

# The child death review process in Wales

## Roles and responsibilities for GPs

# **ALL WALES CHILD DEATH REVIEW PILOT STUDY**

## **Information and Guidance for General Practitioners**

### **1. BACKGROUND**

In England the Regulations introduced under The Children Act 2004 required Local Safeguarding Children Boards (LSCBs) to set up a process for reviewing **all** deaths of children from 1<sup>st</sup> April 2008. The purpose of the process is to examine whether there are common factors associated with particular causes of child death which, once identified, can be addressed through local initiatives. Much of the process is based on experiences from the USA, where reviews are well established.

The child death review process in England outlines two approaches to reviewing the death of a child; A Child Death Overview Panel (CDOP) for all deaths in the LSCB area and a Rapid Response Team (RRT) to make initial assessments about the circumstances of all unexpected deaths in the area. General Practitioners play a key role in both processes, at the time of death, and subsequently, providing an insight into the circumstances of the death such as relevant medical and family history and also in supporting the family.

### **2. INTRODUCTION**

The Welsh Regulations under The Children Act 2004 currently (October 2009) do not require individual LSCBs to review all child deaths, as the Welsh Assembly Government (WAG) wanted to consider taking an all-Wales approach to conducting reviews of all child deaths. The National Public Health Service for Wales has been commissioned to undertake a pilot study on behalf of the WAG to examine the practicality of this. The Pilot began in July 2009 and is expected to last for one year. The Pilot will:

- Collect, analyse and review information about child deaths in Wales with a view to identifying common and preventable factors;
- Develop partnerships between organisations involved in the reporting and investigation of the death of a child, and with members of the public;
- Lead to improved ways of safeguarding children's health and wellbeing and better allocation of resources.

The Child Death Review Pilot will concentrate on three tasks. These are:

1. Ascertaining all child deaths (0 to <18 years) from October 1<sup>st</sup> 2009 until the end of the Pilot;
2. Establishing national reviews of deaths, initially focussing on suicides and apparent suicides since October 1<sup>st</sup> 2006;
3. Testing the feasibility of establishing local reviews/case discussions and integrating completion of information requirements into current processes.

### **3. CHILD DEATH REVIEW PILOT (July 2009 to July 2010)**

#### **3.1. Ascertainment**

Basic information about all child deaths will be collected to support public health surveillance and provide a basis for selecting cases that may be reviewed by the National Child Death Review Panel. It is expected that notifications will be provided from a number of sources. These include Local Safeguarding Children Boards and Local Health

Boards.

### **3.1.1. Consent and Confidentiality**

The information will be collected on a standard form: Notification of Child Death Form A. The information that will be collected relates solely to the deceased and is not subject to the Data Protection Act (DPA). A duty of confidentiality applies and it is important that parents/carers are made aware that basic information about their child's death will be notified and a leaflet has been drafted. It is intended that provision of this leaflet, along with verbal explanation about the Child Death Review process by an appropriate professional, will be worked into already established 'when a child dies' processes.

### **3.1.2. GP Involvement**

Following the death of a child the GP is likely to play a pivotal role in providing ongoing advice and support, in collaboration with other professionals. It may be considered appropriate that information about the child death review process be relayed by the GP to the family in these circumstances.

## **3.2. National Child Death Reviews**

### **3.2.1. Panels**

A National Panel will review selected child deaths during the pilot. The Panel will be chaired by the Clinical Lead for the Pilot, Professor Jo Sibert. The panel will have a fixed core membership of professionals, with an option to co-opt other professionals or individuals that can make a specific contribution.

The purpose of the Panel is to review all the information about a child's death in order to:

- Identify whether there are any trends emerging locally or nationally;
- Identify lessons that can be learned about the patterns of child deaths.

The Panel will review anonymised case summaries and consider whether they can make any recommendations to improve the safety and wellbeing of children. The Child Death Review Support Team will agree ownership of recommendations with stakeholders and follow up implementation of these within agreed timescales.

### **3.2.2. Guiding Principles**

The guiding principles established by the National Resource Center for Child Death Review, Washington D.C. that will be adopted for the Reviews in Wales are:

- Reviews are multi-disciplinary;
- Reviews are not investigations;
- Reviews do not replace agency roles and responsibilities in responding to deaths;
- Reviews use the narrative along with data;
- Factors in child deaths are so multidimensional that responsibility for a death doesn't belong to any one place;

- Reviews focus on fixes in the future - not who is at fault and who should be blamed;
- Reviews look for fixes from an ecological perspective.

### **3.2.3. Information Requirements**

It is intended that information that has already been collected will provide the basis for the case summaries and 'new' information will not be requested. Sources will include the Child Death Agency Report Form B (completion facilitated by the LSCB), Serious Case Review Reports (if available) and Coroners Transcripts.

#### **3.2.3.1. Consent and Confidentiality**

The sources listed above will include information relating to the background of the deceased, such as details about their mother, father or other household members.

In order for this information to be shared (where it is not already in the public domain), consent will be required from the individuals to whom it relates. Work has been undertaken by the Child Death Review Support Team to ascertain how this can be achieved; with minimal distress to those affected. This has included contact with bereavement organisations and those who have carried out similar studies and impact assessments. Feedback suggests that while the initial approach may cause some distress, families generally welcome the opportunity for lessons to be learned and put to use in safeguarding other children.

It has been concluded that each approach will need to be considered on a case-by-case basis.

### **3.2.4. Suicide/Apparent Suicide**

During the Pilot the Child Death Review Panel will review cases of Suicide/Apparent Suicide since October 1<sup>st</sup> 2006. The Panel membership includes a child psychiatrist, a child psychologist, a consultant paediatrician, a consultant in public health, and representatives from the police, education, social services, Children in Wales, and the Office of the Children's Commissioner for Wales.

### **3.2.5. Other Types of Death**

It is hoped that there will be opportunity to review other types of death prior to the end of the Pilot, such as Sudden Unexpected Death of an Infant (SUDI).

### **3.2.6. GP Involvement**

It is anticipated that only a small number of deaths will be reviewed during the Pilot.

#### **3.2.6.1. Liaison with Families/Carers**

The Child Death Review Support Team will liaise with the relevant LSCB to discuss each child death which is identified for review. A decision will be made in conjunction with the LSCB and other professionals, such as GPs, as to whether an approach may be made to the family/carer to obtain permission to review the death.

It is possible that the GP may be best placed to approach the family. The Clinical

Lead will liaise with the GP to discuss how this will be done.

### **3.3. Establishing Local Case Discussions/Reviews and Integrating Information Requirements**

#### **3.3.1. Local Case Discussions/Reviews**

The Pilot will seek to investigate the feasibility of local case discussions/reviews for certain child deaths e.g. death from drowning. It is hoped that this concept can be tested with local pathfinder collaborations putting cases forward for Review to the National Panel if it is considered that lessons can be learned on a wider basis.

#### **3.3.2. Integrating Information Requirements into Current Processes**

It is also intended that the practicalities of integrating completion of Child Death Review forms into already established processes will be tested.

#### **3.3.3. GP Involvement**

GPs may be asked to contribute to local case discussions or reviews by providing insight into the child's medical history and any family history that may have contributed to the death of the child. This will be dependent on those LSCB areas that wish to inform the recommendations of the Pilot and are likely to be small in number.

## **4. STATUTORY OBLIGATIONS**

Although practices do not yet have a statutory obligation to support the Child Death Review Pilot, it is important to remember that a child death is a rare occurrence and Practices should aim to cooperate fully.