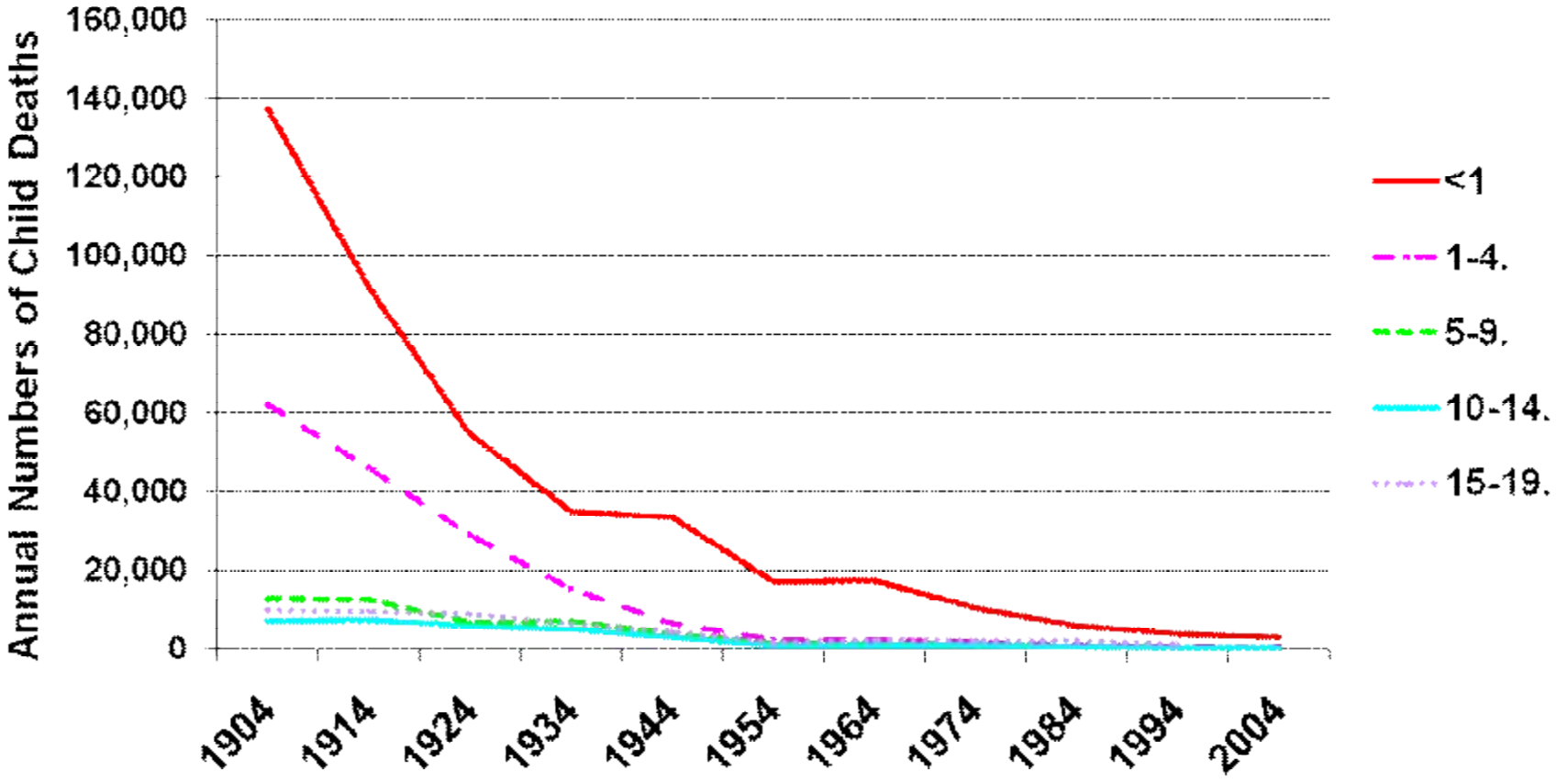
Child Death Review: Learning Lessons, Taking Action

THE UNIVERSITY OF WARWICK

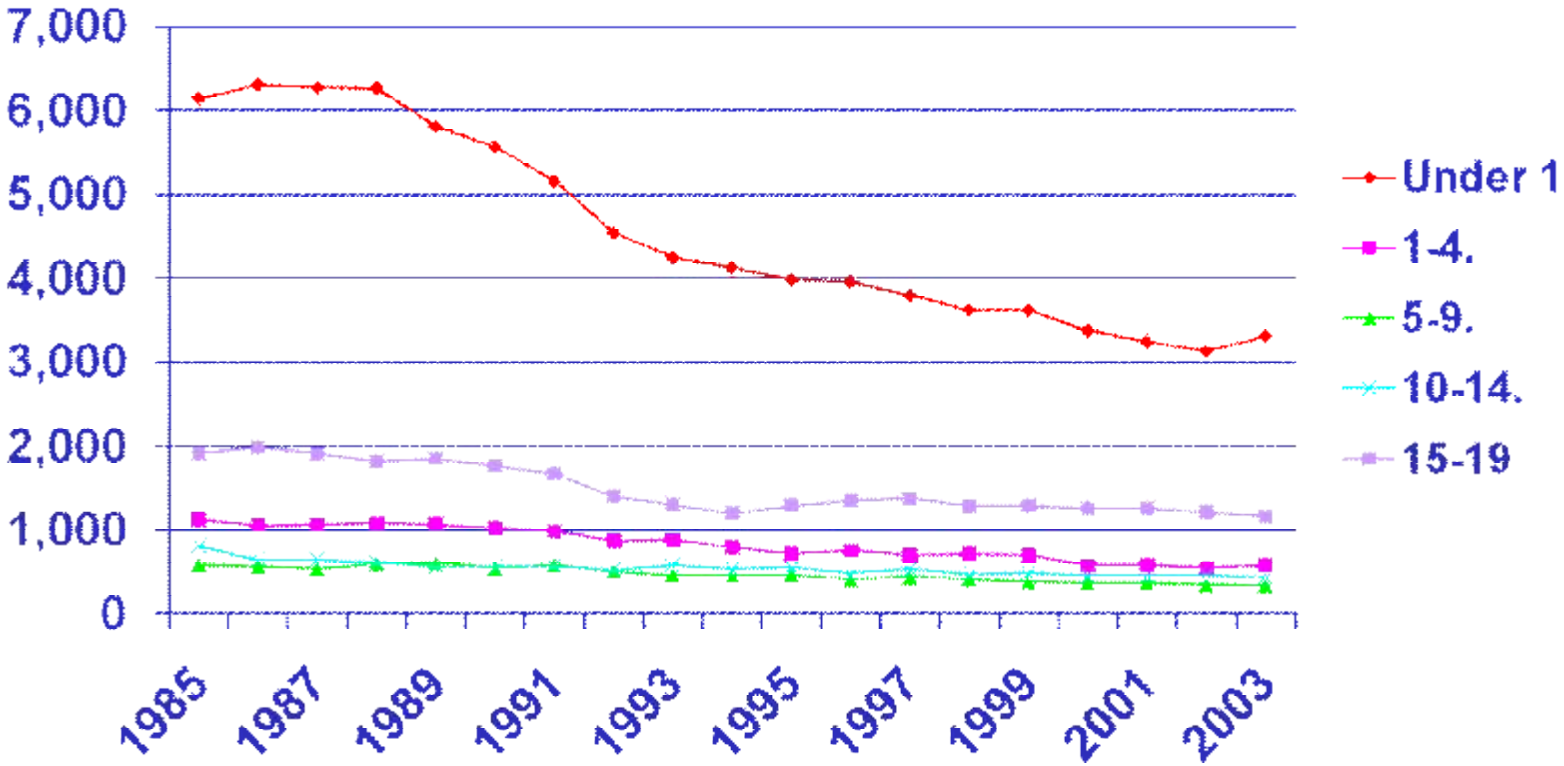
A tribute to Charlie

Childhood deaths in the UK

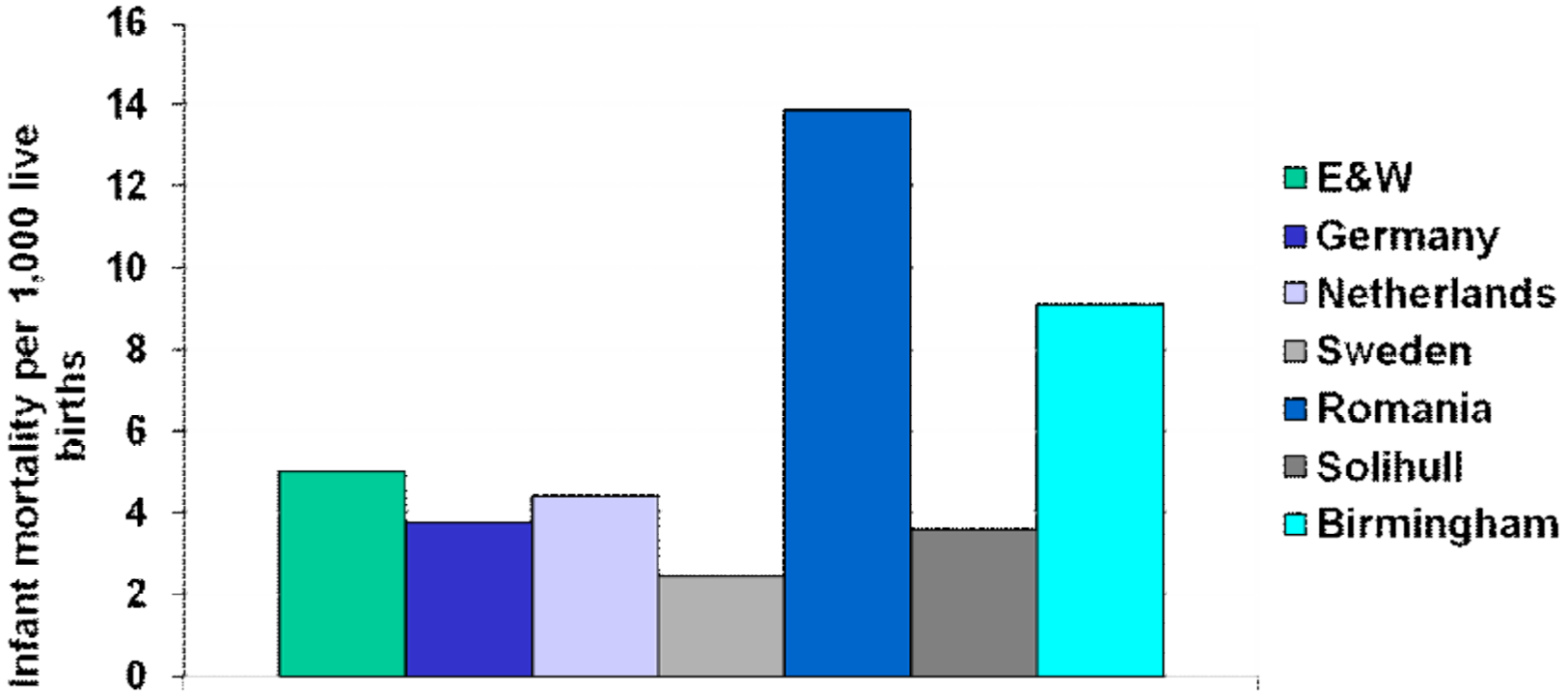


Source: Sidebotham & Fleming (2007)

Child Mortality 1985 - 2003



Infant Mortality 2003-5

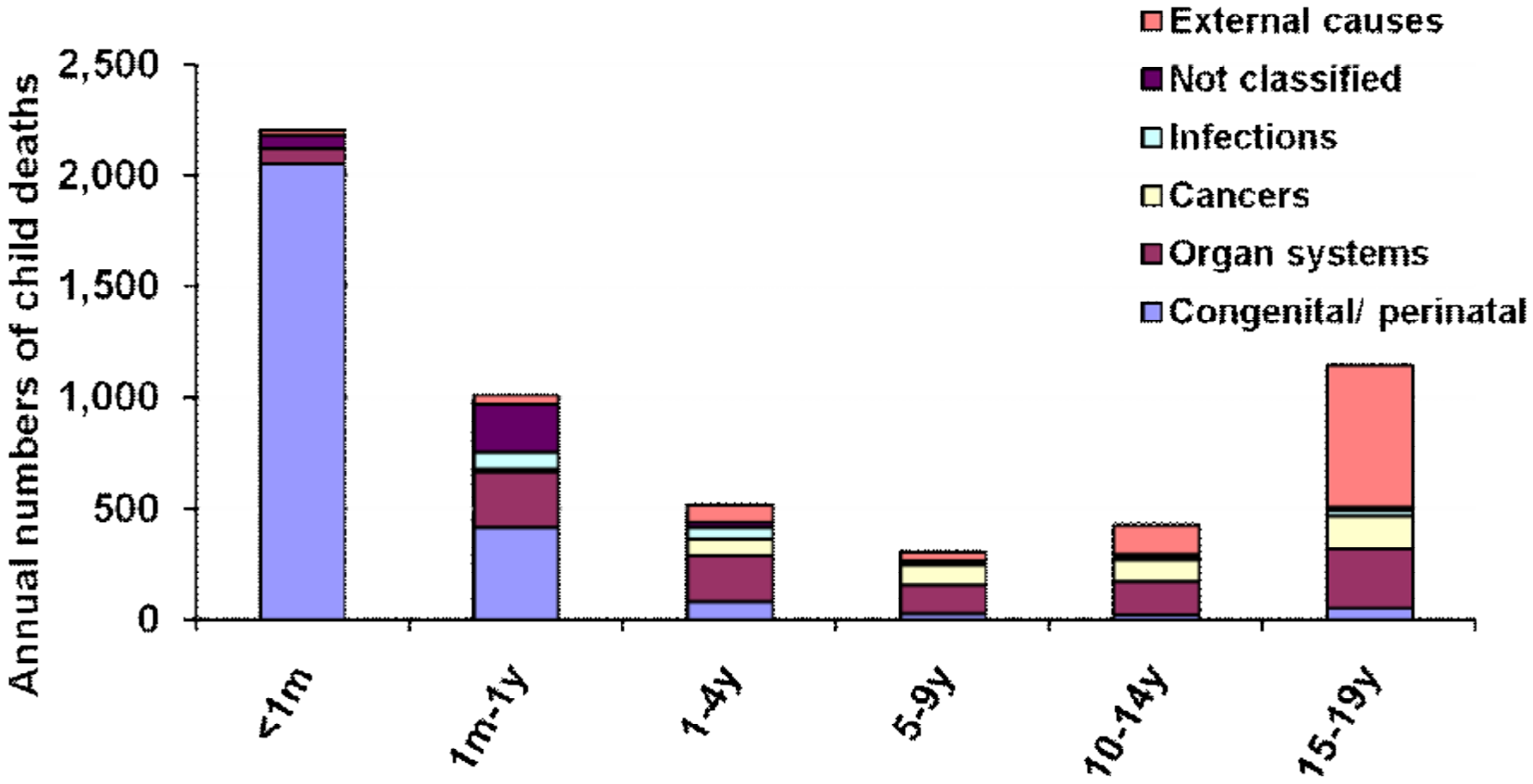


= 333 excess infant deaths in W Midlands 2003-5

Categories of childhood deaths

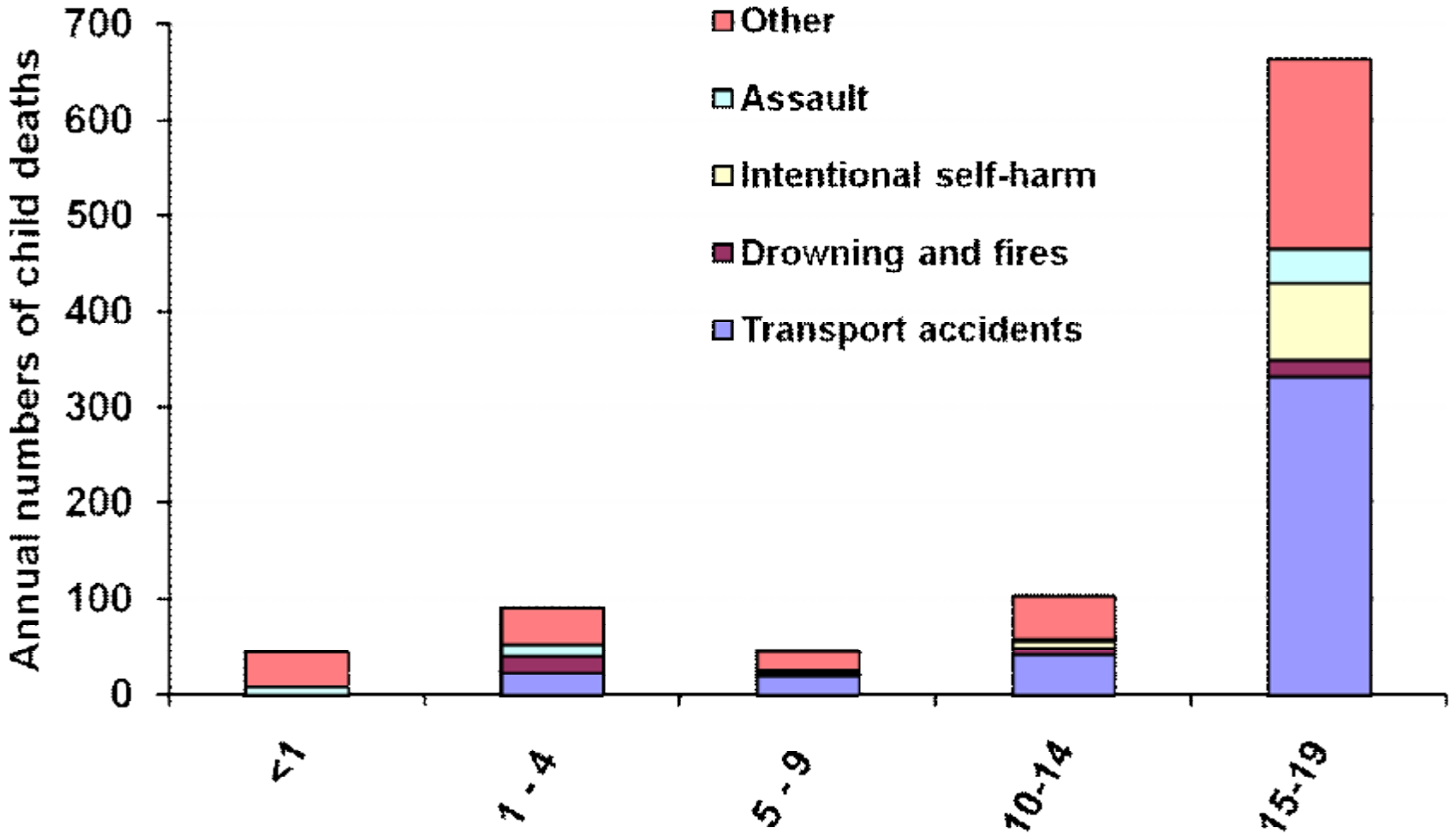
- Expected deaths from natural causes
- Unexpected deaths from natural causes
- Unexpected deaths from external causes
  - Accidents
  - Homicides
  - Suicides
- Unexpected deaths that remain unexplained

Causes of childhood death



Sidebotham & Fleming, 2007

External causes of childhood death



Office for National Statistics, DR, 2008

Working Together
Ch 7 – Child death review processes

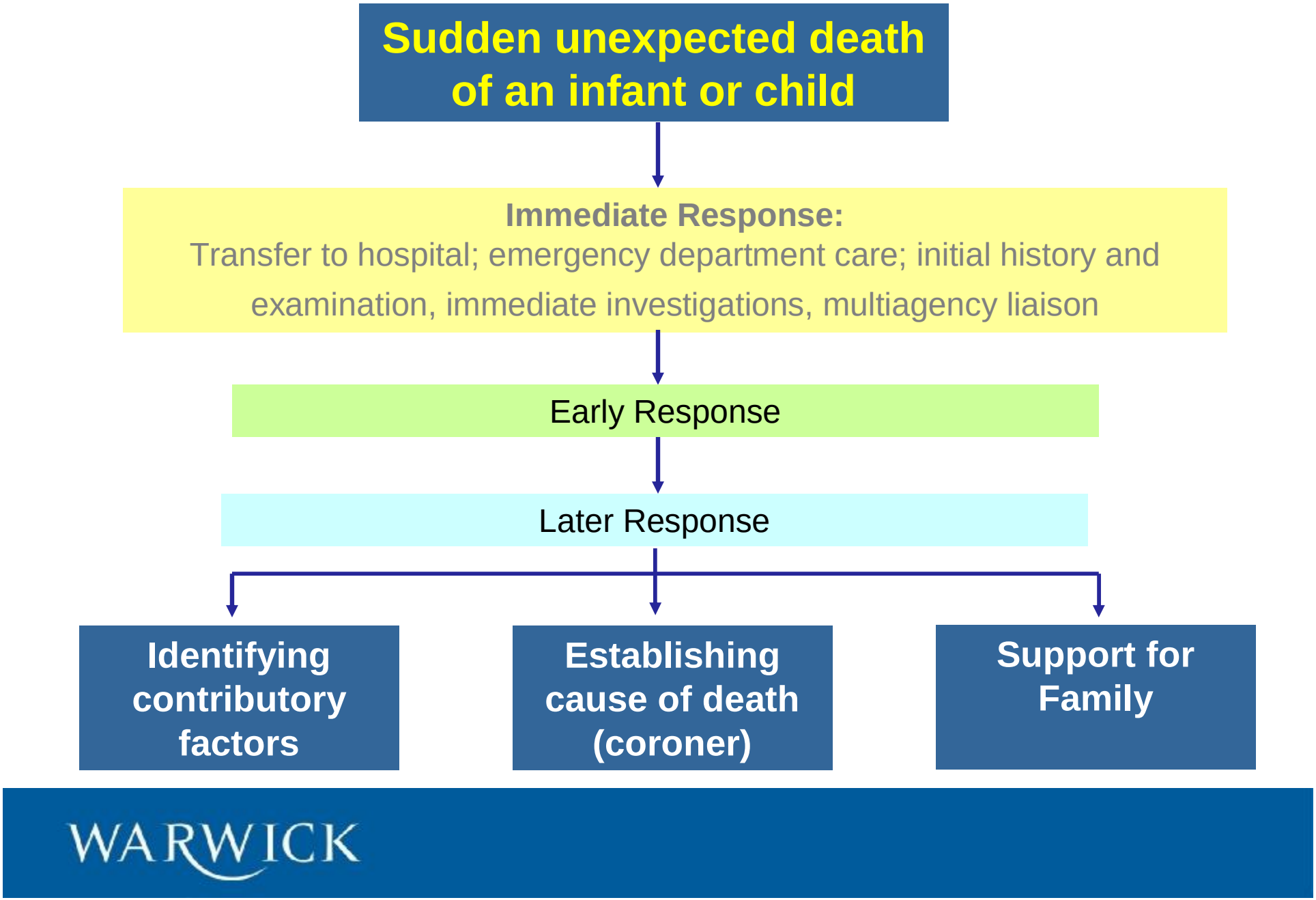
- a rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child
- an overview of all child deaths in the area, undertaken by a panel.

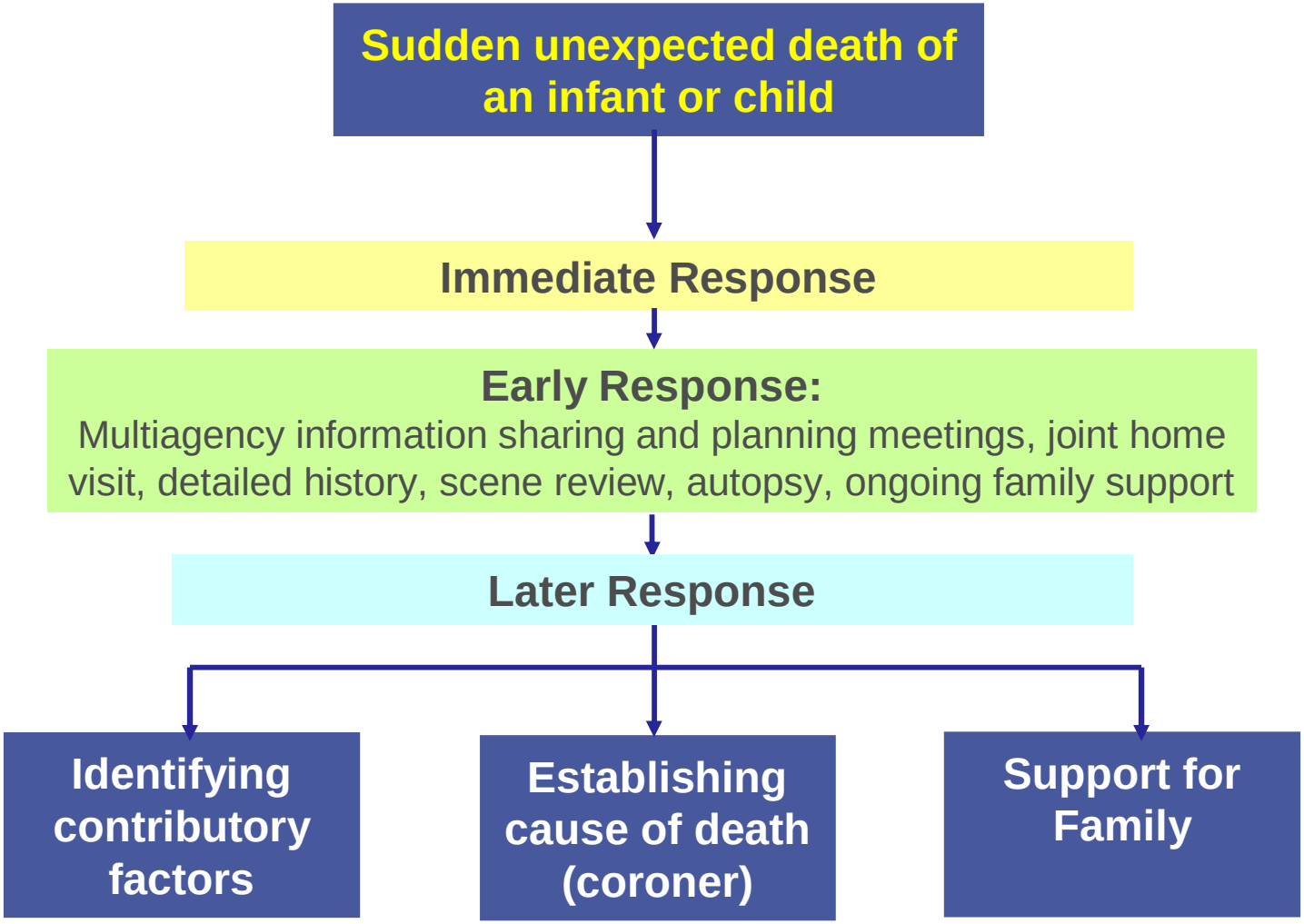
Child Death Review Processes Purpose

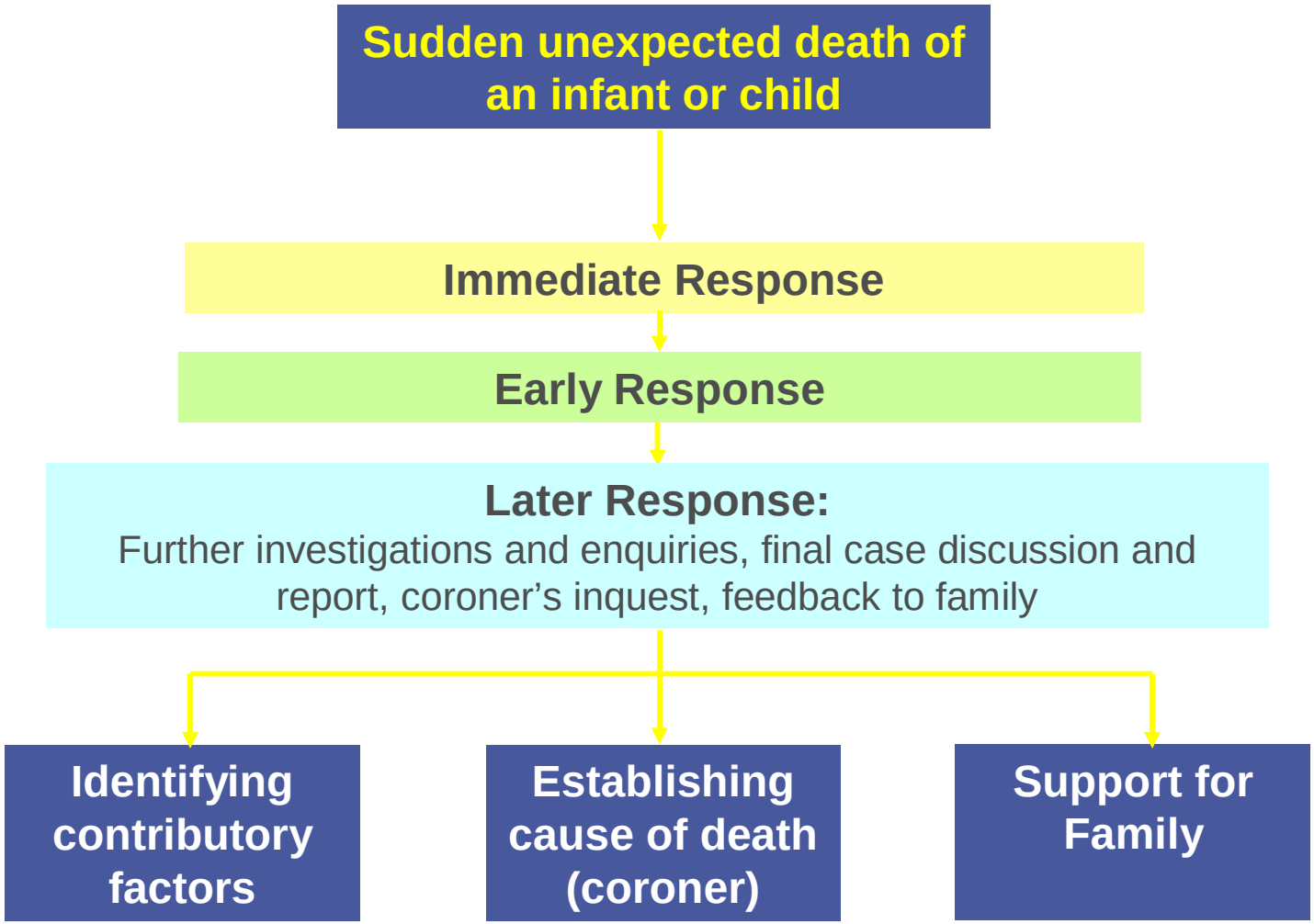
- To establish, where possible, a cause or causes of death (in conjunction with the coroner)
- To identify any potential contributory factors
- To provide ongoing support to the family
- To learn lessons in order to reduce the risks of future child deaths

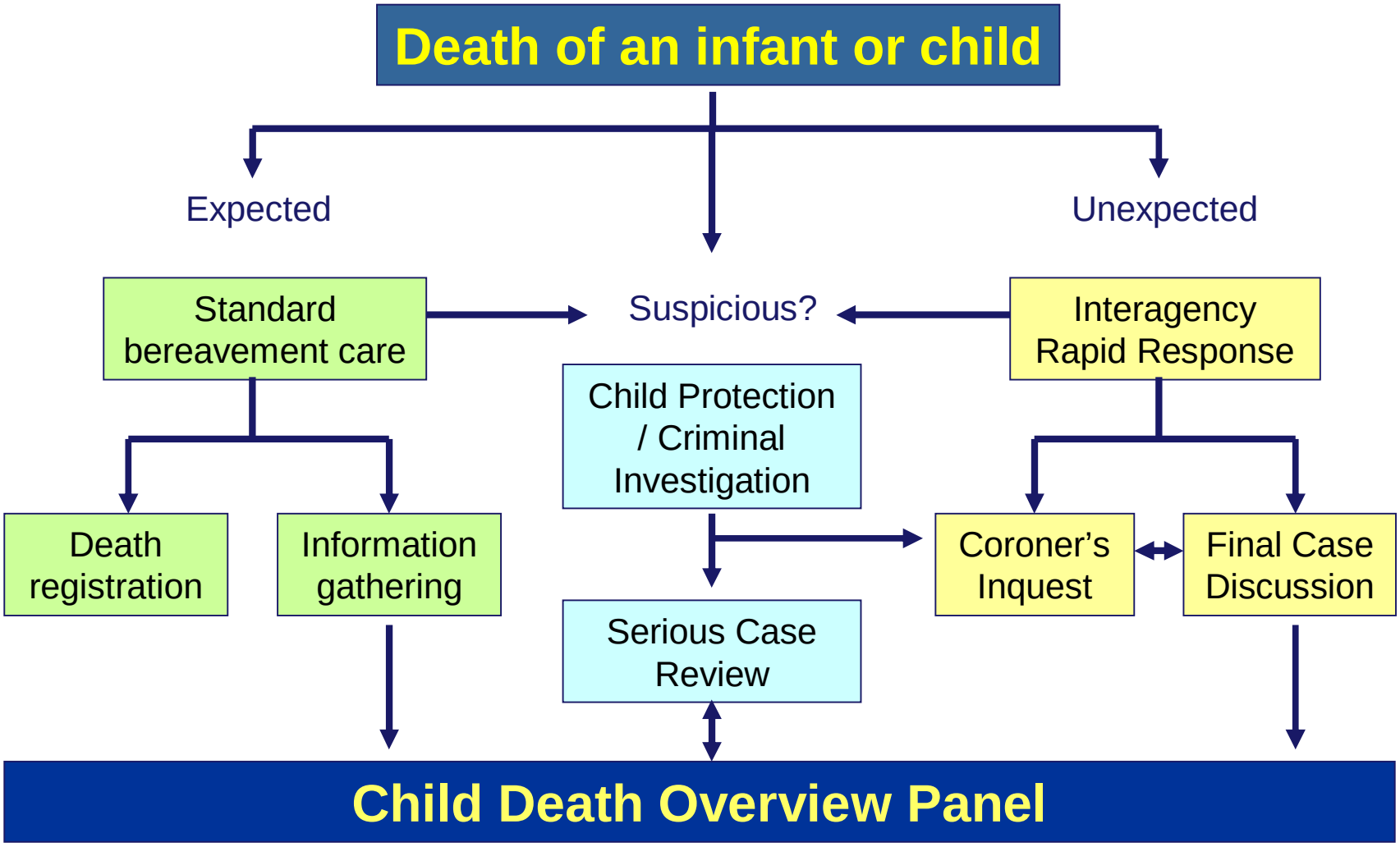
Principles underlying the rapid response

1. Family centred
2. Joint agency
3. Systematic yet sensitive
4. “Golden hour” principle


Sudden unexpected death of an infant or child
Immediate Response:
Transfer to hospital; emergency department care; initial history and examination, immediate investigations, multiagency liaison
Early Response
Later Response
Identifying contributory factors
Establishing cause of death (coroner)
Support for Family


Sudden unexpected death of an infant or child
Immediate Response
Early Response:
Multiagency information sharing and planning meetings, joint home visit, detailed history, scene review, autopsy, ongoing family support
Later Response
Identifying contributory factors
Establishing cause of death (coroner)
Support for Family


Sudden unexpected death of an infant or child
Immediate Response
Early Response
Later Response:
Further investigations and enquiries, final case discussion and report, coroner's inquest, feedback to family
Identifying contributory factors
Establishing cause of death (coroner)
Support for Family


Death of an infant or child
Expected
Unexpected
Standard bereavement care
Suspicious?
Interagency Rapid Response
Child Protection / Criminal Investigation
Death registration
Information gathering
Coroner's Inquest
Final Case Discussion
Serious Case Review
Child Death Overview Panel

Principles underlying the overview of all child deaths

1. Every child's death is a tragedy
2. Learning lessons
3. Joint agency working
4. Positive action to safeguard and promote the welfare of children

The process of child death overviews

Death of an infant or child

Next working day

Notification

CDOP Administrator/Manager

Data Collection

3-6 months after the death

Child Death Overview Panel

Analysis

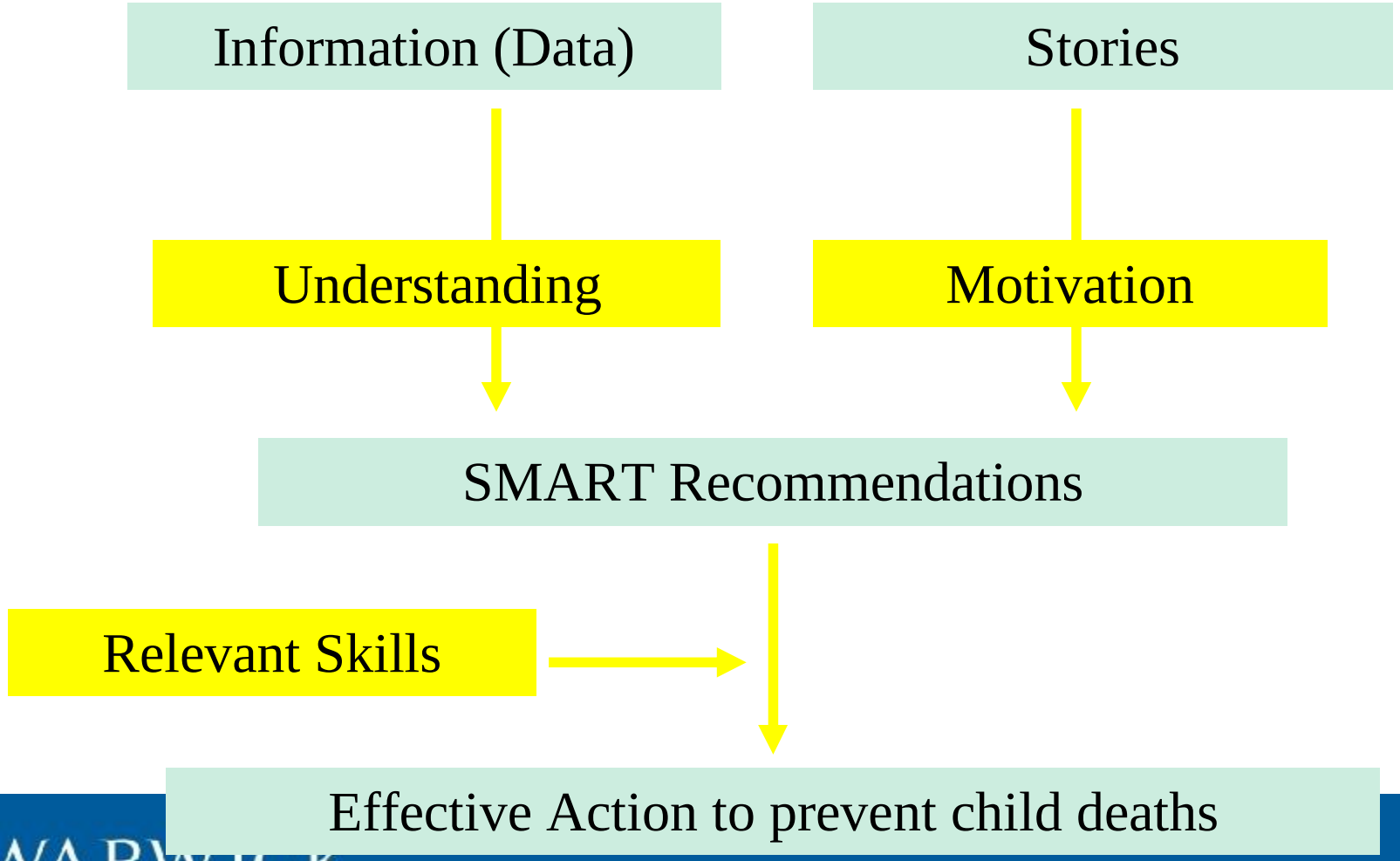
Report / Recommendations

Annual and interim reports

Local Safeguarding Children Board

Preventive Action

Achieving effective outcomes



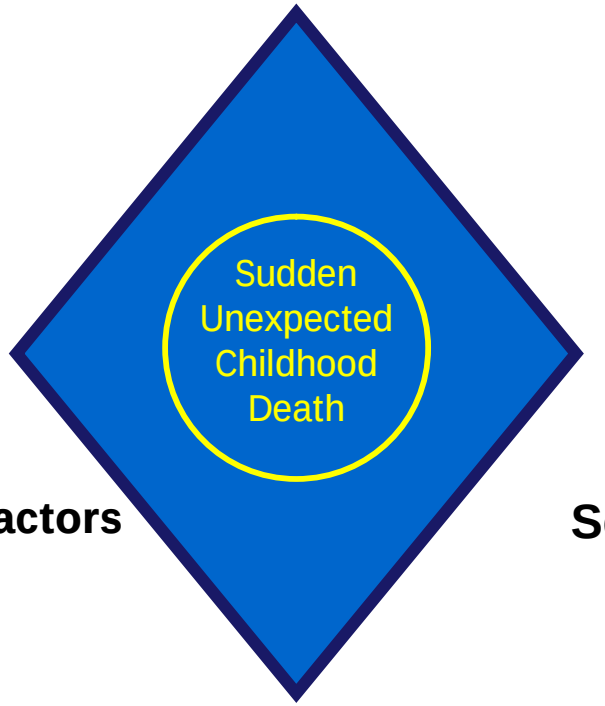
Other data & information sources

- Case information
- Hospital data
- Other Reviews
- Local & national demographic data
- Media
- Topic based searches
- Medical literature

Factors Contributing to Childhood Deaths

Factors intrinsic to the child

- Acute or Chronic illness
- Disability
- Prematurity/ low birth weight
- Age, gender, ethnicity
- Behaviour difficulties



Parental care

- Age
- Marital status
- Substance misuse
- Health, Mental health
- Learning difficulties
- Abuse or neglect

Family and environmental factors

- Social class
- Geographic spread
- Social isolation
- Unsafe environments

Service provision and need

- Service needs
- Services provided
- Gaps in provision
- Information sharing

Preventability

Modifiable factors identified	**The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths**
No Modifiable factors identified	**The panel have not identified any potentially modifiable factors in relation to this death**

Taking action to prevent child deaths

- Strengthening Individual Knowledge and Skills
  - Promoting Community Education
  - Training providers
- Advocacy and health promotion
- Changing organisational structures and practice
- Mobilizing communities
- Influencing policy and legislation

Best Practices In Prevention-Oriented Child Death Review

- BP Home
- Drowning
- Youth Suicide
- Unintentional Firearm Injury
- Motor Vehicle Occupant Injury
- Child Abuse
- About Us
- Our Process
- Search
- Contact
- Links
- Recommendation Generator
- CDR Home

Welcome to Best Practices in Prevention-Oriented Child Death Review

This site was created by the Harborview Injury Prevention and Research Center as a tool to assist Child Death Review (CDR) team members and other public health professionals working to prevent child injury death. It is designed as an aid in making prevention-oriented recommendations as part of the local child fatality review process. Development of this site was supported in part by HRSA, through its EMS-C Targeted Issues Grant Program (1H34MC02543-01-033).

The site examines a broad range of interventions designed to prevent injury and death due to drowning, suicide, firearms, abuse and motor vehicle crashes — the top causes of injury death for children age 0–18 living in Washington State.

For each injury mechanism, we identified interventions of particular interest to public health oriented CDR teams. Working with experts in each content area, we reviewed and rated the strength and quality of published evidence supporting the efficacy of these interventions. Our reviews were used to establish a consensus rating of the research supporting each intervention and allowed us to identify evidence-based best practices in injury prevention for each studied mechanism. A more detailed description of our process is available here.

Top

To begin your query, please click on one of the mechanisms links ▾

Mechanisms:

- Drowning
- Youth Suicide
- Unintentional Firearm Injury
- Motor Vehicle Occupant Injury
- Child Abuse

Resources

- Click here to download Dr. Johnston's synopsis of strategies for enhancing the prevention efficacy of local Child Death Review groups.
- Click here to search PubMed for articles from 2006/11/01-2008/06/04.

Child Death Review: What can be achieved?

- Automatic Car windows
- SUDI awareness – parents and health professionals
- Child safety abroad
- Carbon Monoxide monitoring

Summary

- It is every family's right to have their child's death properly investigated
- Proper management of SUDC involves an intensive, interagency approach
- Many child deaths are potentially avoidable
- 4 Prime objectives
  - Establishing cause of death
  - Identifying contributory factors
  - Supporting the family
  - Learning lessons to prevent future child deaths