From the Chief Medical Officer
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For Action:
Chief Executive, HSC Board
Chief Executives, HSC Trusts
(for distribution to All Governance leads)
Medical Directors, HSC Trusts
(for onward distribution to all Medical Practitioners)
Chief Executive, Public Health Agency
Executive Medical Director/Director Public Health, PHA
Directors of Social Work, HSC Trusts
Directors of Nursing, HSC Trusts
Dr Margaret O'Brien, Assistant Director for GMS, HSCB
All General Practitioners and GP Locums *(for onward distribution to practice staff)*

Dear Colleague

PROCESS FOR REPORTING CHILD DEATHS

HSS(MD) 1/2016 outlined changes to the Child Death Reporting process and provided specific guidance on the process to be implemented within HSC Trusts when a child death occurs. It also advised that a pilot would commence on 1 February 2016 and would run until 31 January 2017.

The pilot has been favourably received and an evaluation of the pilot will be conducted by the HSCB/PHA over the next few months. **Trusts should continue to review all Child Deaths and report them to the HSCB/PHA.**

All child deaths must be reviewed, including those in a community setting. You should use either the RM&M Review process or a community based clinical peer review process which satisfies HSCB/PHA requirements as outlined in the guidance attached at Table 1.

Please note stillbirths are not currently being reported through this process.

Dr Michael McBride
Chief Medical Officer

cc Dr Joanne McClean, PHA
Mrs Heather Reid, PHA

This letter is available on the Department of Health website at https://www.health-ni.gov.uk/topics/professional-medical-and-environmental-health-advice/hssmd-letters-and-urgent-communications

Table 1	Child Death Reporting Process – RM&MRs
Step 0	Following a Child Death, a certifying doctor should, • complete the Initial Record of Death on the Regional Mortality and Morbidity Review System (RM&MRs) including any contact with the Coroner if appropriate; and • notify the Safeguarding Board if the death meets the criteria for a case management review (appendix 1).
Step 1a	For a Child Death that occurs in **hospital**, which includes all child deaths arriving in the ED e.g. accidents, proceed from step 2a onwards.
Step 1b	For a Child Death that occurs in the **community**, either a, (i) Hospital based clinician e.g. Palliative Care Consultant or Oncologist, responsible for that child, should ensure that they record and peer review the death within their hospital as step 2a onwards; or a (ii) Community Paediatrician should ensure the death is recorded and that they can peer review the death within a hospital service as from step 2a onwards; or the case has a (iii) Child Death Notification Form completed and a community based peer review meeting held which satisfies HSCB/PHA requirements. A Child Death occurring in the community may (rarely) not already be known to Community Paediatricians or have entered the hospital system through ED e.g. Sudden Unexpected Death in Infancy and Childhood (SUDIC). In these cases, it is expected that Consultant Paediatric Pathologists, (if involved), will alert the hospital governance teams who will ensure the death is recorded and peer reviewed.
Step 1c	If a consultant becomes aware of a Child Death in another jurisdiction, (that was in receipt of HSC services in NI and referred elsewhere for treatment e.g. UK, ROI), they should ensure the death is recorded on to the RM&MRs, using the outcome drop down of 'Death outside of Northern Ireland' and follow the steps as prescribed below. This Child Death will have already been certified elsewhere or previously notified to the Coroner. Their death should also be reviewed in the other jurisdiction and details of that review will be shared with the referring NI Consultant, for further discussion at an M&M meeting.
Step 2A	ALL child deaths must be recorded onto the RM&MRs. The Consultant[§] should review the circumstances of the death, complete the Consultant review section, confirm the record is complete and correct and then sign-off. The case will be forwarded to the next M&M meeting. The designated M&M lead must then schedule the case for review and discussion at the next M&M meeting. They should be held on a regular basis to ensure timely review of all child deaths.
Step 2B	If the death meets the SAI criteria, the Consultant[§] must also ensure that the SAI process is initiated. At its conclusion, the outcome of the SAI investigation should be communicated through the M&M lead for discussion at the next scheduled M&M meeting.
Step 3	The M&M meeting should be held to review all the child deaths and any completed SAI investigations that have occurred since the previous meeting.
Step 4	The M&M meeting should be multidisciplinary in nature. The M&M lead should lead a review of, i. The clinical details relating to the case including admission diagnosis; ii. The cause of death; ***** iii. Any avoidable factors identified during the discussions; iv. Any discussion with the Coroner and its outcome; v. Any lessons to be learned, especially of the identified avoidable factors; vi. Actions required including those aimed at repeating any avoidable factors. If information comes to light during the course of the M&M meeting indicating that the case should now be reported as an SAI or to the Coroner, this must be done immediately.
Step 5	Once the M&M meeting has finished the review of the case and all the fields of the M&M record have been completed, the Child Death Notification Form will appear under the 'Notification and Legal Documents' section of the Patient Summary. Your Trust governance team or audit unit should be alerted that the CDNF has been generated for their action and issue to the HSCB/PHA.

Notes

Criteria for reporting a Child Death

Any death of a live born child in Northern Ireland that occurs on or after 1 February 2016 and before the child's 18th birthday; this includes any death of a child who is normally resident in Northern Ireland, who dies outside Northern Ireland while receiving health or social care services following a referral from a HSC Trust.

Child Death in the Community – Step 1b

The death of a child in the community will require a similar process of clinical peer review to that occurring after a death in hospital.

(i & ii) This can be achieved by reviewing the death during a hospital M&M meeting where either the Hospital Consultant (who had cared for the child when in hospital) or the Community Paediatrician takes the lead. There would therefore need to be a robust liaison process between the hospital and community services in these circumstances so that each are aware of the details entered onto the MCCD or given to the Coroner and the exact circumstances of the death. This is to be certain that the hospital clinical peer review covers all aspects of the death, including those features that occurred in the community.

(iii) The clinical peer review could also occur in the community if there is a community based clinical peer review process which satisfies HSCB/PHA requirements.

§ Consultant

This would ordinarily refer to the Consultant in charge of the patient and/or whoever was involved in the episode of care at the time of the child's death. It could also be a Clinical Director, the Associate Medical Director or other senior clinician.
It may be a Community based Physician/Paediatrician.

All child deaths must be reviewed and notified within 12 weeks. This includes deaths:

- reported to the PSNI, Coroner;
- being investigated as an SAI; and
- awaiting findings from a post mortem.

This is to ensure that any learning is disseminated to the clinicians at the M&M meeting as soon as possible. For cases that are being investigated by the Coroner or the PSNI the discussion should be confined to the medical management and clinical matters of that case which require a forum discussion to highlight important matters of learning that clinical staff are aware of.

Appendix 1

Safeguarding Board criteria

Regulation 17 of the SBNI Regulations state -

"17.—(1) In exercising its function under section 3(4) of the Act (case management reviews) the Safeguarding Board must undertake a case management review in such circumstances as are described in paragraphs (2) and (3).

(2) Where —

(a) a child has died or been significantly harmed;

(b) any of the following apply–

(i) abuse or neglect of the child is known or suspected;

(ii) the child or a sibling of the child is or has been placed on the register maintained by a HSC trust which lists each child resident in the area of the trust who, following an investigation by that trust under Article 66 of the Children (Northern Ireland) Order 1995(1), is subject to a plan to safeguard that child from further harm and promote his health and development; or

(iii) the child or a sibling of the child is or has been looked after by an authority within the meaning of Article 25 of the Children (Northern Ireland) Order 1995;

(c) the Safeguarding Board has concerns about the effectiveness in safeguarding and promoting the welfare of children of any of the persons or bodies represented on the Safeguarding Board by virtue of section 1(2)(b) and (4) of the Act; and

(d) the Safeguarding Board determines that there is significant learning to be gained from the case management review which, if applied effectively, will lead to substantial improvements in practice in safeguarding and promoting the welfare of children in Northern Ireland

(3) Where the Safeguarding Board has determined that a case demonstrates that any of the persons or bodies represented on the Safeguarding Board by virtue of section 1(2)(b) and (4) of the Act, have worked effectively (individually or in partnership) and that there is outstanding positive learning to be gained from the case which will lead to improved practice in safeguarding and promoting the welfare of children across Northern Ireland.

It should be noted that all four strands of **Regulation 17(2)** [(a), (c) and (d), and at least one element of (b)] must be satisfied for the requirement for a CMR to be triggered, that is, in circumstances where a child has died or been significantly harmed.

Notifications should be made to: cmr.notifysbni@hscni.net