July 2009

# The child death review process

## Roles and responsibilities for GPs

# The Child Death Review Process
## Roles and Responsibilities for GPs

## 1. Background
The Department for Children Schools and Families document, '*Working Together to Safeguard Children'*, 2006 sets out guidance intended to protect and promote the welfare of children. The document outlines the responsibilities of Local Safeguarding Children Boards (LSCBs) to ensure effective co-ordination between individuals and organisations throughout local authority areas and sets out the review process following a child's death. As part of the Children Act 2004, LSCBs became mandatory in April 2008 and as a result, the procedures set out regarding the Child Death Review Process became statutory.

It is important to note that the process covers all children and young people up to their 18th birthday (excluding babies stillborn). For the purposes of continuity, this note will refer to individuals before their 18th birthday as a child.

## 2. Purpose of the child death review process
The death of a child is a tragedy in any circumstance and local authorities and health professionals have a duty to investigate all child deaths regularly and systematically. LSCBs are required to review the death of every child that is normally resident in their area and the child death review process is in place to ensure that bereaved families are supported in their grief, that other siblings and the wider public are protected from similar circumstances and that reasons for the death are investigated.

The child death review process 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.

## 3. GPs involvement during a child death review process
### 3.1 The unexpected death of a child
GPs are often the first point of call for families when family members are unwell and as a result, it is entirely possible that GPs will be the first professional at the scene of an unexpected child death.

The unexpected death of a child is defined as a child's death "that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death"[1] [2].

GPs must follow the procedures for professionals who are first on the scene of a child death as set out in *Working Together to Safeguard Children'*. The guidance state that where appropriate, resuscitation should always be attempted and arrangements should be made to transport the child to A&E. However, if it is apparent that resuscitation would be inappropriate and there is evidence that moving the body might disturb a potential crime scene, the child should be left in situ and the

[1] Fleming, P. J., Blair, P. S., Bacon, C. and Berry, P. J. (2000). *Sudden Unexpected Death in Infancy*. *The CESDI SUDI.*

[2] Royal College of Pathologists and the Royal College of Paediatrics and Child Health (2004). *Sudden unexpected death in infancy. A multi-agency protocol for care and investigation. The Report of a working group convened by the Royal College of Pathologists and the Royal College of Paediatrics and Child Health*. London: Royal College of Pathologists and the Royal College of Paediatrics and Child Health. www.rcpath.org.

police should be informed. The police will make a decision as to whether a criminal investigation will be necessary.

A brief immediate history of the deceased should be taken at the scene to ensure that the RRT will have as much information available to them to investigate the death. This should include circumstances of the death and information about the position and condition of the body on discovery.

It is important that families feel supported in the initial stages after the death and if this role falls to the GP, care should be taken to ensure that all advice is impartial and appropriate to the situation. Despite the difficult circumstances that an unexpected child death can produce, GPs are reminded to be professional and not make any speculations on the cause of death.

## 3.2 Rapid Response Team (RRT)

The RRT is intended to take immediate preliminary action when an unexpected child death occurs. RRTs are made up of key professionals who would in normal practice have some involvement with the unexpected death of a child. They include healthcare and social care professionals, the police and are usually led by a paediatrician. The group is expected to contact other professionals such as health visitors and GPs who would be able to provide insight into the circumstances of the death such as relevant medical and family history. RRTs are required to gather preliminary information from all agencies to assess the circumstances of the death and to make decisions quickly about the protection of other siblings, and if necessary whether to commence a serious case review.

Depending on the circumstances of the death, RRTs will contact GPs for information about the child and the family. The information provided will have a direct influence on both the decision made about the safety of any siblings and could inform any further investigations resulting from their preliminary findings. It is important that all information provided to RRTs (and any other investigating team) is clear and accurate and can be supported by witness statements or evidence.

RRTs are also responsible for ensuring that the family has access to support following the death and throughout the review process. This is often provided by a family liaison officer or local equivalent depending on the circumstances of the death. However, GPs may be expected to provide further assistance such as medical support or referrals to national and local agencies and support services such as bereavement counselling.

## 3.3 The Child Death Overview Panel

The CDOP is responsible for reviewing the death of all children in their geographically designated area and the RRT will report their findings to the panel. Meetings are held at regular intervals throughout the year to ensure that all child deaths are investigated in a timely fashion. The panel has a fixed core membership of professionals, with an option to co-opt other professionals or individuals who can provide an insight into a particular death.

The CDOP has a duty to analyse all deaths and report their findings to the LSCB. The panel produces a short report summarising the circumstances of the death based on information from local health services, community services, children's services, schools and other agencies. The panel also considers the support that the family received following the death to see if any improvements can be made to local procedures.

The panel will be able to make an assessment into the care that individuals and organisations provided prior to and after the death. This may lead to recommendations that the team believes could reduce the risk of this happening in the future, thereby preventing future deaths. GPs might

be involved in this process as they may be required to provide insight into the child's medical history and any family history that may have contributed to the death of the child.

### 3.4 Results of the review

When a child dies as a result of a terminal illness where the GP had a central role in their care or as a result of a condition which the GP had recently given advice on or treated, it is possible that the care the child received may be assessed by the review panel and the way that the practice handled the care may be considered.

In these circumstances, practices should review the care that they provided and in most instances the review panel will make recommendations into how practice can be improved. Although highly unlikely, there may be times when the review finds that the death was in part a result of the care that the child received from the practice. In such circumstances GPs are advised to contact their MDO with details of the findings.

## 4. Important considerations

### 4.1 Consent and confidentiality

GPs tend to have a greater knowledge of younger children than older children and there will be times when it seems that a GP would not be able to provide any insight into the death at all. GPs can also be invited to be part of the review process as they will be able to provide information about the family. In all circumstances, GPs should be mindful of patient consent and confidentiality.

The GMC document 0-18 years: guidance for all doctors encourages doctors to, (when possible) seek consent from children to share information with relevant parties; however, it is unlikely that consent will have been sought in all cases. The guidance states that the reasons for disclosure (without consent) are in circumstances when "(a) a child or young person is at risk of neglect or sexual, physical or emotional abuse; (b) the information would help in the prevention, detection or prosecution of serious crime, usually crime against the person; (c) a child or young person is involved in behaviour that might put them or others at risk of serious harm, such as serious addiction, self-harm or joy-riding."

GPs are responsible for assessing the information that they hold about the child and other members of the family and considering the consequences of releasing this information to the review process. Issues relating to Gillick/Fraser competence should be considered and the effect that the disclosure of this information may have on the family must be considered and should only be released if absolutely necessary to the investigation. It is not advisable to release entire case notes to the review panel for the reasons stated above, and too much information may overwhelm the CDOP and make findings unclear.

### 4.2 Statutory obligations

Although practices do not have a statutory obligation to inform the RRT or CDOP, it is important to remember that a child death is a rare occurrence and practices should aim to cooperate fully with the RRT and the CDOP. However, involvement in the process may be time consuming and as it is not statutory under the GMS contract, practices should expect to receive recompense from the PCO for the time spent preparing for and attending any meetings (including travelling time) and reasonable costs incurred in the process. Practices may also charge a professional fee for their services. Any request for fees should be made and agreed with the PCO before producing a report or attending meetings.