*From the Deputy Chief Medical Officer*
Dr Paddy Woods

HSS(MD)1/2016

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Our Ref: HSS(MD)1/2016
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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**

**TO NOTE:**

i) the important changes notified by the Health and Social Care Board, to the Serious Adverse Incidents (SAI) criteria in respect of the reporting of child deaths, which will take effect from 1st February 2016; and

ii) the specific guidance on the process to be implemented within HSC Trusts when a child death occurs.

In October 2013, the requirement to report the death of every child as an SAI was introduced. The rationale behind this change was to provide clarity in terms of reporting all child deaths and to enhance the culture of learning and review. The inclusion of this criterion was also pertinent at the time due to the ongoing Inquiry into Hyponatraemia-related Deaths with the decision to report the death of any child as an SAI welcomed by the Chair of the Inquiry.

The report "The Right Time, The Right Place" by Sir Liam Donaldson on governance arrangements across the HSC (January 2015) indicated that the current requirement for all child deaths to be reported and investigated as SAIs seemed to be having "*a detrimental effect on the system*". He also stated that "*the process itself was distressing for families, burdensome for staff, and was not producing any useful learning*". Hence, he recommended that, "*the deaths of children from natural causes should not be classified as Serious Adverse Incidents.*"

The Department, working in partnership with the HSCB and a range of other stakeholders across the HSC, including Trusts and PHA, has agreed to pilot a new process for reviewing and reporting child deaths. This process includes a multidisciplinary review of all child deaths at Mortality and Morbidity (M&M) meetings as a prime method of scrutiny. Trusts will need to ensure that appropriate and proportionate processes are in place to allow every child death to be reviewed at a multidisciplinary mortality and morbidity meeting within eight weeks of the death occurring. Detailed information about the new process is included in the attached appendices.

The HSCB has advised that the mandatory requirement to report the death of a child as an SAI will be removed with effect from 1 February 2016. The pilot period will therefore commence on 1 February 2016 and will run through until 31 January 2017, when an evaluation of the process will be conducted.

**Regional Mortality and Morbidity Review System**

Simultaneously, the Department is currently introducing for both adults and children a Regional Mortality and Morbidity Review System (RM&MRS) to provide greater assurance of the processes surrounding death certification in Northern Ireland. This will be based on the functionality of the systems and processes already in operation in the BHSCT and the SHSCT. Once complete, this system will allow for the electronic recording and review of **all** deaths in hospitals, with each death being considered as part of an M&M meeting. It is anticipated that this electronic system will be fully operational in all Trusts by April 2017.

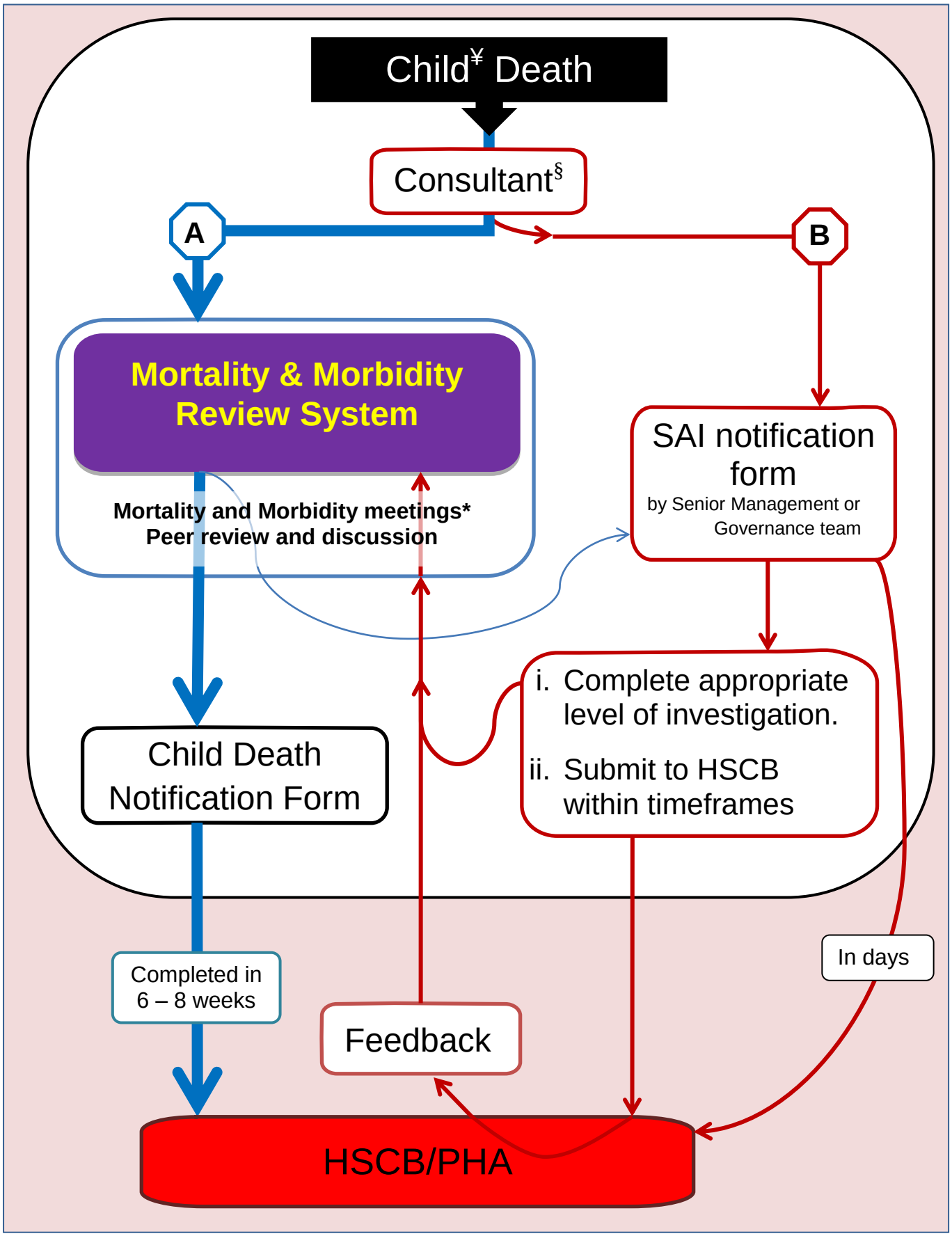
Until then, a paper based process to review all child deaths will be introduced in all Trusts, except for the Belfast HSC Trust, which will continue to record all deaths on the M&MRS already in place. The schematic and guidance attached describes the new process to be followed.

**Dr Paddy Woods**
**Deputy Chief Medical Officer**

Cc Dr Joanne McClean, PHA
Mrs Heather Reid, PHA
Mrs Anne Kane, HSCB

This letter is available on the DHSSPS website at
www.dhsspsni.gov.uk/index/phealth/professional/cmo_communications.htm

# Child Death Review Process Schematic



From the 1st February 2016, the following guidance should be used for all child deaths.

Principles

1. All Child¥ Deaths must undergo a clinical peer review process e.g. M&M meeting.
2. All Child¥ Deaths must have a Child Death Notification Form (CDNF) completed and forwarded to the HSCB/PHA.
3. Where a Child Death has required an SAI investigation, the report's recommendations must be discussed at the next scheduled M&M meeting.

Child¥

This guidance applies to every child up to their eighteenth birthday. This includes babies at any gestational age who are born alive and subsequently die.

Child Death in the Community

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. 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.

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.

Process

The revised process for child deaths is outlined in the following pages:

**Table 1** is the process for all HSC Trusts to follow, other than Belfast HSC Trust.

**Table 2** is the process to be followed by Belfast HSC Trust.

| Table 1 | Child Death Reporting Process – ALL Trusts other than BHSCT |
|---|---|
| Step 0 | Following a Child Death, a certifying doctor should,<br>• complete a Medical Certificate of Cause of Death; or, if appropriate,<br>• notify the Coroner; and<br>• 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<br>(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 from step 2a onwards; or a<br>(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<br>(iii) Child Death Notification Form completed and a community based peer review meeting held as from step 2a onwards.<br>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 using the Child Death Notification Form and follow the steps as prescribed below. This Child Death will have already been certified elsewhere or previously notified to the Coroner.<br><br>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<br>A | The Consultant[§] should review the circumstances of the death and ensure sections 1 - 5 of the Child Death Notification Form are completed and sent to the designated M&M lead.<br><br>The designated M&M lead must then schedule the case for review and discussion at the next M&M meeting. These should be held on a regular basis to ensure timely review of all child deaths. |
| Step 2B<br>B | If the death meets the SAI criteria (appendix 2), the Consultant[§] must also ensure that the SAI process is initiated.<br><br>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.<br><br>The M&M lead should lead a review of,<br>i. The clinical details relating to the case including admission diagnosis;<br>ii. The cause of death; *<br>iii. Any avoidable factors identified during the discussions;<br>iv. Any discussion with the Coroner and its outcome;<br>v. Any lessons to be learned, especially of the identified avoidable factors;<br>vi. Actions required including those aimed at repeating any avoidable factors.<br>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 | Child Death Notification Form sections 6 – 9 should be completed and issued to the HSCB/PHA via the Trust governance team or audit unit. |

| Table 2 | Child Death Reporting Process - BHSCT |
|---|---|
| Step 0 | Following a Child Death, a certifying doctor should,<br>• complete a Medical Certificate of Cause of Death; or, if appropriate,<br>• notify the Coroner; and<br>• 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,<br>(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<br>(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<br>(iii) Child Death Notification Form completed and a community based peer review meeting held as from step 2a onwards.<br>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 using the Child Death Notification Form and follow the steps as prescribed below. This Child Death will have already been certified elsewhere or previously notified to the Coroner.<br>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<br>A | ALL child deaths must be recorded onto the M&MR system on the Intranet.<br>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.<br>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<br>B | If the death meets the SAI criteria (appendix 2), the Consultant§ must also ensure that the SAI process is initiated.<br>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.<br>The M&M lead should lead a review of,<br>i. The clinical details relating to the case including admission diagnosis;<br>ii. The cause of death; *****<br>iii. Any avoidable factors identified during the discussions;<br>iv. Any discussion with the Coroner and its outcome;<br>v. Any lessons to be learned, especially of the identified avoidable factors;<br>vi. Actions required including those aimed at repeating any avoidable factors.<br>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 report fields should be populated and issued to the HSCB/PHA via the Trust governance team or audit unit. |

**Notes**

§ 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.

* = For the discussion of ALL deaths which 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.

HSC Health and Social Care Board | HSC Public Health Agency

| rm Identifier | "[H & C number]" |
|---|---|

# Child Death Notification form

## 1. CHILD'S DETAILS

| | | | |
|---|---|---|---|
| Date of birth | | If neonate | "[Gestational Age]" |

## 2. DETAILS OF THE DEATH

| | | | |
|---|---|---|---|
| Hospital / Place of death name | "[Hospital or place of death where child died.]" | | |
| Ward | "[Ward or Unit where child died.]" | | |
| Date of Death | | Time: | |
| Death in the Community or outside NI | "[Details of circumstances]" | | |

| | |
|---|---|
| Brief clinical details | "[Enter brief clinical details of case.]" |
| Admission diagnosis | "[Enter brief admission diagnosis, if known.]" |

## 3. OUTCOME – MCCD details (if known)

| *MCCD* | Cause of Death | Interval |
|---|---|---|
| *Ia* | "[Record exact details as entered on MCCD]" | |
| *Ib* | "[Record exact details as entered on MCCD]" | |
| *Ic* | "[Record exact details as entered on MCCD]" | |
| *II* | "[Record exact details as entered on MCCD]" | |

## 4. OUTCOME - CORONER details

| | | | |
|---|---|---|---|
| *Coroner contacted – 'discussed' – MCCD issued.* | "[Yes or No]" | Date | "[date Coroner contacted]" |
| *Coroner notified: - for Coroner's PM.* | "[Yes or No]" | Date | "[date Coroner contacted]" |
| *Coroner notified: MCCD/proforma requested.* | "[Yes or No]" | Date | "[date Coroner contacted]" |
| Cause of Death | "[Enter cause of death, if known. ]"<br>"[Attach or enter Coroner's verdict when known.]" | | |

## 5. FURTHER QUESTIONS

| | |
|---|---|
| Was there an expectation, realised at the time of admission, that this patient would die during this admission? | "[Yes or No]" |
| Further details. | "[Enter details here]" |
| Did the patient receive palliative End of Life Care? | "[Yes or No]" |
| Did the patient receive treatment from the multi-disciplinary Specialised Palliative Care Team? | "[Yes or No]" |

| Form Identifier | "[H & C number]" |
|---|---|

## 6. MORTALITY & MORBIDITY MEETING DETAILS

| | |
|---|---|
| M&M meeting date | "[M&M meeting date.]" |
| Discussion details | "[Record brief details of M&M discussion.]" |
| Lesson learned | "[Details of any lessons learned.]" |
| Action agreed | "[Details of any action agreed, timescale + who is responsible.]" |
| Lesson learned | "[Details of any lessons learned.]" |
| Action agreed | "[Details of any action agreed, timescale + who is responsible.]" |
| Lesson learned | "[Details of any lessons learned.]" |
| Action agreed | "[Details of any action agreed, timescale + who is responsible.]" |
| Lesson learned | "[Details of any lessons learned.]" |
| Action agreed | "[Details of any action agreed, timescale + who is responsible.]" |
| Lesson learned | "[Details of any lessons learned.]" |
| Action agreed | "[Details of any action agreed, timescale + who is responsible.]" |

## 7. FINAL CATEGORISATION

| | |
|---|---|
| Categorise death using the scale below | "[Enter category number]" |

1. There were no areas of concern or for consideration in the management of this patient.
2. There were areas for consideration but they made no difference to the eventual outcome.
3. There were areas of concern but they made no difference to the eventual outcome.
4. There were areas of concern which may have contributed to this patient's death.
5. There were areas of concern which CAUSED the death of this patient who would have been expected to survive.

An area of concern is where it is believed that areas of care should have been better.
An area for consideration is where it is believed that areas of care could have been improved whilst recognising that there may be issues for debate.

## 8. SERIOUS ADVERSE INCIDENT (SAI) REFERRAL

| | | |
|---|---|---|
| Has a SAI previously been reported? | "[Yes or No]" | "[SAI incident number.]" |
| Following a M&M review, has a SAI needed to be reported? | "[Yes or No]" | "[SAI incident number.]" |

## 9. REPORTER DETAILS

| | | | |
|---|---|---|---|
| Date of Completion | "[Enter date form is completed.]" | | |
| Full name | "[Enter full name of the person completing form.]" | | |
| Title | "[Enter job title.]" | | |
| Organisation: | "[Full Department name.]" | Tele: | "[Full telephone number.]" |

| | |
|---|---|
| E-mail address | "[Email address.]" |

Please return this form to: cdnotifications@hscni.net

**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

## 4.0 DEFINITION AND CRITERIA (as at 1 February 2016)

### 4.1 Definition of an Adverse Incident

**'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'.**[1] arising during the course of the business of a HSC organisation / Special Agency or commissioned service

The following criteria will determine whether or not an adverse incident constitutes a Serious Adverse Incident.

### 4.2 SAI criteria

4.2.1. serious injury to, or the unexpected/unexplained death of:

- a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
- a staff member in the course of their work
- a member of the public whilst visiting a HSC facility;

4.2.2. unexpected serious risk to a service user and/or staff member and/or member of the public;

4.2.3. unexpected or significant threat to provide service and/or maintain business continuity;

4.2.4. serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

4.2.5. serious self-harm or serious assault *(including homicide and sexual assaults*)

- on other service users,
- on staff or
- on members of the public

by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare*

[1] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

*services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.6. suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.7. serious incidents of public interest or concern relating to:

- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner.

**ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.**

**HSCB/PHA Contacts**

**SAI**
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**Child Death Notifications**
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