



**NSPCC Northern Ireland Response to DHSSPS Consultation 'Regional Multi-Agency Procedure to be followed in cases of Sudden Or Unexpected Child Deaths from Birth to 18 years'**

December 2006

## **Background**

1. The NSPCC is the lead voluntary child protection agency. The Society is unique in having statutory powers under the Children (NI) Order 1995 and operates 20 projects in Northern Ireland. These include a broad portfolio of services relating to child protection and prevention, safeguarding, working with victims, family support, training and consultancy, research and policy development. A children's rights perspective permeates all aspects of our work and the United Nations Convention on the Rights of the Child (UNCRC) is fundamental to the delivery of child protection in its widest sense.
2. The NSPCC has long been concerned that the systems for investigating and reviewing child deaths in Northern Ireland are inadequate for ascertaining the extent to which maltreatment is a factor in child deaths and how child deaths might be prevented. The NSPCC have published research reviewing the workings of Child Death Review Teams (CDRTs) in America and how these might best apply to UK arrangements (Bunting & Reid, 2005) and has given evidence to the Luce Inquiry on Coroner reform when it visited Northern Ireland. The Society welcomes the publication of the DHSSPS consultation document and is wholly supportive of the implementation of regional multi-agency procedures to be followed in the cases of sudden and unexpected child deaths.
3. We have discussed the procedures outlined in the consultation document with practitioners and managers and have identified a number of areas where we think that the arrangements might be strengthened.

## **All Child Death V Sudden or Unexpected Child Deaths**

4. The consultation clearly defines the unexpected or sudden death of a child under 18 as central to the CDR process, establishing the Coroner as the lead professional and the decision to order a post mortem as the trigger for a CDRM. Whilst this will capture the majority of suspicious or unexplained child deaths, NSPCC is concerned about the potential for excluding cases where children die for apparently explainable reasons but where abuse is directly or indirectly a factor in the death. We recommend a post-mortem examination should be carried out in all cases of unexpected child death. There is also research evidence [May-Chahal (2004) etc] which suggests that in some cases where a child has died for seemingly explainable reasons, e.g chronic organic illnesses, other factors such as maltreatment may also play a part.

We have some concerns that by setting the threshold at a Coroner's post mortem, we may miss some of these cases in NI.

5. Equally, in England & Wales the child review process established by the Children Act 2004, stipulates that all Local Safeguarding Children's Boards be required to establish a screening process to cover the deaths of all children. Some LSCBs have already established this practice, and we understand an evaluation study is currently being conducted. Whilst understanding the rationale for the current remit and threshold of the procedures, NSPCC recommends that the protocol be reviewed once the process has become established and certainly within 12 months. We are of the view that the procedure should be developmental and consideration should be given to extending them to cover **all child deaths** in Northern Ireland, as well as their applicability to apparent life threatening events (ALTEs) and near misses.

## Data Collection

6. The procedures make limited reference to information gathering and appropriate collation and dissemination. Clearly information sharing between professionals involved in specific child death cases will play a valuable part in achieving a better understanding of the factors leading to the death and identifying those deaths in which maltreatment has, unfortunately, played a part. However, a particular strength of the CDR process as established in other jurisdictions such as America, is the preventative component. This is based on the systematic collation of standardised data relating to child deaths which enables trends to be identified and targeted preventative strategies developed. Thought needs to be given to what information needs to be collected in relation to the NI process and who will have responsibility for data housing, analysis and dissemination. The creation of a regional body with oversight of the CDR process, data collection and dissemination of prevention messages would be a useful addition.
7. The Confidential Enquiry in Maternal & Child Health (CEMACH) is currently in the process of piloting a child death review process. The aim of this is to obtain an overview of all child deaths from 28 days to 18 years over a one year period (2006) in the South West, West Midlands, North East of England, Wales and Northern Ireland. Core data on all child deaths identified in these regions is collected and detailed local multidisciplinary reviews are conducted on a subset of deaths with a focus on identifying preventable and avoidable factors. To facilitate this CEMACH has developed detailed standardised questionnaires. Given their obvious expertise in this area, NSPCC would suggest that liaison with this agency, if currently not on-going, would greatly facilitate the development of a systematic data collection process. This needs to be utilised from the outset of the implementation of the regional procedures to ensure that lessons from

child deaths are not lost. It would be helpful to cross-reference CEMACH's findings from its confidential enquiry in NI with the findings generated by the implementation of the NI regional child death review protocol.

### **Regional analysis of data and structures to support the Protocol**

8. We appreciate that the protocol is very operational and is being developed ahead of the Department's consultation on new safeguarding structures, in particular the Regional Safeguarding Board. Analysing the data regionally and taking action from any learning is a key function of child fatality/child death review processes and some further policy development will be required in terms of the co-ordinating and oversight role of the Safeguarding Board in this regard.
9. The NSPCC would suggest that the SACPC group and Regional group amalgamates [there is commonality of membership] with a view to taking on oversight of the protocol in the interim, pending future new structural arrangements. The group could oversee any implementations difficulties, and act as a reference group for the development of the protocol, and be responsible for the regional analysis of information.

### **General**

10. NSPCC would like to reiterate its support for the development of the regional, multi-agency procedures for sudden and unexpected child deaths. We feel that implementation of these procedures will greatly enhance our understanding of the circumstances of child deaths and, with appropriate information systems in place, will contribute to preventing future deaths in Northern Ireland that have abuse or other preventable causes.

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**15<sup>th</sup> December 2006**

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## **References**

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May-Chahal C, Hicks S, Tomlinson J. 2004. *The Relationship Between Child Death and Child Death Maltreatment: A Research Study on the Attribution of Cause of Death in Hospital Settings*. NSPCC Policy & Practice Research Series. NSPCC: London.