

Unexpected or Traumatic Death of a Child

How the unexpected death of a child is defined

The death of an infant or child (under 18 years old) which:

- was not anticipated as a significant possibility 24 hour before the death: or
- where there was a similarly unexpected collapse or incident leading to or precipitating the event which led to the death.

The Regulations relating to child death reviews

The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

(a) collecting and analysing information about each death with a view to identifying—

(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);

(ii) any matters of concern affecting the safety and welfare of children in the area of the authority;

(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

(b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

Each death of a child is a tragedy and enquiries should keep an appropriate balance between forensic and medical requirements and supporting the family at a difficult time. Professionals supporting parents and family members should assure them that the objective of the child death review process is not to allocate blame, but to learn lessons. The Review will help to prevent further such child deaths.

The responsibility for determining the cause of death rests with the coroner or the doctor who signs the medical certificate of the cause of death and therefore is not the responsibility of the Child Death Overview Panel (CDOP).

The South West Peninsula Child Death Overview Panel

Legislation requires that every child death is reviewed by a Child Death Overview Panel which is a subcommittee of the Local Safeguarding Children Board. This is mandated by the Children Act (2004) and explained in Working Together to Safeguard Children (2013)¹.

The four Local Safeguarding Children Boards for Cornwall & the Isles of Scilly, Plymouth, Torbay and Devon have formed one Child Death Overview Panel for the South West Peninsula. This Panel

¹ <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

meets once a month to review anonymised summaries of each child death, for children aged from birth to 17 years 364 days who are normally resident in the South West Peninsula. Deaths of children not normally resident in the Peninsula but that occur within the SW Peninsula area may also be reviewed.

The Child Death Overview Panel is a comprehensive and multi-disciplinary review aiming to understand why and how children die. The core purpose is to identify patterns and trends and implement interventions with a view to preventing future deaths of a similar nature.

All agencies are represented on the Panel and include: the Health Service, Social Services, Education, Ambulance, Police, and the Local Safeguarding Children Board. Specialist experts are co-opted to join a particular child death overview panel meeting when there are cases requiring their input, for example: the Fire Service, accident prevention experts, Drugs & Alcohol service and any other service that may have a contribution to make.

The work of the Child Death Overview Panel is summarised in an annual report.

For more information contact:
 SW Peninsula Child Death Overview Panel Office
 Admin Block, Mount Gould Hospital
 Mount Gould Road
 Plymouth
 PL4 7QD
 Tel: 01752-434161 E-mail: PCHCIC.swcdop@nhs.net

Specific responsibilities of relevant bodies in relation to child deaths (<http://www.online-procedures.co.uk/swcpp/procedures/working-together-2013/chapter-5-child-death-reviews/providing-information-to-the-department-for-education/>)

Specific responsibilities of relevant bodies in relation to child deaths	
Registrars of Births and Deaths (Children & Young Persons Act 2008)	Requirement to supply the LSCB with information which they have about the death of persons under 18 they have registered or re-registered. Notify LSCBs if they issue a <i>Certificate of No Liability to Register</i> where it appears that the deceased was or may have been under the age of 18 at the time of death. Requirement to send the information to the appropriate LSCB (the one which covers the sub-district in which the register is kept) no later than seven days from the date of registration.
Coroners (Coroners Rules 1984 (as amended by the Coroners (Amendment) Rules 2008)	Duty to inquire and may require evidence. Duty to inform the LSCB for the area in which the child died within three working days of the fact of an inquest or post mortem. Powers to share information with LSCBs for the

	purposes of carrying out their functions, including reviewing child deaths and undertaking SCRs.
Registrar General (section 32 of the Children and Young Persons Act 2008)	Power to share child death information with the Secretary of State, including about children who die abroad.
Medical Examiners (Coroners and Justice Act 2009)	It is anticipated that from 2014 Medical Examiners will be required to share information with LSCBs about child deaths that are not investigated by a coroner.
Clinical Commissioning Groups (Health and Social Care Act 2012)	Employ, or have arrangements in place to secure the expertise of, consultant paediatricians whose designated responsibilities are to provide advice on: <ul style="list-style-type: none"> • commissioning paediatric services from paediatricians with expertise in undertaking enquiries into unexpected deaths in childhood, and from medical investigative services; and • the organisation of such services.

Guidance for Early Years and Childcare Providers and Children's Centres in the event of the unexpected death of a child.

When a child dies unexpectedly, staff, volunteers, children and families will be shocked. Unexpected deaths might be due to a sudden illness, a road traffic (or other) accident or abuse. If the death is due to suspected suicide, there will be additional considerations. Staff, volunteers, children and families are likely to have additional questions and will want to know if they could have done anything to prevent the death.

In the event of any death of child, the early years and childcare provider should be notified by the Child Death Overview Panel (CDOP); if not already by the parents; and should be invited to the Initial Case Discussion which will happen the first working day following the death. This means that if the death occurs over a weekend, the Initial Case Discussion will be held on the Monday and Early Years and Childcare Providers and/or Children's Centre may find it very useful to attend this meeting.

Issues to consider immediately:

- **Support for children:** *contact the Educational Psychology Service who will prioritise early years and childcare provider/children's centres and visit immediately to offer support to the children.*
- **Check the child's record and create a family tree/genogram:** this will enable you to ensure that you have recognised any other relatives attending the provider or children's centre e.g. siblings who might have different surnames, cousins etc. who will need particular support. Where you know the child has siblings in at another early years and childcare provider,

children's centre or school contact them to ensure that they are aware. If the early years and childcare provider or children's centre has information regarding an absent parent, you will need to inform the CDOP so that they can make sure this parent is included.

- **Consider carefully how you will contact the child's family:** This will depend on how well you know the family and the circumstances at the time. Things that might be helpful are: having someone with you when you meet the family, for example a manager, committee chairperson, or proprietor. Ensure that you treat both parents equally. Be led by what the family wants at this difficult time.
- **Consider the child's immediate friendship group:** they might need particular support
- **Use the incident book** to record relevant information such as phone calls / visitors because this will assist in remembering things and give really clear feedback to CDOP.
- **Support for Staff / Volunteers** don't forget the impact on the staff. The Educational Psychologist can assist you in supporting staff.
- **Make use of local charities** who can offer support for example, Samaritans, Cruse, Winston's Wish List. Have charity business cards with phone numbers available around the site so that they can be picked up by staff, volunteers, parents and children.
- **Press and Social Media** Contact the Devon County Council Press Office 01392 382173 who will be able to guide you through any press interest. Inform staff / volunteers of the likelihood of press interest and offer assistance in knowing what to say should there be calls from the press. On-line press releases can be especially damaging for staff, volunteers, parents and children especially when emotive language is used. Social Media and comments pages on websites for press allow comments from people that may not have even have known the child. Do not be tempted to respond instead contact the press office for advice. Talk to staff / volunteers about Social Media comments and ensure that they report and request removal of any inappropriate comments. Keep your management group and DCC informed of press interest.
- **Counselling** remember that children and staff may not necessarily need immediate counselling. They need to know that it is natural to feel grief. If in the longer term they are not coming to terms with this grief then counselling might be appropriate.
- **Consider setting up a book of condolence** for adults and children to sign. This can then be given to parents at the appropriate time (check all comments first). Some providers may decide to set up a memory box for the family; this involves asking children, other families and staff to write down memories for the family.
- **Flowers** it is possible that flowers will be placed in a prominent place at the setting. Ensure that these are treated with respect and consider a date when you will collect the cards and remove the flowers, possibly on the day of the funeral but discuss this with the parents. The content of the cards should be checked before passing to the parents.
- **Start thinking about the funeral;** flowers/donations, staff cover for those that want to attend or even closure of the setting to allow all staff to attend. Consider offering childcare for young children to allow their parents / carers to attend if they wish.

Later Considerations

- **Consider attendance at the funeral.** Staff, volunteers, children and families may wish to attend. Children should be accompanied by their own parents / carers and the wishes of the bereaved family should be respected for example they may not want young children present, or they may have thoughts about a dress code
- **Consider how best to gather the child's possessions** and return them to the family. This needs to be done sympathetically and in a planned way, ensure time is allowed for this as parents might want to go through the possessions.
- **The Coroner's Inquest** will be held within a few months of the death. There is likely to be media interest. Consider if you need to attend the inquest and plan your key messages and stick to these.
- **Parental Requests:** Grieving parents requests might be difficult to accommodate especially around birthdays/anniversaries.

Useful Contact Further Advice

Educational Psychology Service	Exeter East & Mid 01392 287233 South Devon 01392 287270 North Devon 01392 388566
CRUSE	www.cruse.org.uk
Winston's Wish	www.winstonswish.org.uk
MIND	www.mind.org.uk/help/advice_lines
Samaritans	www.samaritans.org
Child Death Review Team Lead nurse for Child Death Review and Child Death Review Coordinator	General contact PCHCIC.swcdop@nhs.net The manager is Carol Evason-Coombe
EYCS Commissioning Manager	
North Devon Melissa Filby	01271 388901
South & West Devon Sue Bolt	
Exeter, East and Mid Devon Nikki Phillips	01392 383000