BACCH response to Revisions to Chapter Five - Child Death Reviews

Question	**Agree: Yes or No**	**If no, reasons why:**
15. In reviewing the circumstances around the death of a child, the overarching aim is to prevent future child deaths. We have heard from stakeholders that the term “preventable” has posed a hindrance to learning. Instead of asking about preventability, we propose that the child death review process should consider and identify “modifiable factors”. That is, contributory factors to a death that could be modified to reduce the risk of future child deaths. Do you agree with this approach?	**No**	Without becoming hamstrung by semantics it might be more helpful to identify "contributing factors" and then identify "modifiable factors" with a clear link to evidence-based actions required to implement strategies/interventions which will modify the contributing factors on an individual, community and national basis. This issue should be considered both from the perspective of an individual family and that of the community, for example if a child drowns in a garden pond. The individual response could be to fill in the pond, if further children were planned, but on a community basis the fencing of ponds and swimming pools would be logical. On a national basis legislation to ensure swimming pools are fenced when building would be logical (as they do in Australia).
16. We have heard from stakeholders that the distinction between ‘expected’ and ‘unexpected’ child deaths can lead to confusion (partly because it may depend from whose viewpoint the question is being considered). We propose a new approach, which allows each individual death to be responded to appropriately, rather than determining whether or not a death meets certain criteria for investigation. This is about working differently, and changing the initial stages of the process. It does not imply an additional burden. Do you agree with this approach?	**Yes**	
17. The Wood Review recommended that the area covered by child death reviews should cover ‘a population size that gives a sufficient number of deaths to be analysed for patterns, themes and trends of death’. The new legislation gives the child death review partners flexibility to agree that two or more local authority areas may work together as a single area. We are proposing that the geographical ‘footprint’ of the arrangements should be locally	**No**	The proposed changes would reduce the number of CDOPs from approximately 152 to less than 50. If neonatal death were reviewed within the structure of neonatal networks that would further reduce the numbers requiring review by approximately an additional 50%. Currently the burden of reviewing neonatal deaths outweighs the added value of including them within CDOP remit. There may also be authorities with no logical neighbouring authority

agreed, based on patient flows across existing networks of NHS care. Child death review partners should come together to develop clear plans outlining the administrative and logistical processes for their new arrangements. Child death review 'footprints' should typically cover a child population such that they review 80-120 child deaths each year Do you agree with these proposals?		for them to join up with. Overall although the aim of reducing the number of CDOPs, particularly those that review few deaths, is laudable, it may lead to very large populations needing to be reviewed purely because the child health is very high, and therefore child mortality is very low.
18. We propose that families should be assigned a "key worker" to act as a single point of contact who they can turn to for information on the child death review process, and who can signpost them to sources of support. This is already best practice and should not imply an additional burden. More information on the role of the key worker is available in chapter 6.5.1 of the Child Death Review Statutory Guidance. Do you agree with this proposal?	**Yes**	A focus on providing families with support following a child death is supported. A key worker could contribute to this, providing they have appropriate training and support. This should be specified as not all professionals have experience or the necessary competencies to deal with death. Many authorities have brought in the Specialist Nurse in Child Deaths who acts as the main key worker. However clearly organisations who have tertiary neonatal units, or oncology units etc will provide their own key workers to support these families. We also need to consider that all families are individuals and that some families may wish for support which is not tied to the hospital trust.
19. We propose that every child's death is reviewed at a child death review meeting involving practitioners directly involved in the the child's care, prior to being discussed anonymously by the Child Death Overview Panel (CDOP). The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved. It would (for example) take the form of a final case discussion following a Joint Agency Response to a sudden unexpected death in infancy; or a hospital-based mortality meeting following a death on a neonatal unit. The purpose of the child death review meeting is to ensure local learning and reflection. In contrast, the purpose of the CDOP is to provide independent scrutiny of each case, ensuring this is from a multi-agency perspective. Do you agree with this proposal?	**No**	In practice it is often very difficult for all practitioners involved with a child to meet following their death. It is unclear how the learning and reflection could be taken forward by individual practitioners. For example, following the death of a child cyclist the learning might be that local cycle paths and safe Routes to School should be implemented, while a national basis there should be a change in legislation to enable children to cycle on paths (as they do in Scotland). We would also have concerns that hospital reviews may miss out important people relevant to the child, i.e. Social Care, Education etc. Some families value the Independent review that the external Child Death Review is currently. There are also children who would be missed, 17 year old who dies while driving a car will be taken to the mortuary, because he will not have been recognized to be a child.
20. Practitioners involved in the care of the child who died should be invited to attend the child death review meeting. If they cannot attend, they should submit a report, for which a Form B may be used. We propose that Child Death Overview Panel administrators	**Yes**	

work closely with child death review partners to gather and collate these reports. Please see Chapter 4 of the Child Death Review Statutory Guidance for more information on this process. Do you agree with this proposal?		
21. A revised Form C is proposed at Appendix 5 of the Child Death Review Statutory Guidance. We have heard from stakeholders that two of the form's domains - 'family and environment' and 'parenting capacity' - are not helpful distinctions. We propose changing these domains to 'Social environment including family and parenting capacity', and 'Physical environment', respectively. Do you agree with this proposal?	**No**	The important issue here is not the overall title of the domains, but the content and definition of the factors collected to enable consistent and standard analysis. How for example is parental capacity defined and measured? What physical environmental factors will be included?
22. We have heard from stakeholders that in many cases reports from child death review meetings (particularly hospital mortality meetings) are not routinely sent to CDOPs. We propose that all child death review meetings should routinely send a report to the CDOP, to inform its independent review of the case. This approach is intended to strengthen the link between the local review and the CDOP process, while also allowing for the right balance between local reflection and independent scrutiny of practice. Do you agree with this proposal?	**Yes**	
23. Chapter 7 of the Child Death Review Statutory Guidance outlines expectations in a number of specific circumstances, including: deaths of UK-resident children overseas; deaths of children with learning disabilities; deaths of children in adult healthcare settings; suicide and self-harm; deaths in inpatient mental health settings and deaths in custody. Do you feel we have covered an appropriate range of specific situations? Are the suggested approaches for each of these appropriate and workable?	**Yes** **No**	Most of these proposals are reasonable and workable. The overlap with LeDeR seems unnecessary, only a child death review/CDOP process is required. The expectations regarding deaths of UK-resident children overseas are in general unworkable, particularly if the body is not returned to the UK. If there are concerns that the death may be due to Neglect or another form of abuse then it is almost impossible to obtain the information which is critical in safeguarding the other children in the family. Equally suggesting modifiable factors to another country is unlikely to be responded to. If the body is not returned to the UK then the Coroner is not involved, there is no second Post Mortem etc. All this increases the difficulty in dealing with these deaths.

24. We have heard from stakeholders that some types of deaths (e.g. suicides) may best be reviewed at a themed CDOP meeting. This may apply when deaths from a particular cause are of small number and/or require specialist expertise to inform the discussion. In these circumstances, we propose that neighbouring CDOPs and designated doctors for child death liaise and co-ordinate their approach. Do you agree with this approach?	**Yes**	Themed meetings around specialist care for example oncology should be devolved to clinical networks as they have both the expertise and requirement to improve. Themed meetings on a national basis for rare causes of death would be welcome, particularly those causes of death that are associated with high levels of morbidity in non-fatal cases. Road traffic accidents come to mind.
Are there any other comments you wish to make concerning the changes proposed?	**Yes**	1. Is it necessary to review deaths of any gestation? Could Babies born under 22 weeks gestation be treated as Stillbirths? 2. Annual CDOP report to be published. Further detail of what is required in the report and if a specific time period is required due to smaller numbers of a certain category, such as death due to deliberate harm, being identifiable. 3. CDR meetings are dependent on waiting for final PM report (which can take 6 months or more to arrive). 4. Membership of CDOP – There is no mention of Public Health lead apart from the chair. 5. Need access to updated leaflets for parents/professionals and updated training materials for delivering training to professionals on the CDOP process. 6. No involvement of CDOP panel members with the child – how is that practicable? This will be a particular with themed panels where a specialist for that geographical area will most likely know of the individuals and will be expected to attend the themed day.

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