Institution: University of Warwick and Liverpool School of Tropical Medicine

Unit of Assessment: A2 – Public Health, Health Services and Primary Care

Title of case study: Improving Child Death Reviews Nationwide

1. Summary of the impact

Every year over 5,000 children and young people in the UK die. Previous research suggests that 20-25% of these deaths may be preventable, and in comparison to many other European countries, the UK has higher child mortality rates. Child Death Review processes, introduced in the USA in the 1970s have been proposed as a means of learning from child deaths and driving prevention initiatives. Prior to 2008, the UK had no national system for reviewing and learning from children's deaths.

From 2006 to 2007, a team from Warwick Medical School led by Dr Peter Sidebotham undertook government-funded research examining a number of Local Authorities across England who had set up pilot Child Death Overview Panels (CDOPs). The findings from this research were instrumental in developing national policy and procedures for child death reviews. The Warwick research emphasised the importance of a multi-agency approach to reviewing all child deaths, with a strong public health focus on learning lessons for prevention, and robust systems for notification and gathering information. This, together with other research by Warwick Medical School on fatal child maltreatment published between 2009 and 2011, has contributed to updated national policy and interagency practice to safeguard children.

Although it is too early in the process to demonstrate any impact on the ultimate goal of reducing preventable child deaths, CDOPs have now been established in every Local Authority in England, as well as an all-Wales panel, and current work in Scotland and Northern Ireland is considering how best to implement such reviews. These panels are reviewing all child deaths in England, resulting in local prevention initiatives, and national returns enabling a clearer picture of the nature of preventable child deaths.

2. Underpinning research

Annually, over 5,000 children and young people aged 0-19 die in the UK. Although numbers of child deaths have fallen in all age groups, the rate of decline has slowed in the past 30 years, and in comparison to many other European countries, child mortality in the UK remains high. A recent analysis of WHO data concluded that if the UK health system performed as well as that of Sweden, as many as 1,500 children's lives might be saved each year. Recent National data indicate that 20% of deaths reviewed have identified modifiable factors – a finding that is in keeping with other internationally reported studies. The aim of child death review is to examine the circumstances of all children's deaths in order to identify such modifiable factors, to learn from them, and to inform local and national prevention initiatives. Prior to 2006, there were no standardised approaches to reviewing child deaths in the UK.

From 2006 to 2007, we evaluated four basic components of the child death review process[1]: how Local Safeguarding Children Boards (LSCBs) went about establishing the overview panels; the systems for notification of deaths and data collection; processes for analysing case data; and the outputs of the process. The research team identified the importance of using multiple sources for notification of child deaths and for gathering information about the circumstances and any contributory factors. We made recommendations on the structure and membership of panels and developed templates for notification, data collection and analysis, and the involvement of parents in the process. We identified potential barriers to effective working including lack of understanding and cross-boundary issues, and how some panels had attempted to overcome these barriers.

This research tied in with previous research carried out from 2003-2007 by Dr Sidebotham with Professor Peter Fleming at the University of Bristol on the epidemiology of sudden unexpected death in infancy. As part of this research, we developed coordinated procedures for health, police and social services in responding to unexpected child deaths. Dr Sidebotham analysed further data on how these processes worked at Warwick Medical School between 2005 and 2007, focusing in particular on how police officers and health professionals could effectively work together in investigating unexpected deaths.[2] The analysis showed that it was possible for police officers and health professionals to respond promptly to unexpected child deaths, gather comprehensive information about the circumstances of those deaths, and provide ongoing support to bereaved families. The approaches used in this research have been adopted as national policy in responding to unexpected child deaths (Section 5, source B). Since 2010, the Warwick team has been carrying

out further research through an NIHR doctoral research fellowship to assess how parents and professionals perceive these processes, their utility in investigating unexpected deaths, and their impact on bereaved parents.

In 2009 Dr Sidebotham carried out further research at Warwick exploring nationwide data on violent child deaths.[3] Between 2005 and 2011, he collaborated with Professor Marian Brandon at the University of East Anglia (UEA), carrying out national analyses of data from Serious Case Reviews (statutory inter-agency reviews which take place following any child death or serious injury from abuse and neglect).[4-7] Dr Sidebotham was the PI for work looking at the patterns of child maltreatment fatalities, comparing different national data sets (from the Home Office, Office for National Statistics, and Department for Education) to determine the incidence of fatal child maltreatment, and analysing the case characteristics of different types of fatal maltreatment. Both these pieces of work have been important in providing government with measures of the overall incidence and changing patterns of violent child deaths. This work has demonstrated that overall numbers and rates of violent child deaths have fallen; that declines in rates have plateaued over recent years, particularly among teenagers; that different data sources are needed for a full understanding of national rates; and that there are heterogeneous patterns of violent child deaths requiring different approaches to identification and prevention. This work has been widely reported in the media and has helped develop our understanding of how we learn from Serious Case Reviews. The research has emphasised the importance of professionals having an understanding of child development, and of taking account of the full context of cases of abuse and neglect, including parental characteristics such as domestic violence, mental ill-health and substance misuse.

In 2009, Dr Sidebotham led an assessment of the approaches to carrying out Serious Case Reviews.[7] This research highlighted the ongoing value of Serious Case Reviews in both local and national learning; the importance of broadening the scope of national analysis of such reviews; and of focusing such reviews on underlying systems issues, not just individual practice. It highlighted the value of learning from good practice as well as when things go wrong, and that learning should be embedded as an ongoing process throughout the review.

University of Warwick researchers:

Dr Peter Sidebotham, Associate Professor in Child Health (2005-13) – PI [1, 3, 7]; joint PI [4-6]; Collaborator [2]
Catherine Ellis (2010-12) – Research Assistant [5, 7]
Shahid Perwez (2007-8) – Research Fellow [1]
Janice Koistenen (2007-8) - Project Manager [1]
Ben Atkins (2009) - Medical Student [3]
Jane Hutton, Professor of Statistics (2009) – Collaborator [3]
Colette Solebo (2010) - Research Assistant [7]

External collaborators:

Professor Jan Howarth, Professor of Child Welfare, Department of Sociological Studies. University of Sheffield (2007-8) [1] (2010) [7]
Dr. Catherine Powell, Senior Lecturer, University of Southampton (2007-8) [1] (2010) [7]
Professor Peter Fleming, Professor of Infant Health & Developmental Physiology, University of Bristol (2003-7, PI) [2]
Professor Marian Brandon, Director for the Centre for Research on Children and Families, University of East Anglia (2005-11, Joint PI) [4-7]

3. References to the research (Warwick authors are underlined)

1. P. Sidebotham et al. *Preventing Childhood Deaths: a study of "Early Starter" Child Death Overview Panels in England*. London: Department for Children Schools and Families, 2008
2. P. Sidebotham et al. Responding to unexpected infant deaths: experience in one English region. *Archives of Disease in Childhood* 2010; **95:291**-295. doi:10.1136/adc.2009.167619
3. Sidebotham P, Atkins B, Hutton JL. Changes in rates of violent child deaths in England and Wales between 1974 and 2008: an analysis of national mortality data. *Archives of Disease in Childhood* 2012; **97:193**-199. doi: 10.1136/adc.2010.207647. (**REF2 UoA2 submission**)
4. M. Brandon et al., *Understanding Serious Case Reviews and their impact - a biennial analysis of Serious Case Reviews 2005-07*. London, Department for Children, Schools and Families,

2009. (Cited in 'When to suspect child maltreatment, NICE, 2009'; Working Together to Safeguard Children, HM Government, 2010; the Munro review of child protection in England, 2011; Child Protection Companion, RCPCH, 2013)
5. M. Brandon et al., *New learning from Serious Case Reviews: a two-year report for 2009-2011.* London: Department for Education, 2011. (Cited in the Munro review of child protection in England, 2011; Child Protection Companion, RCPCH, 2013)
6. Sidebotham P, Bailey S, Belderson P, Brandon M. Fatal child maltreatment in England, 2005-9. *Child Abuse and Neglect* 2011; **35:** 299-306. http://dx.doi.org/10.1016/j.chiabu.2011.01.005 (**REF2 UoA2 submission**).
7. P. Sidebotham et al. *Learning from Serious Case Reviews: report of a research study on the methods of learning lessons nationally from Serious Case Reviews*. London, Department for Education, 2010

Grants

- Preventing future child deaths. 2006-2007 (16 months); funded by Department for Education and Skills (EOR/SBU/2006/045; £185,209). **Dr Peter Sidebotham (PI)**; Shahid Perwez.
- Learning from Serious Case Reviews. 2009 (6 months); funded by Department for Children, Schools and Families (EOR/SBU/2007/016; £36,945). **Dr Peter Sidebotham (PI)**; Dr Colette Solebo; Dr Janice Koistenen; Catherine Ellis.
- Biennial analysis of Serious Case Reviews, 2005-7. 2007-2009 (24 months); funded by Department for Children, Schools and Families (EOR/SBU/2007/016; £70,673). **Dr Peter Sidebotham**, co-applicant with Dr Marian Brandon, University of East Anglia.
- Biennial Analysis of Serious Case Reviews, 2009-11. 2010-2011 (16 months); funded by Department for Children, Schools and Families (EOR/SBU/2010/045; £118,261). **Dr Peter Sidebotham**, co-applicant with Dr Marian Brandon, UEA; Dr Carol Hawley, Catherine Ellis.

4. Details of the impact

The Preventing Child Deaths project[1] carried out from 2006 to 2007 was the focal point of an ongoing programme of research into child death review processes being carried out by the Warwick team. This work has had a direct influence on national policy and practice in interagency working to safeguard children and has formed the basis of a national training programme and templates for use by CDOPs. [A] The basic procedures to be followed in response to a child's death were outlined in statutory national guidance (Working Together to Safeguard Children) in 2006. This guidance was expanded in 2010[B] and incorporated the templates and tools developed through the 'Preventing Child Deaths' Warwick research. A further revision in 2013, again draws on these research findings, and Dr Sidebotham was involved in the consultation on this guidance, and provided advice directly to the DfE. [C]

CDOPs have now been established by all 152 Local Safeguarding Children Boards (LSCBs) in England, as well as a national panel for Wales. The governments in Scotland and Northern Ireland are currently developing similar processes, and Dr Sidebotham is currently supporting the Safeguarding Board for Northern Ireland as they seek to develop their processes. [D] The research report on Preventing Child Deaths[1] included a series of appendices with examples of terms of reference for CDOPs, forms for notification and data collection, a *pro forma* for data analysis, and audit tools for the child death review processes. To assist LSCBs in carrying out child death reviews, the DfE commissioned Warwick Medical School to lead development work on national templates for these reviews[A], recognising the expertise of the research team and the learning from this research. These templates, which are available on the DfE website [A], are now used as the primary data collection tools for all 93 CDOPs in England, and form the basis of annual returns by CDOPs to the DfE. The website [A] includes the following citation: 'In accordance with Working Together to Safeguard Children (paragraph 7.2) all Local Safeguarding Children Boards (LSCBs) need to keep information about each child's death… *'In order to assist LSCBs in this task, the Department commissioned Warwick University to lead development work on the templates, which can be used by all LSCBs.'*

The Preventing Child Deaths research identified a number of learning needs for practitioners from all agencies involved in child welfare and CDOP members, and in light of this, the government commissioned Warwick Medical School to develop national training materials to support the introduction of these child death review processes. This led to the production of a training CD,

which was distributed to all LSCBs in England and made available on the DfE website. [A] In addition, over 800 professionals from health, police and social care agencies across England have attended training courses in child death review at Warwick Medical School since it was established in 2007. The outcomes of this work are therefore embedded in professional practice in responding to and learning from childhood deaths across the country, and are reflected in local protocols and in annual reports from the CDOPs. Dr. Sidebotham has helped child death review experts from European countries, Australia and the United States[C], and has been invited to deliver seminars in the Netherlands, Australia and Northern Ireland on this topic. These seminars have contributed to the development of similar processes in the Netherlands and Northern Ireland. [D]

In 2011, as a result of his expertise in this area, Dr Sidebotham was appointed the academic lead for the Health Quality Improvement Partnership-commissioned Clinical Outcomes Review Programme, Child Health Reviews-UK. [E] In 2013, he was appointed to a Royal College of Paediatrics and Child Health (RCPCH) working group on child mortality, and has presented work from this at a RCPCH policy breakfast (April, 2013), and at the Conservative Party conference (September 2013).

Dr Sidebotham's work with Professor Marion Brandon of UEA on fatal child maltreatment and Serious Case Reviews has an ongoing influence on wider aspects of child protection. This work is cited in Working Together, 2010[B], is frequently cited in local Serious Case Reviews across the country, and features regularly in local and national training programmes in child protection. It is cited in the RCPCH *Child Protection Companion*, and the NICE guidance, *When to suspect child maltreatment*, which forms the basis of clinical guidance for paediatricians, GPs and other clinicians in recognising and responding to child maltreatment. In 2010 to 2011, Professor Eileen Munro undertook a review of Children's Safeguarding in England, which influenced subsequent Government revisions of safeguarding children guidance in England (Working Together, 2013). Dr Sidebotham contributed evidence to this review and was a member of the Learning from Practice review stream. [F] In 2012 Dr Sidebotham was invited by the RCPCH to contribute to its Child Protection Companion[F], a working guide for paediatricians, which cites the Sidebotham and Brandon research on Serious Case Reviews and other work by Sidebotham and his colleagues. The recent review into the death from abuse of Daniel Pelka, which cites the Brandon & Sidebotham research, has generated a lot of media interest into how we learn from Serious Case Reviews. As a result of this, Dr Sidebotham's research was featured in a BBC 'Inside Out' documentary (9 September 2013, available on request).

5. Sources to corroborate the impact

A. Research reports from this research programme and related government-funded research, along with the national templates and training materials, can be found on the Department for Education website (www.education.gov.uk), including National templates for LSCBs to use when collecting information about child deaths.

B. Working Together (2010) contains the current national statutory guidelines on safeguarding children. Chapter 7 outlines the procedures for child death review, and draws on the work of the Warwick Medical School. This guidance has recently been superseded by Working Together (2013), which retains the procedures for child death review covered in the previous guidance.

C. **Supporting Letter** available from: Former Safeguarding Children Policy Advisor, Department for Education until 2012), currently Social Worker and President of the International Society for the Prevention of Child Abuse and Neglect (ISPCAN). (Identifier 1).

D. **Supporting Letter** available from: Chairman, Safeguarding Board for Northern Ireland. (Identifier 2).

E. The Child Health Reviews-UK programme was one of a series of Clinical Outcomes Review Programmes commissioned by HQIP (RCPCH). This incorporated a themed review of mortality and serious morbidity in children and young people with epilepsies for which Dr Sidebotham was the academic lead. The study findings were published in September 2013.

F. The Munro review of child protection for which Dr Sidebotham was a member of the Learning from Practice group, cites the work of Warwick Medical School in all three reports. F. Dr Sidebotham was a contributing author for the RCPCH Child Protection Companion, 2013, a working guide for all paediatricians. Dr Sidebotham's work is repeatedly cited throughout this Companion.