Northern Lincolnshire Child Death Review arrangements 2019

NL Child Death Review Partners

Legislative & Statutory Framework

- Children Act 2004
- Working Together to Safeguard Children 2007, 2010, 2015

- Children and Social Work Act 2017
- Working Together to Safeguard Children 2018
- Child Death Review Statutory and Operational Guidance (England) 2018

Why the Change?

- Origins in Safeguarding
- Definition ‘unexpected’
- Concept of ‘preventability’
- Lacked relevant health care metrics in data-sets
- Disconnect between Hospital and CDOP processes
- No national leadership
- Large variation in approach within CDOP and Hospitals
- Lack of evidence of effectiveness

The New Framework - 1

- Lead responsibility shifted from DfE to DHSC
  - NHS England with the job card
- Child Death Review Partners
  - Local Authority (public health function)
  - CCGs in locality
- Introduces a standardised approach to childhood mortality to enable thematic learning at a local and national level
- Development of the National Child Mortality Database
- Designed to capture the expertise and thoughts of the professionals that have cared for the child

The New Framework - 2

- To identify modifiable contributory factors to reduce the risk of future child deaths
- To improve the experience for bereaved families
  - Development of a new "key worker" role
    - single point of contact with the bereaved for information on the child death review process
    - signpost them to sources of support.
- Larger footprint of the CDOPs with a minimum 60 deaths per year
  - two or more areas to deliver CDR functions together

Which children does it apply to?

- ✓ All children under 18 years of age regardless of the cause of death
- ✓ Death of any baby where signs of life are seen at any gestation & where a death certificate has been issued
- ✓ **Does include the stillbirth of a baby where no professional is in attendance**

- X Does not include "witnessed" stillbirths, late fetal loss, or terminations of pregnancy

Who is responsible for the process?

From Immediate Response through to CDRM

- Setting where the child dies
- Except where child's care has been transferred very recently

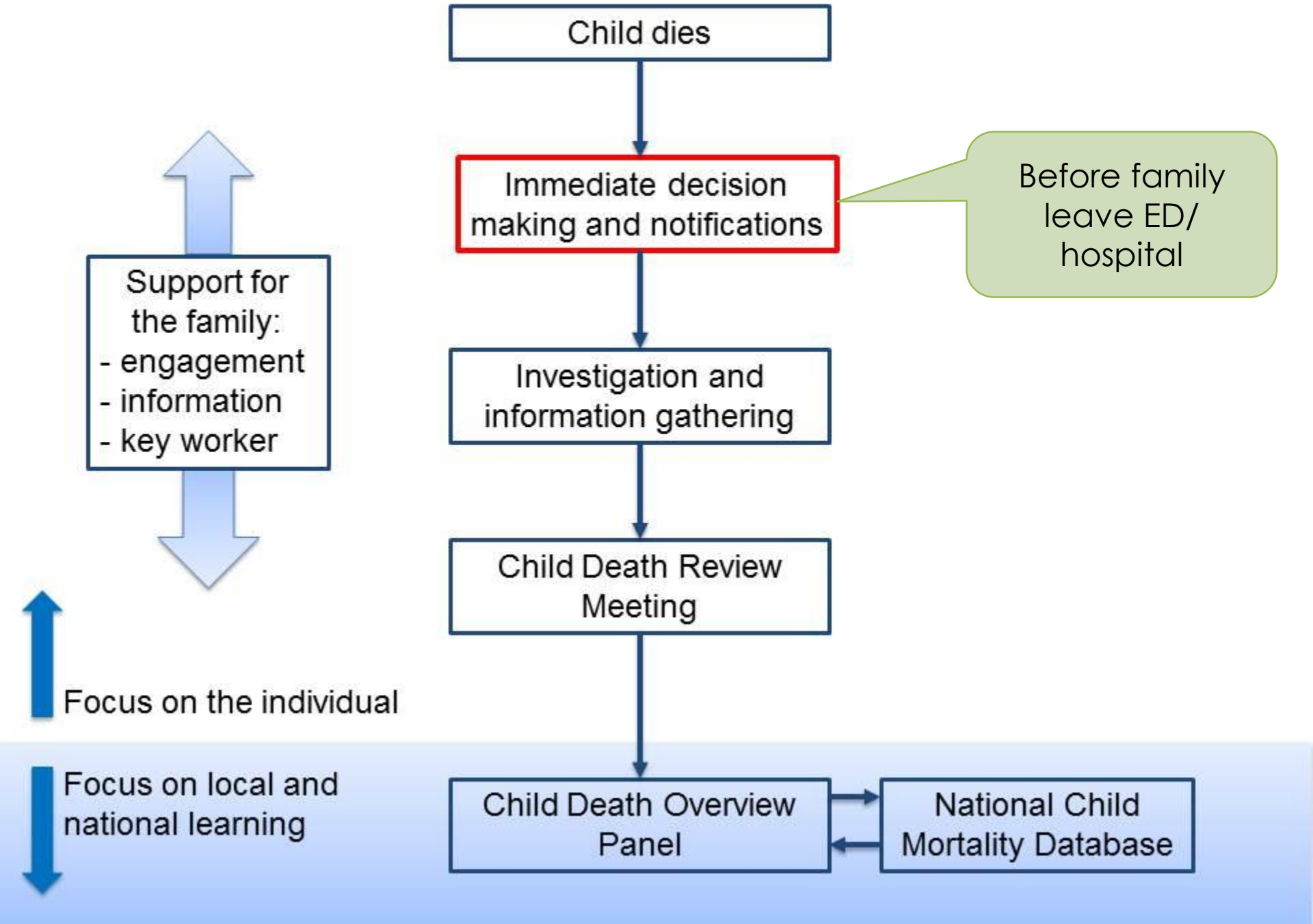
CDOP

- Where child is resident

OR

- Where child dies

Where learning which be best achieved


Child dies
Immediate decision making and notifications
Before family leave ED/ hospital
Support for the family:
- engagement
- information
- key worker
Investigation and information gathering
Child Death Review Meeting
Focus on the individual
Focus on local and national learning
Child Death Overview Panel
National Child Mortality Database

Immediate decision making & notifications

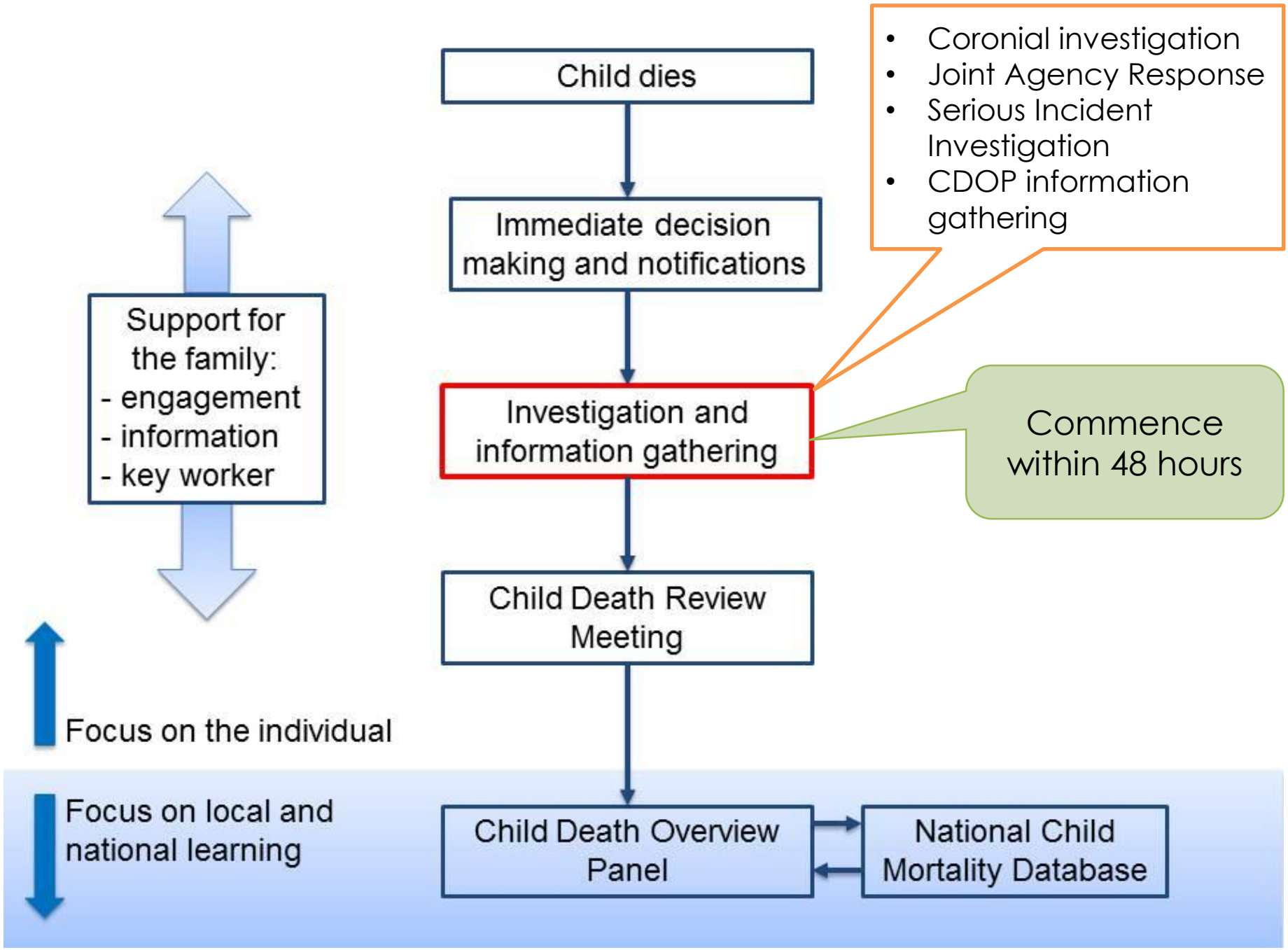
Who

- Consultant, GP, or other HCP in attendance at end of life
- Senior nurse, midwife, (or HV) in attendance at end of life
- Other relevant professionals
  - **JAR team**
  - coroner's officer
  - hospital patient safety team
- Medical Examiner

What

- Support to family
- **? JAR**
- ? MCCD
- ? Service delivery issue
  - SI or other review
- Safety issues
  - Other children
  - Family
  - Professionals
- Notifications

- Proforma
- Checklist


Child dies
Immediate decision making and notifications
Investigation and information gathering
Child Death Review Meeting
Child Death Overview Panel
National Child Mortality Database
Support for the family:
- engagement
- information
- key worker
Focus on the individual
Focus on local and national learning
Coronial investigation
Joint Agency Response
Serious Incident Investigation
CDOP information gathering
Commence within 48 hours

Joint Agency Response

New

☒Unexpected Death

☑JAR triggered if Death:

- due to External causes
- Is sudden and there is no immediate apparent cause
- Occurs in custody or where child detained under Mental Health Act
- Where the initial circumstances raises any suspicions that death may not have been natural
- In the case of stillbirth where no health professional in attendance

Joint Agency Response

New

☑ A JAR should also be triggered if

- child brought into hospital in moribund state, successfully resuscitated, but then expected to die. In such circumstances a JAR should be initiated at point of presentation and not at the moment of death.

JAR & Investigations

some deaths

Who leads

- Lead health professional assigned
  - doctor, senior nurse or health visitor with appropriate training and expertise.
- Responsibilities to ensure
  - all health responses are implemented
  - on-going liaison with the police and other agencies.

What

- Post mortem examination and other peri-mortem tests
- Coronial Investigation
- Joint Agency Response
- Serious Incident Investigation
- When > 1 parallel investigations a case manager should be appointed to have oversight of processes

Reporting Form (quantitative and qualitative data) (previously Form B)

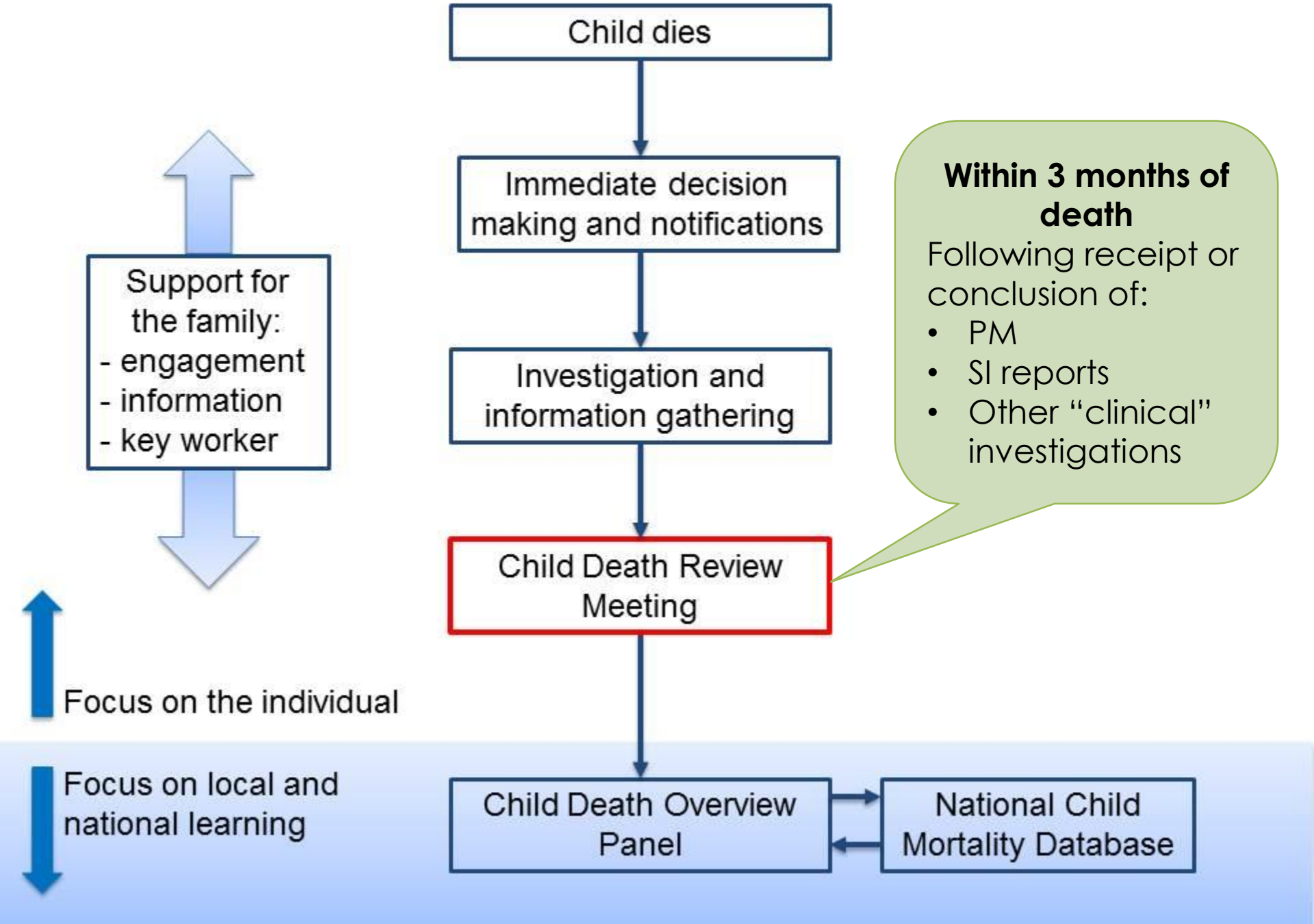
all deaths

- Identifying details
- Circumstances of death
- Factors intrinsic to the child (ethnicity, disability, birth weight, gestation)
- Factors in social environment including parenting capacity (parental illness, smoking, drug dependency, domestic violence)
- Factors in physical environment
- Factors in service provision (issues with diagnosis, treatment, communication, teamwork, incidents, carer's concerns

eCDOP – provision of information

- Single system which amalgamates and collates information from all sources
  - Where completed reduces workload
- Quality of information required
  - Returns will be returned if not completed
- Principles of record keeping including timeliness of completion MUST be adhered to
- Response is mandatory including clear NIL return
- N/K should be an exception
  - only be utilised if the service or organisation DOES NOT hold the information, not just where it is not in the record
- KEY to ensuring local and national learning

- Guidance will be issued


Child dies
Immediate decision making and notifications
Investigation and information gathering
Child Death Review Meeting
Child Death Overview Panel
National Child Mortality Database
Support for the family:
- engagement
- information
- key worker
Within 3 months of death
Following receipt or conclusion of:
• PM
• SI reports
• Other "clinical" investigations
Focus on the individual
Focus on local and national learning

Child Death Review Meeting (CDRM)

- Multi-professional meeting
  - Discusses all matters relating to an individual child's death
- Includes professionals
  - directly involved in the care of that child
  - involved in the investigation into his or her death.
- Chaired (or attended) by Lead Health Professional
- Should be " flexible and proportionate"
- Other meetings can be utilised:
  - e.g. mortality and morbidity meeting, perinatal mortality meeting,
  - Should be individual consideration of each child within meeting
- outcome of the child death review meeting should be forwarded to the relevant CDOP, to provide a "standardised output"

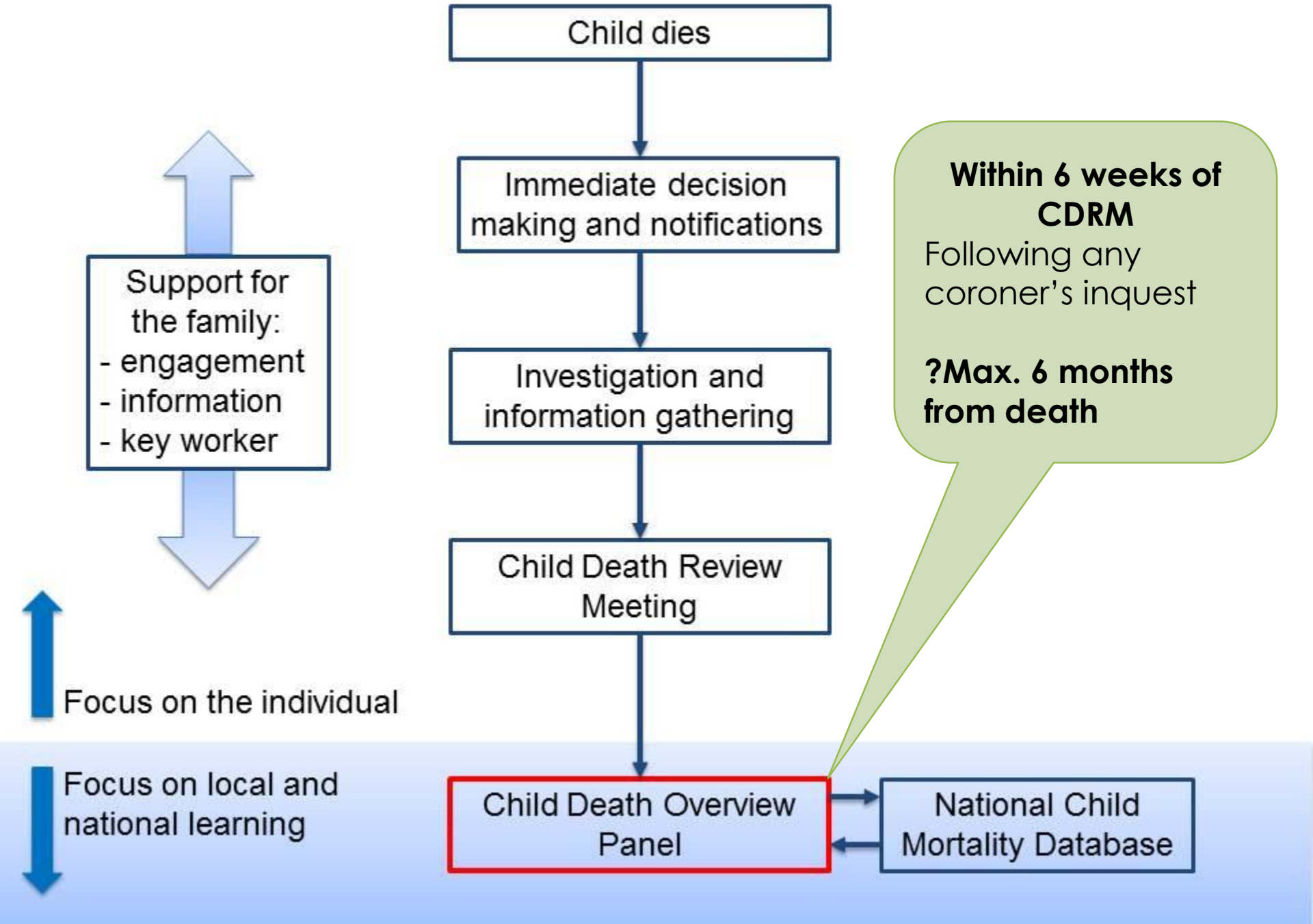
Child Death Review Meeting

- Review case history
- Ascertain modifiable factors
- Identify learning
- Review family support
- Complete Draft Analysis form
- Review support to staff

Analysis form (quantitative and qualitative data) (previously Form C)

- Outcome of CDRM provided on via draft Analysis Form

- Scores (0-2) contributory factors across domains intrinsic to the child, social environment and parenting capacity, physical environment, and service delivery
- Judgment as to whether any of determined factors might be modifiable
- Categorisation of death (1-10)
- Learning points and actions


Child dies
Immediate decision making and notifications
Investigation and information gathering
Child Death Review Meeting
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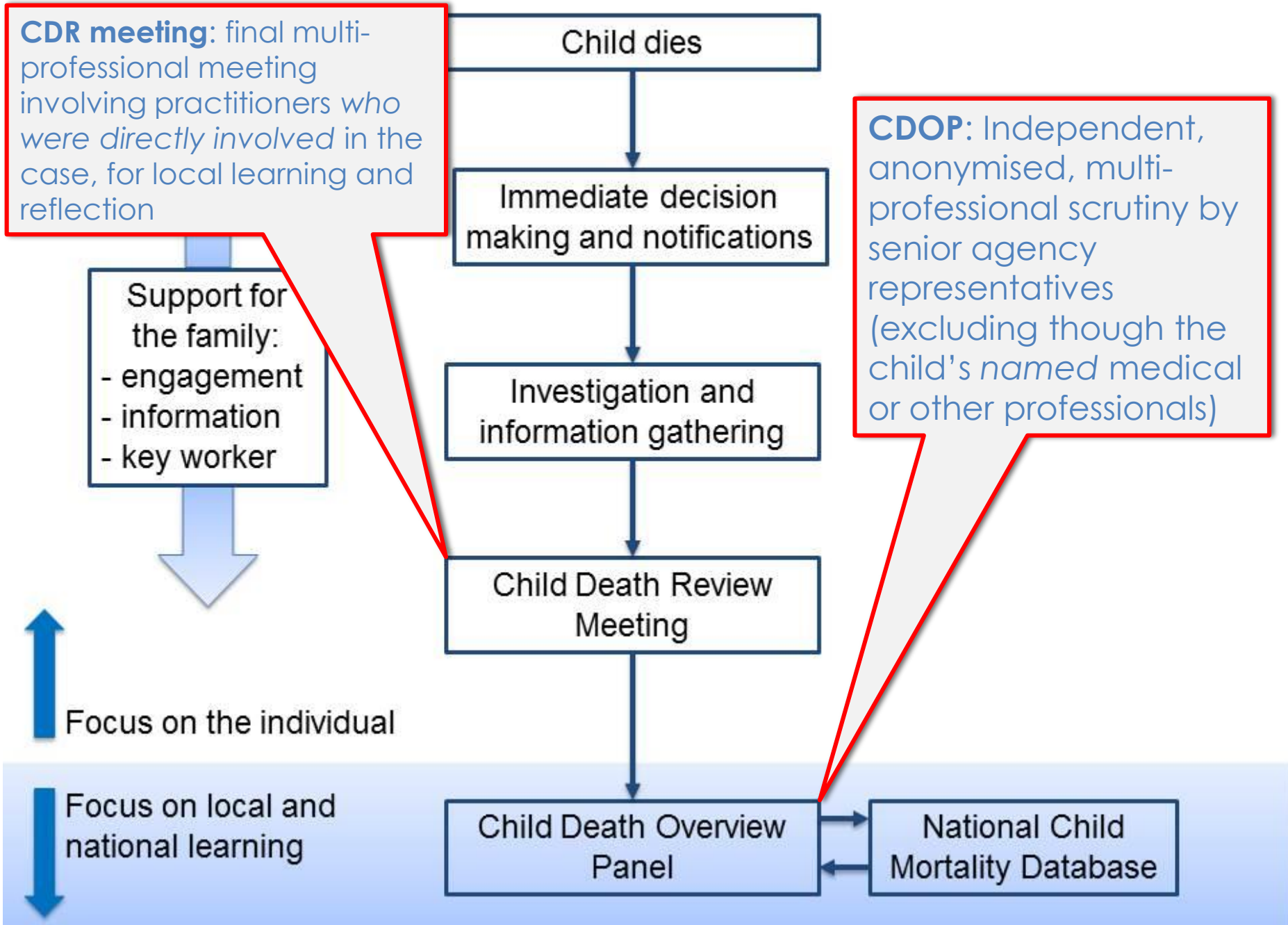
National Child Mortality Database
Support for the family:
- engagement
- information
- key worker
Focus on the individual
Focus on local and national learning
Within 6 weeks of CDRM
Following any coroner's inquest
?Max. 6 months from death


CDR meeting: final multi-professional meeting involving practitioners *who were directly involved* in the case, for local learning and reflection
Child dies
Immediate decision making and notifications
Support for the family:
- engagement
- information
- key worker
Investigation and information gathering
Child Death Review Meeting
CDOP: Independent, anonymised, multi-professional scrutiny by senior agency representatives (excluding though the child's *named* medical or other professionals)
Focus on the individual
Focus on local and national learning
Child Death Overview Panel
National Child Mortality Database

Aim of CDOP

- To review & confirm/ challenge outcome of CDRM
- Make recommendations to CDR partners and other organisations where learning is identified
- Notification if child abused or neglected
- Notify cause of death queried
- Produce Annual Report
- Contribute to regional and national research

Panel Membership

- Public health
- Designated Doctor for child deaths
- Acute or community doctor (dependent on Designated Doctor skills
- Children's social care
- Police;
- Designated Nurse for Safeguarding
- Primary care: GP or health visitor
- Senior nurse and/or midwife
- Lay representation; and

On case by case basis

- coroner's office, education, housing, council services, health and wellbeing board, ambulance services, or hospices.

Team around the family

- **Key worker**
  - Readily accessible single named point of contact
  - Some-one family can turn to for information and support
  - Help co-ordinate meetings between family and professionals
  - Represent the 'voice' of the parents at meetings
  - Responsibility of organisation where child died to nominate key worker
  - Role could be undertaken by a range of professionals
- **Medical Lead**
  - child's paediatrician, neonatologist, or JAR lead health professional; should liaise closely with Key Worker
  - Responsible for family follow-up, explaining results PM, other investigations, and outcome CDR meeting
- **Case manager** : co-ordinate across investigations
- **Other professionals**: coroners officer, police family liaison officer, GP, social worker, school nurse, HV

Specific situations

- Deaths overseas of children normally resident in England
- Children and young people with learning disabilities (LeDeR)
- Deaths of children and young people in adult healthcare settings (essentially adult ITUs): Learning from Deaths provides overarching framework with following caveats
  - Notification of CHIS, CDOP, GP
  - Close liaison with Designated Doctor who should:
    - Ascertain whether JAR needed
    - Identify which paediatric professionals should be present at adult M&M
    - Attend adult M&M for purpose of completing draft Analysis form
- Suicide and self harm
- Inpatient mental health settings
- Deaths in custody

Questions