HIPS Child Death Review Process

Scope

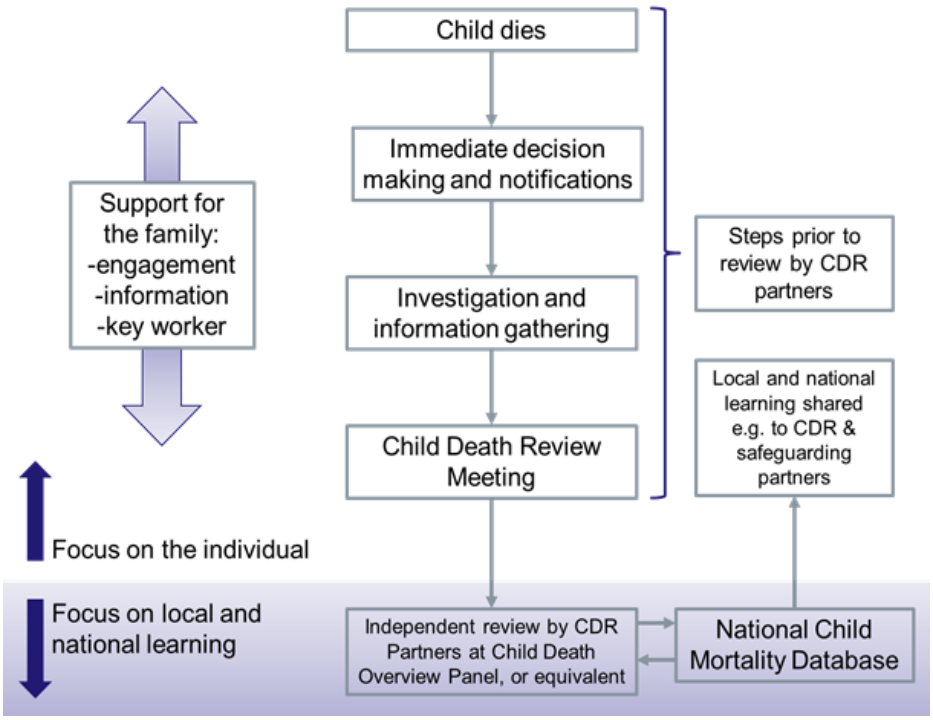
This guidance sets out the agreed process for implementing the Child Death Review. This should be read in conjunction with Working Together to Safeguard Children 2018, the Child Death Review Statutory and Operational Guidance 2018 and the Sudden Unexpected Death in Infancy and Childhood 2016.

Child Death Review

Child Death Review (CDR) is the process followed when responding to, investigating, and reviewing the death of any child under the age of 18, from any cause. It runs from the moment of a child's death to the completion of the review by the Child Death Overview Panel (CDOP).

The process is designed to capture the expertise and thoughts of all individuals who have interacted with the case in order to share information and identify opportunities to save the lives of children, as set out in the Child Death Review Statutory and Operational Guidance 2018.

The flow chart below sets out the main stages of the child death review process:



The child death review process covers children where a child is defined in the Children Act 2004 as a person under 18 years of age.

A child death review must be carried out for all children regardless of the cause of death. This includes the death of any live-born baby where a death certificate has been issued. In the event that the birth is not attended by a healthcare professional, child death review partners may carry out initial enquiries to determine whether or not the baby was born alive. If these enquiries determine that the baby was born alive the death must be reviewed.

For the avoidance of doubt, it does not include stillbirth, late foetal loss, or a termination of pregnancy (of any gestation) carried out within the law.

- Stillbirth: a baby born without signs of life after 24 weeks gestation
- Late foetal loss: where a pregnancy ends without signs of life before 24 weeks gestation
- Planned termination: where there is a live birth after a planned termination of pregnancy carried out within the law

There are occasions where the designation of a child death as **Expected** or **Unexpected** is not always clear. The CDR flow chart in Appendix 1 seeks to clarify to all agencies at what point a Child Death Review Meeting (CDRM) will take place.

This process includes circumstances where a child has been admitted to hospital following an unexpected collapse, has been successful resuscitated but only expected to survive for a short time. In these circumstances, the JAR 1 process should be undertaken as if the child has died and a home visit undertaken as normal. Guidance on this can be found in Child Death Review Statutory and Operational Guidance 2018 under the section on **unusual clinical situations**.

Child Death Review Meeting

The Child Death Review Meeting (CDRM) is the final multi-professional meeting where all matters relating to an individual child's death are discussed by the professionals directly involved in the care of that child during life and their investigation after death. This takes place prior to the review at the CDOP. Full guidance on the aims and responsibilities for this meeting are outlined in Chapter 4 of Child Death Review Statutory and Operational Guidance 2018.

This meeting will take two routes. In the case of an **UNEXPECTED death** the nature of this meeting will vary according to circumstances. Key is the initial immediate consultation with the specialist nurse, police and social worker to determine if the death triggers the Joint Agency Response (JAR). If the joint decision is that it does not trigger a JAR, the case will fall into the process for an **EXPECTED death** and the CDR and CDOP processes are followed.

If the JAR process is triggered, consideration should be given throughout as to the necessity for continuing to a JAR 2 and then JAR 3 (CDRM). If at any time information becomes available that suggests the death was **EXPECTED**, there is no requirement to continue the full JAR process. In the case of **UNEXPECTED** death, the CDRM will form part of the final case discussion in the JAR 3.

The CDRM should not be an overly bureaucratic process and is scalable according to the individual circumstances of the death. The meeting should be focused on local learning and take place once the results of the post mortem and other investigations are known. Where possible this should be within three months, although it is accepted that sometimes this may not possible due to the complexities of the death.

In all cases, the Analysis Form should be completed at the CDRM and then sent to the CDOP. The CDRM should consider the domains contained in the Analysis Form, determine their level of influence (0-2), identify any modifiable factors and categorise the death (1-10) as set out in the Analysis Form. Cause of death, learning points and any local actions should also recognised. Once the Analysis Form is completed at the CDRM, it should be provided to the CDOP.

Appendix 1

HIPS Detailed Child Death Review Process

The agreed HIPS process for Child Death Review for both Expected and Unexpected child death is as follows: