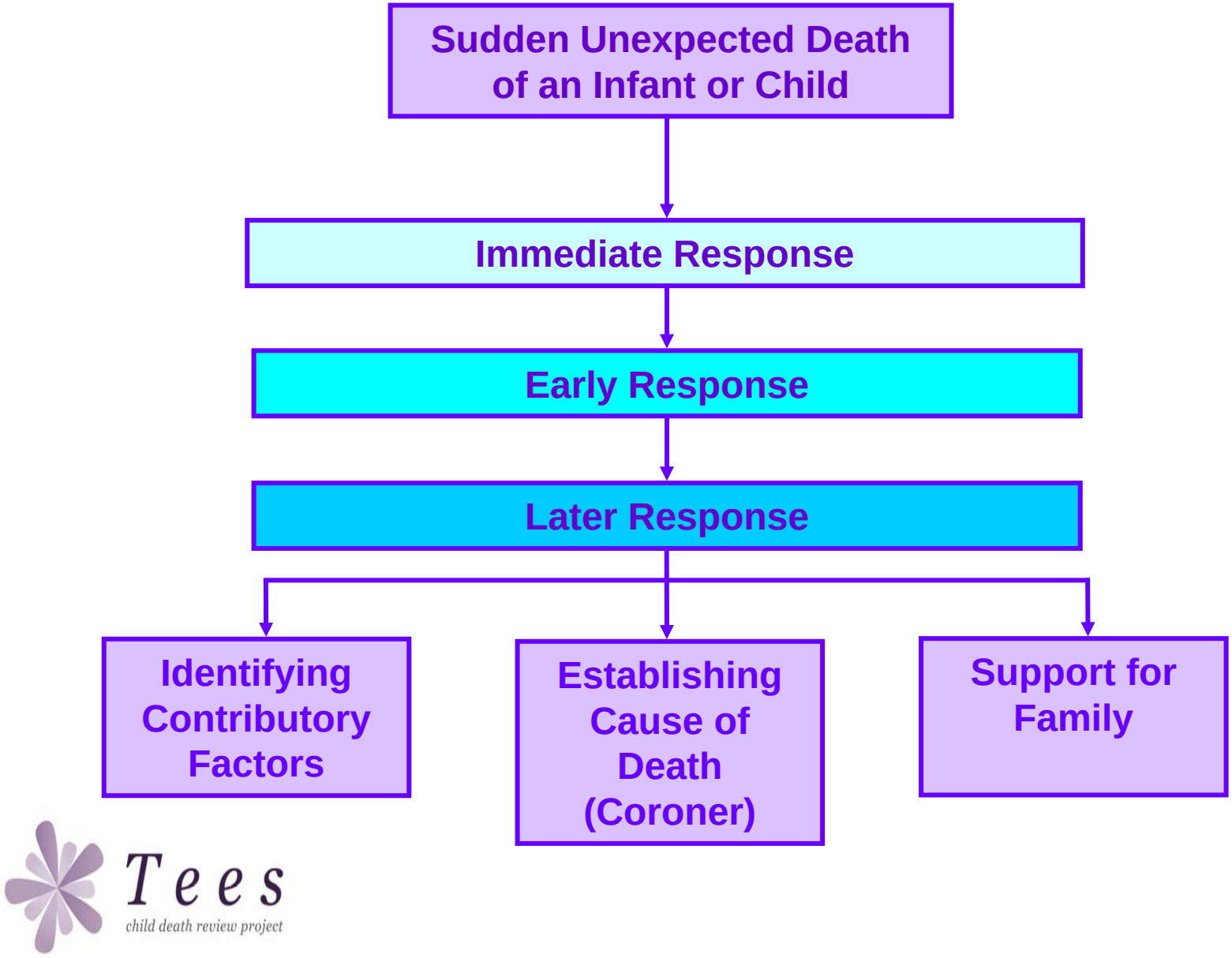

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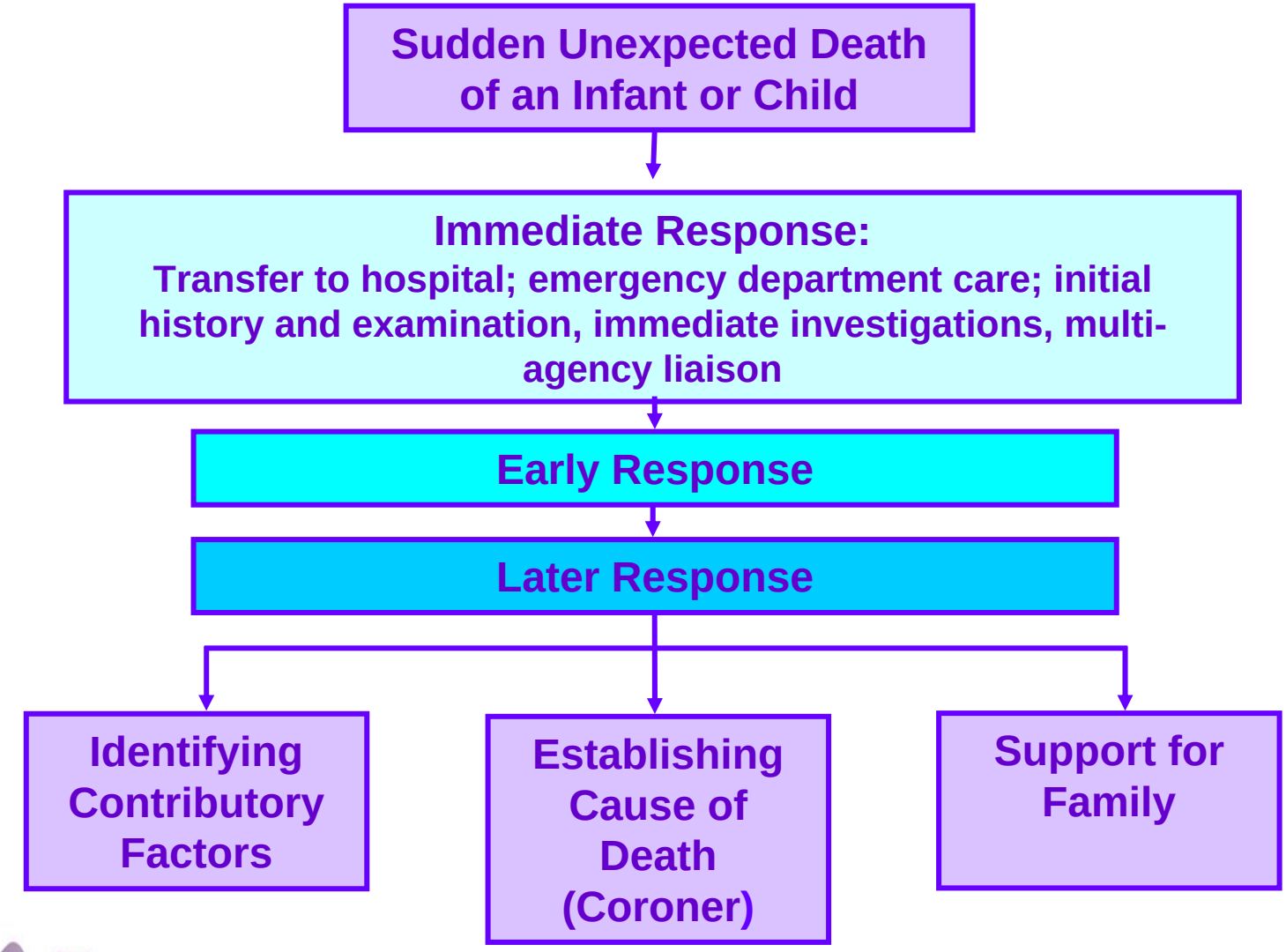

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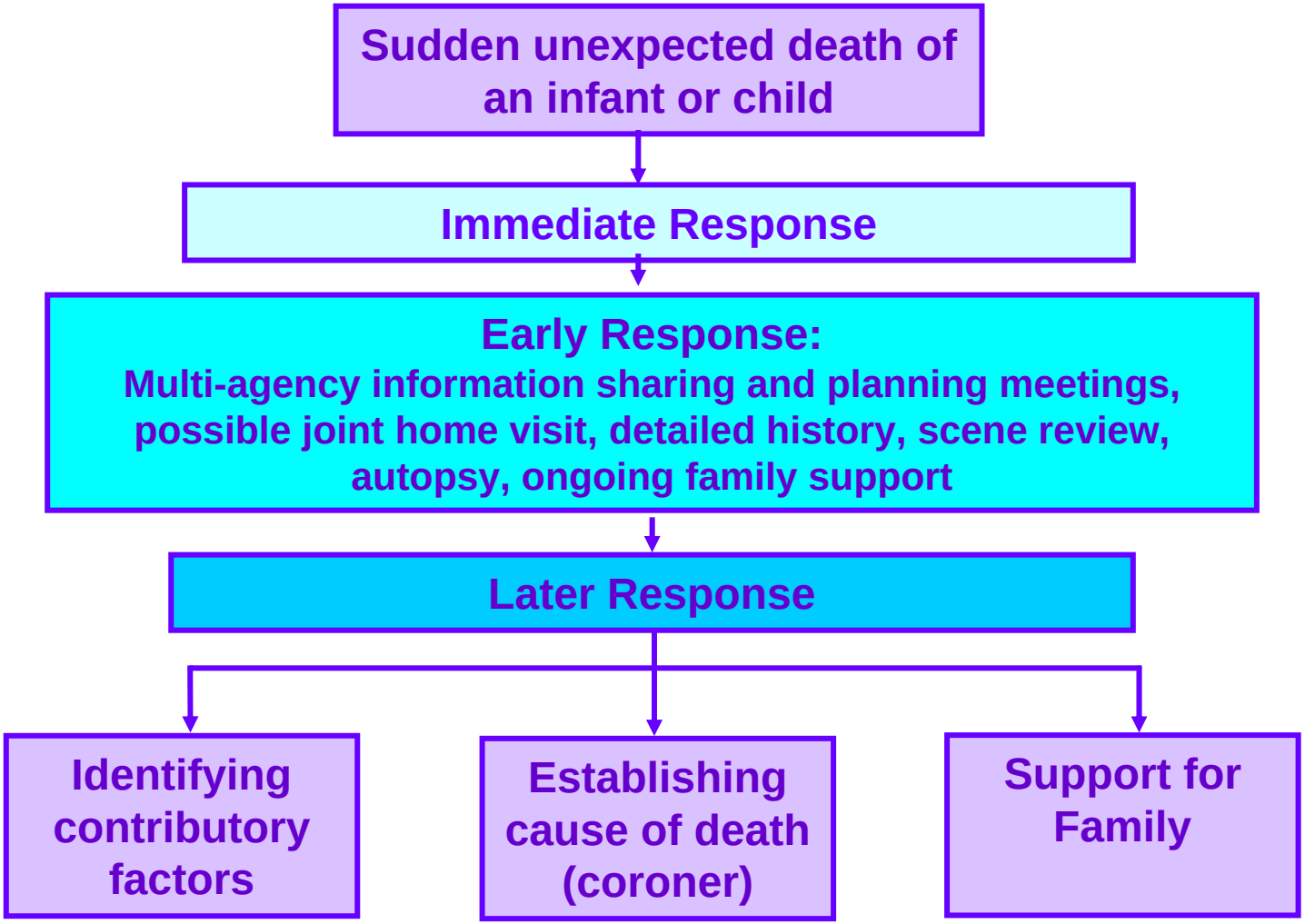

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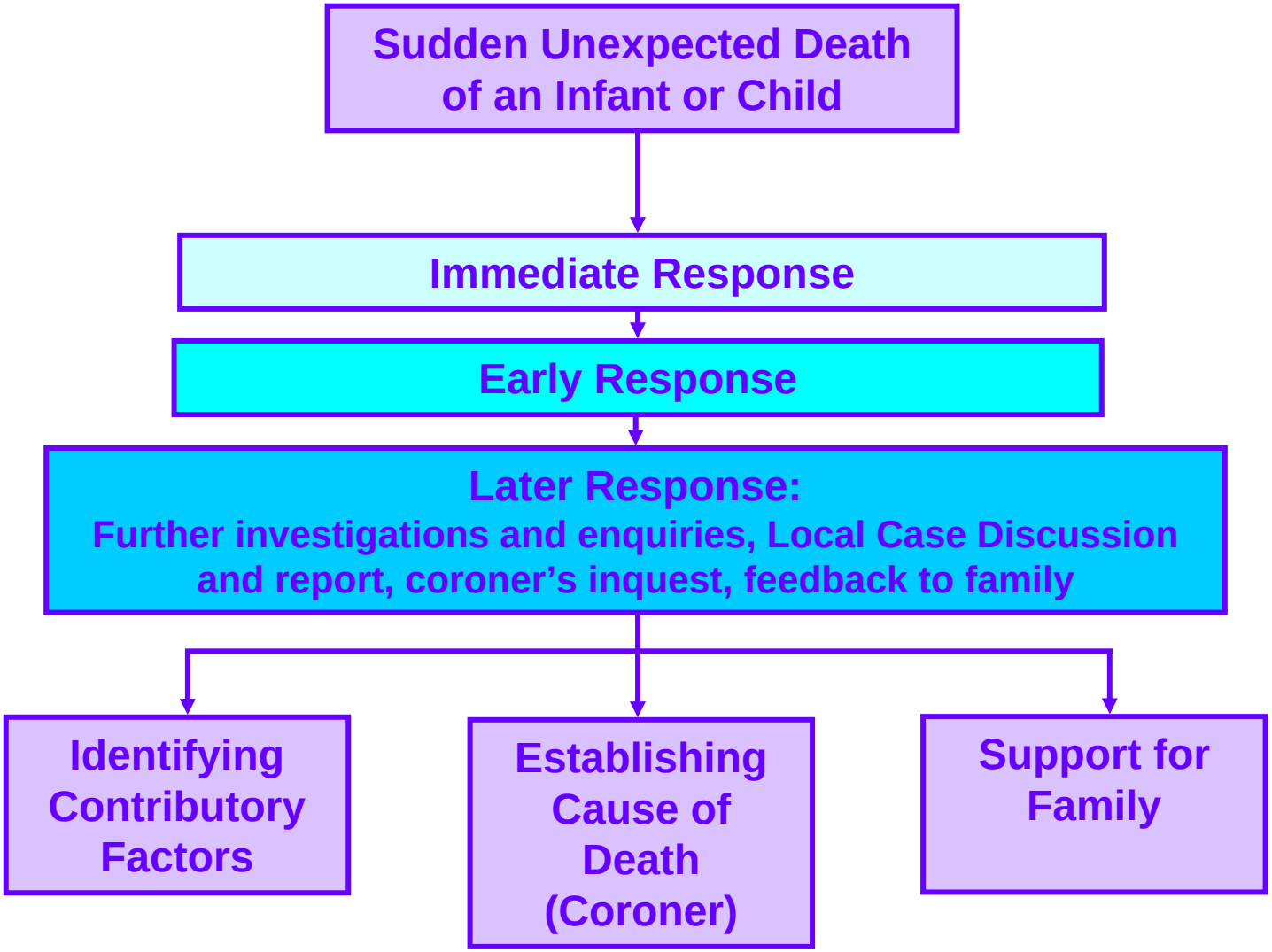

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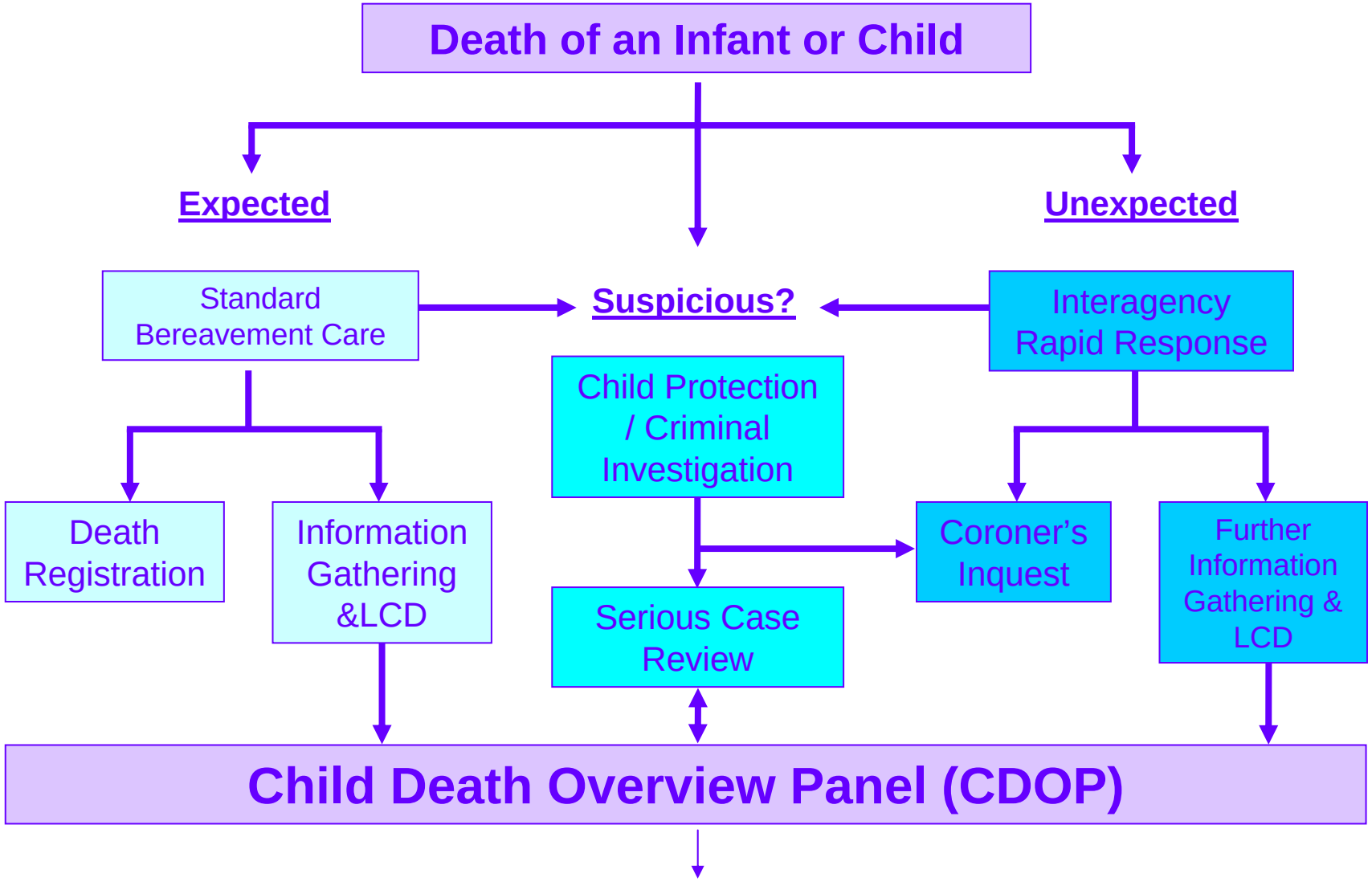

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Purpose of Child Death Overview/CDOP

Collecting and analysing information about each 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 area of the Authority
- Any wider Public Health or safety concerns arising from a particular death or from a pattern of deaths in that area

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Summary

It is every family's right to have their child's death properly investigated

Proper management of childhood deaths Involves a thorough and systematic, yet sensitive inter-agency approach

Child Death Review Procedures DO:

- **Seek to understand why children die**
- **Address the possible needs of bereaved families**
- **Consider lessons to be learnt on safeguarding children**

Child Death Review Procedures DO NOT:

- **Replace the work of any organisation or (Single/Multi-Agency)**
- **Professionals involved in statutory investigations following the death of a child**

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What should I expect if a child I work with dies unexpectedly?

- If you are involved with a child who dies unexpectedly, or with the child's family, you will be asked for information about your involvement and then at a later point, invited to a Local Case Discussion. This is likely to be chaired by a Paediatrician and will bring together all those professionals who have knowledge of the family.

- At this meeting the circumstances surrounding the child's death will be explored and information will be shared. As a group you will try to come to a view about why this child died at that particular time and what all services might learn from this to try to prevent future child deaths.

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What should I expect if a child I work with dies unexpectedly? cont.

- If you learn that a child you are working with has unexpectedly died, you should take the usual action your organisation would expect of you.
- In terms of the Child Death Review Procedures, you will be contacted as necessary by the appropriate people as part of the information gathering process and to be invited to any relevant meetings.
- If you feel you need to talk further with someone about what you might need to do, you can speak with staff from the Tees Child Death Review Project by telephoning (01642) 304516. (covering Middlesbrough, Hartlepool, Stockton and Redcar & Cleveland)

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Some local learning and recommendations

- Raising awareness of dangers of rope swings
- More support for siblings including counselling
- 16-18 year olds still to be classed as children and subject to same procedures eg pathology
- Promoting hand held files when children are treated by specialist, regional teams
- Improving communication between teams
- Adopting national FSID leaflets
- More training for Police Officers on procedures to avoid distressing parents unnecessarily
- Recommended SCR Panel to look at cases

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