The Royal College of Pathologists
Pathology: the science behind the cure

National Medical Examiner's Good Practice Series No. 6

Medical examiners and child deaths

March 2022

Author: Dr Alan Fletcher, National Medical Examiner

Contents

The Royal College of Pathologists
6 Alie Street
London E1 8QT
T: 020 7451 6700
F: 020 7451 6701
www.rcpath.org
Registered charity in England and Wales, no. 261035

About the National Medical Examiner's Good Practice Series

Medical examiners – senior doctors providing early independent scrutiny of non-coronial deaths in England and Wales – are a relatively recent development.

While there is extensive guidance available on a wide range of topics for NHS and public sector staff, the National Medical Examiner's Good Practice Series highlights how medical examiners and medical examiner officers can better meet the needs of local communities and work more effectively with colleagues and partners.

The Good Practice Series is a topical collection of focused summary documents, designed to be easily read and digested by busy front-line staff, with links to further reading, guidance and support.

Introduction

The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, extended family and professionals involved in caring for the child. Families experiencing such a tragedy should be met with empathy and compassion. Parents require clear and sensitive communication; they need to understand what happened to their child and to believe that learning from their child's death will improve care for other children. The process of expertly reviewing all deaths of children is grounded in deep respect for the rights of children and their families. It is important that such processes are coordinated and transparent and avoid causing additional distress to bereaved parents.

Medical examiners, through early identification of issues with care, present an opportunity for the NHS to address issues and concerns. Because they are independent, medical examiners can give the bereaved a voice, ensuring their views are given due consideration. Medical examiners provide insight within days of a death, and early feedback from the medical examiner system demonstrates this can help prevent complaints and appeals that may be more painful and damaging if they arise later. Medical examiners help establish as accurately as possible causes of death for the Medical Certificate of Cause of Death (MCCD), which prevents delay and difficulties with registering the death, and provide guidance about whether the case should be notified to the coroner.

This paper focuses on how medical examiners interact with the statutory child death review process, as well as noting related initiatives and issues to review mortality, such as the statutory child death review process in England, and the Procedural Response to Unexpected Deaths in Childhood (PRUDiC) and Child Death Review Programme in Wales. The number of different initiatives, particularly in relation to deaths of children and neonates, could lead to questions about how or where medical examiners should align with other processes. It is important to avoid unnecessary overlap, duplication or confusion.

In considering this, it is important to reflect on the intended arrangements for scrutiny of deaths when the statutory medical examiner system is established. All deaths in England and Wales will be independently scrutinised by a medical examiner or a coroner. There will be no exceptions. By establishing processes for medical examiners to provide scrutiny after the death of a child, we will ensure that bereaved parents benefit from scrutiny in the same way as other bereaved people.

Medical examiners are not a replacement for other processes and should neither complicate matters nor generate unnecessary bureaucracy. This becomes clear when the nature of the medical examiner system is considered. There are three important distinctions in the way medical examiners work in comparison to other review processes (which may share some but not all of these characteristics). Firstly, medical examiners provide independent scrutiny of non-coronial deaths. They will not review deaths for which they or their clinical team provided care. Secondly, bereaved people are put at the centre of the process. Medical examiners give the bereaved an opportunity to ask questions about the causes of death and to raise concerns about the care provided before death. Thirdly, they carry out their scrutiny in the short period (five days) before the death must be registered. This means medical examiners do not carry out in-depth investigations, but they are able to detect issues very soon after a death has occurred. Medical examiners complete a proportionate review of the medical records, and review the proposed causes of death with the doctor completing the MCCD. Where medical examiners detect issues or concerns, they refer these to existing clinical governance processes for a full review. In the case of deaths of children, medical examiners will often be able to provide information to support child death review meetings.

Recommendations for medical examiners – deaths of children

Medical examiners should:

1. Work closely with paediatricians (including paediatric mortality leads in England, and where appointed in Wales) and neonatologists, to establish effective interactions between medical examiners and the local child death review process that maximise the support for bereaved families and minimise potential distress and duplication. Medical examiners should also be conscious of local reporting arrangements for perinatal deaths. Processes and ways of working should ensure all parties are clear about their roles and the steps that will take place after the death of a child, and avoid any potential misunderstandings. In England, this could include the key worker introducing the medical examiner role to the family, for example with general information or an agreed template letter, to inform bereaved families about the medical examiner or medical examiner officer contacting them.

2. Provide independent scrutiny of deaths of children and neonates not taken for investigation by a coroner, as they would for other non-coronial deaths. After the death of a child, medical examiners (or medical examiner officers with delegated authority) should make contact with bereaved families to offer the opportunity of discussion with an independent person in the usual way. Deaths of children will then receive equivalent independent scrutiny to that provided for all other non-coronial deaths, and families who are bereaved after the death of a child will have equal access to a discussion with an independent person.

3. Recognise that, while all deaths require sensitive interactions with bereaved people, the death of a child is likely to be particularly traumatic. Medical examiners and medical examiner officers should ensure that bereaved families are informed clearly that participation in a discussion is entirely voluntary.

4. Take advice from child and neonate bereavement leads on their approach to bereaved parents, and participate in training opportunities. Training is available from organisations such as Child Bereavement UK.

5. Work closely with paediatricians (including paediatric mortality leads) and neonatologists, obstetricians and midwives, to establish processes to capture and disseminate learning, and ensure that actions to improve care for patients are identified and implemented.

6. Pay particular attention to proposed causes of neonatal death. These should fully reflect the broad clinical background of each death, and medical examiners should exercise due care during their usual scrutiny before the death is registered to consider peripartum issues and antenatal care. Again, interactions with obstetricians or midwives and proportionate review of their records, if feasible before completion of the MCCD, may be an important part of scrutiny.

7. Participate in meetings or discussions for child death reviews where desired or considered helpful. In England, this reflects arrangements set out in the statutory Child Death Review guidance; medical examiners should also consider joining child death overview panels if invited to do so, though this needs to be balanced with other review processes such as mortality reviews. In Wales, information sharing/discussions could take place with the Child Death Review Programme. It should be noted that the National Medical Examiner's Good Practice Guidelines state that medical examiners cannot also be their host organisation's mortality lead.

8. Where not satisfied that appropriate action is being taken to address a concern they have identified regarding care of a baby or child(ren) – escalate concerns in line with the National Medical Examiner's Good Practice Guidelines; and where there is a perinatal death in England, to the regional chief midwife and regional lead obstetrician, who will be members of regional-level quality oversight committees.

9. While this paper specifically addresses the interplay between medical examiners and the statutory child death review process, medical examiners should note there are a range of agencies who may become involved in reviewing the deaths of children and neonates, and that there is potential for bereaved families to find this confusing and even overwhelming. There is more information about other agencies and processes on page 14.

Context and background

There have, sadly, been several independent investigations regarding deaths of babies and children (and related areas such as maternity and neonatal services) which found that care was in significant need of improvement. These include the reports of the Morecambe Bay Investigation, Mid Staffordshire Public Inquiry and other ongoing investigations. Writing for the Royal College of Pathologists' *Bulletin*, Dr Bill Kirkup CBE notes that the 'introduction of medical examiners offers a clear opportunity to ensure that these cases are not lost and can be learned from and, where necessary, instances of systemic failure can be identified. To achieve this, medical examiners will need to retain sufficient independence and remain aware that deaths that appear inevitable after a fraught neonatal course may have been entirely avoidable if the management of labour and delivery had been different.'[1]

Action has been taken to improve surveillance and learning. This includes HSIB maternity investigations; Getting it Right First Time; enhancement of the child death review process through analysis of the National Child Mortality Database; and in Wales, existing surveillance of child deaths by the Child Death Review Programme

The latest published data[2] from the National Child Mortality Database in England shows that 73% of deaths of children occur in hospital. The great majority of these deaths occur in tertiary paediatric and neonatal intensive care units. In terms of category of deaths, the percentage breakdown is as follows:

- 33% are due to perinatal or neonatal events, the vast majority of which are due to complications of premature delivery
- 24% are due to inherited chromosomal, genetic or congenital anomalies
- 8% are due to malignancy
- 11% are due to acute or chronic medical conditions including asthma, diabetes and epilepsy
- 5% are due to infection
- 18% are due to external causes (homicide, suicide, trauma and sudden unexplained deaths)
- around 4% are classified as 'sudden and unexpected'.

Medical examiners provide independent scrutiny of non-coronial deaths in England and Wales, including those of children and neonates, using the same principles of scrutiny as they do for other deaths. Good working relationships and processes between medical examiners and paediatric and neonatal services, along with obstetricians and midwives, will help ensure an accurate cause of death is documented on the MCCD and that learning is disseminated, and may reduce unnecessary coroner referrals.

---

[1] Dr Bill Kirkup CBE for the Royal College of Pathologists. Perinatal mortality − are we learning? *The Royal College of Pathologists Bulletin*, July 2021. Available at: www.rcpath.org/profession/publications/college-bulletin/july-2021/perinatal-mortality-are-we-learning.html

[2] National Child Mortality Database. *Child death review data release 2021*. Available at: www.ncmd.info/publications/child-death-data-release-2021

The Ministry of Justice conducted a consultation on coronial investigations of stillbirths in 2019. Medical examiners do not scrutinise stillbirths at present, but they will carry out scrutiny of deaths which may include those related to care during pregnancy and birth. It should be noted that distinguishing a stillbirth and a live birth may not be straightforward and requires a sensitive, careful approach, given the emotional impact on families and the implications for the different processes to be followed. Guidance[3] is available for health professionals to help them assess and document extremely preterm births where, following discussion with the parents, active survival-focused care is not appropriate.

Child death reviews in England

In relation to England, in October 2018, the Department of Health and Social Care (DHSC) published guidance setting out key features of the child death review process, and statutory requirements that must be followed.[4]

The process aims to ensure, as far as is possible, that the review of every child's death is standardised to facilitate learning at a local and national level. The child death review process runs from the moment of a child's death to the completion of the review by a child death overview panel. It includes the immediate actions taken when the child dies, the investigations (coronial, joint agency response, serious incident) that may follow the deaths of children, the local review by professionals who cared for the child, through to the final statutory review at a child death overview panel. The guidance notes that, although investigations following the death of a child will vary, every child's death should be discussed at a child death review meeting. The child death overview panel, under delegated authority of partners in their local area, will also review the case of every child that dies. This review occurs after the medical examiner has completed independent scrutiny, and usually after the death has been registered.

This guidance recognises that supporting and engaging bereaved families is of paramount importance. All bereaved families should have an identified medical lead and a key worker – who provides a single point of contact for the family, and should form a trusted relationship with them. Every death of a child in hospital and in the community is reviewed, and recorded on the National Child Mortality Database.

Child death reviews in England and medical examiners

Publication of the Health and Care Bill confirms the government's intention to establish a statutory system in which medical examiners provide independent scrutiny of all deaths not taken for investigation by a coroner. During 2019–2020, implementation of a non-statutory national medical examiner system commenced in England and Wales[5] to provide independent medical scrutiny of non-coronial deaths. The medical examiner system gives bereaved families an opportunity to raise

---

[3] MBRACE-UK. *Determination of signs of life following spontaneous birth before 24+0 weeks of gestation where, following discussion with the parents, active survival-focused care is not appropriate*. Available at: https://timms.le.ac.uk/signs-of-life

[4] HM Government. *Child death review: statutory and operational guidance*. 2018. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf

[5] NHS Improvement. *The national medical examiner system*. Available at: www.england.nhs.uk/establishing-medical-examiner-system-nhs/non-acute-nhs-trusts-extending-medical-examiner-scrutiny-to-non-coronial-deaths-in-the-community

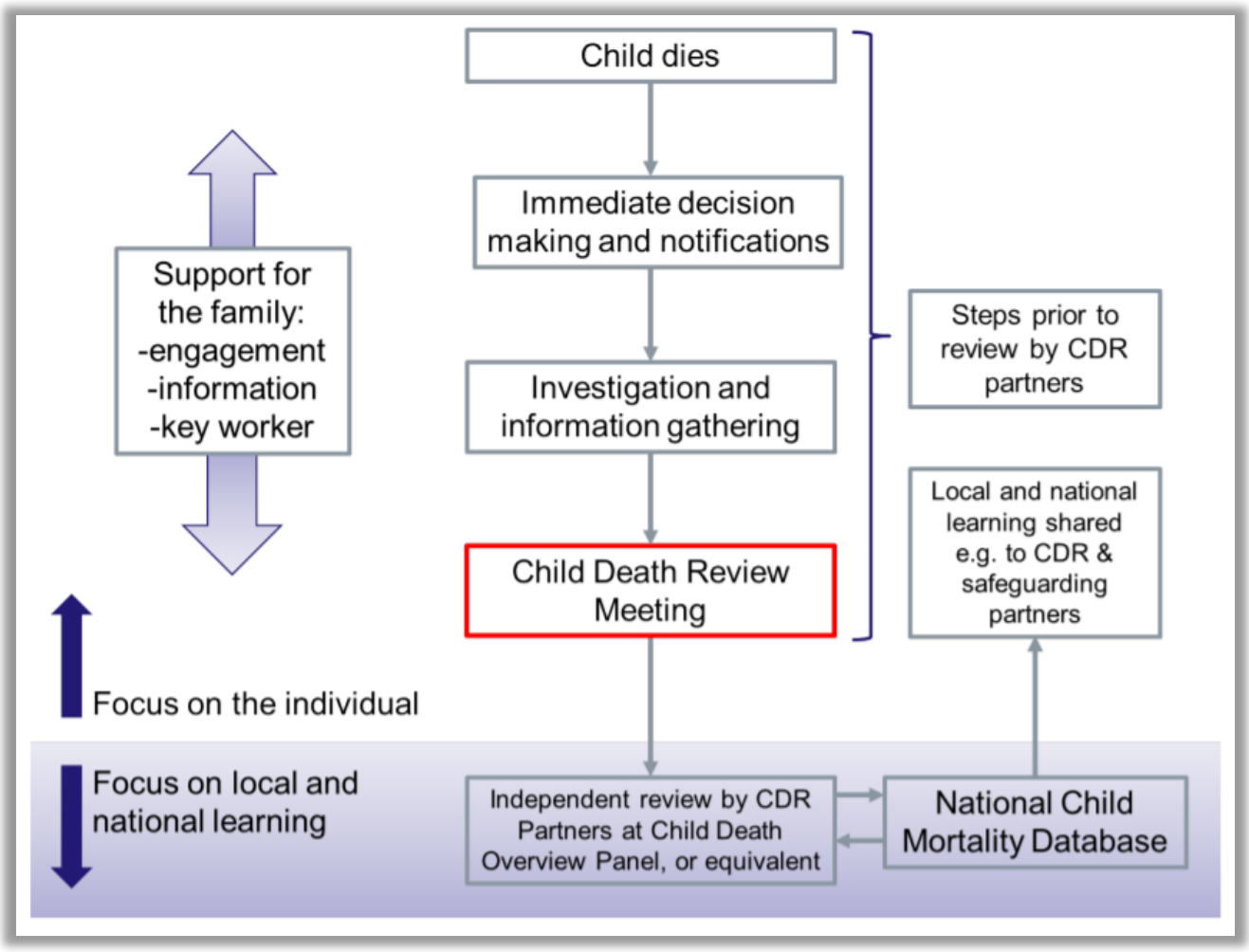
concerns about care provided, ensures the appropriate notification of deaths to the coroner, improves the quality of death certification, and supports local learning by identifying cases and matters that should be considered through clinical governance arrangements. This includes highlighting matters for further consideration through the child death review process.

The interaction between medical examiner scrutiny and a child death review in England is largely determined by the different objectives and timescales of the two processes. Medical examiners are constrained by the requirement for deaths to be registered within five days, and carry out scrutiny of non-coronial deaths within this short window. The child death review process includes immediate decision making and notifications in its early stages, and this time is likely to provide the focus for interaction between medical examiner scrutiny and the child death review process. The statutory child death review guidance notes that once the medical examiner system is introduced, medical examiners should be involved in child death review meetings, which will normally take place some weeks or months after the death.

Medical examiners should gain understanding of paediatric, neonatal and obstetric matters through experience and interaction with local colleagues as they would for other specialty deaths. However, the elements of scrutiny are generic and remain the same (discussion with bereaved people, review of records, and interaction with the doctors completing the MCCD) for child deaths, as do the principles around timeliness of care and escalation of concerns.

A diagram setting out the child death review process in England is included in Figure 1.

Figure 1: Child death review process in England.[6]

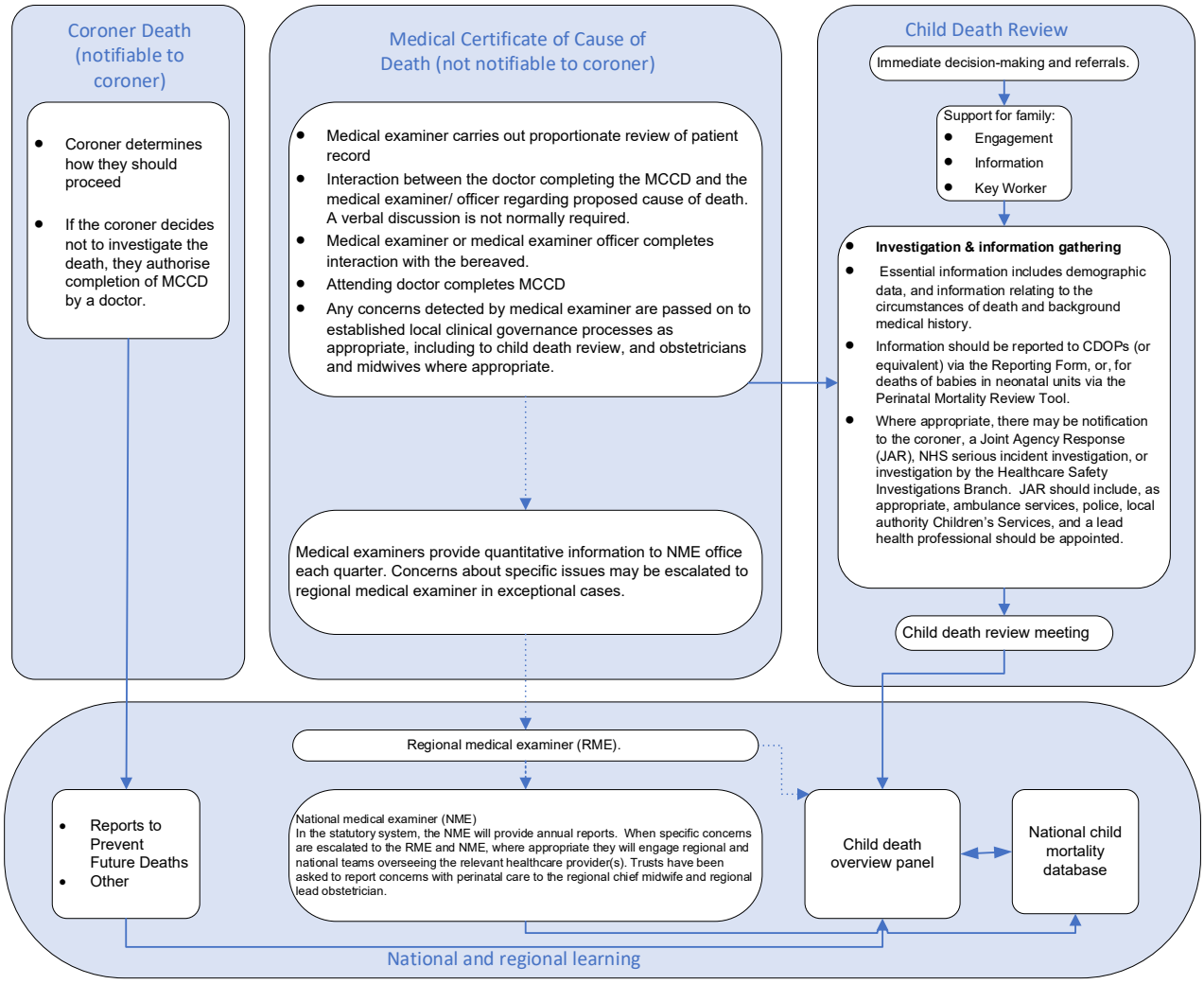


CDR: Child death review.

Of course, if the death is notified to the coroner and taken for investigation, medical examiners will not provide independent scrutiny. Where the death is not referred to the coroner, medical examiners will be a valuable source of information for the child death review meeting. In Figure 2, the potential relationship between medical examiner scrutiny and the child death review process is shown.

[6] HM Government. *Child death review: statutory and operational guidance*, page 16. 2018. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf

Figure 2: Medical examiners and the child death review process in England.



New and future developments in England

NHS England and NHS Improvement are implementing a new perinatal quality surveillance model. Trusts have been asked to report concerns with perinatal care to the regional chief midwife and regional lead obstetrician, who will be members of a regional-level quality oversight committee. As noted in recommendations, medical examiners should use this escalation route where appropriate.

The DHSC remains committed to making the medical examiner system statutory subject to parliamentary approval and when time allows. We anticipate the non-statutory system will continue throughout the financial year 2021/22.

Ongoing work relating to digitising the MCCD, and a digital record system for medical examiners, may present further opportunities to streamline arrangements between medical examiners and the child death review process. For example, it may be possible to align child death review databases and new systems relating to death certification, to improve efficiency and reduce the risk of duplication, although it is too early at present to identify details clearly. In England, the National Child Mortality Database should be notified of deaths within 48 hours, and it will be important to avoid duplication at the point of notification. Medical examiners would normally expect to be

notified within 24 hours, to allow them to complete scrutiny and enable the MCCD to be issued in a timely manner, and sooner if urgent release of the body is requested.[7]

Child death reviews in Wales

In Wales, the Child Death Review Programme (Public Health Wales) reviews all deaths of under 18 year olds, seeking to identify patterns, trends and modifiable factors to reduce preventable deaths of children in Wales. A new patterns and trends report is due during 2022.

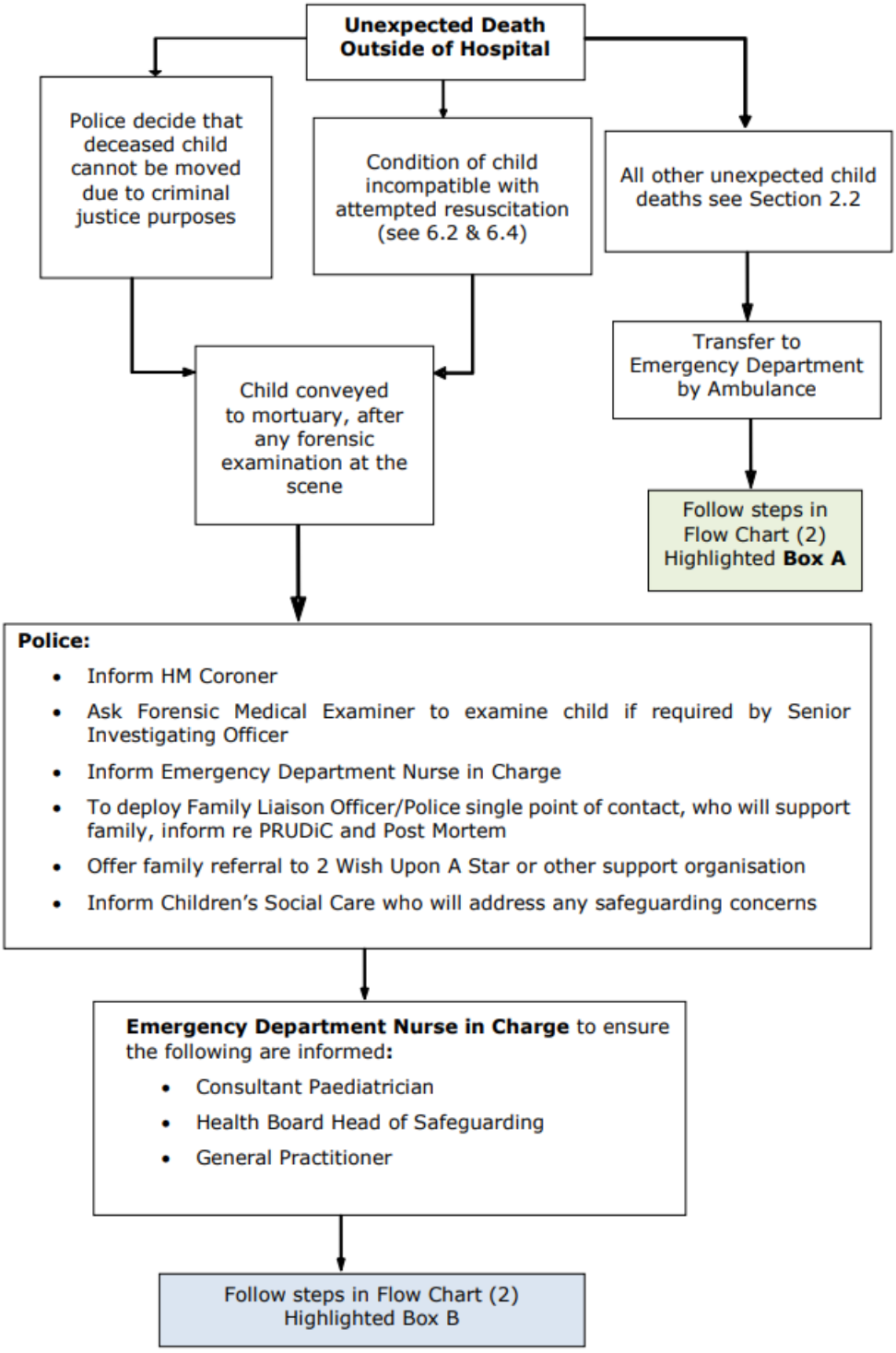
The PRUDiC sets a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the process of communication, collaborative action and information sharing following the unexpected death of a child. This procedural response will be followed when a decision has been made by the police that the death of a child is unexpected and the PRUDiC is to be initiated.

PRUDiC is a multi-agency procedural response intended to ensure a minimum standard across Wales, and is not agency or discipline specific. It outlines what needs to be achieved and gives broad suggestions about the roles of agencies. Any variance should be recorded along with the rationale for digressing from the process. The guidance does not prohibit any existing good practice by agencies or professionals to enhance this procedural response.

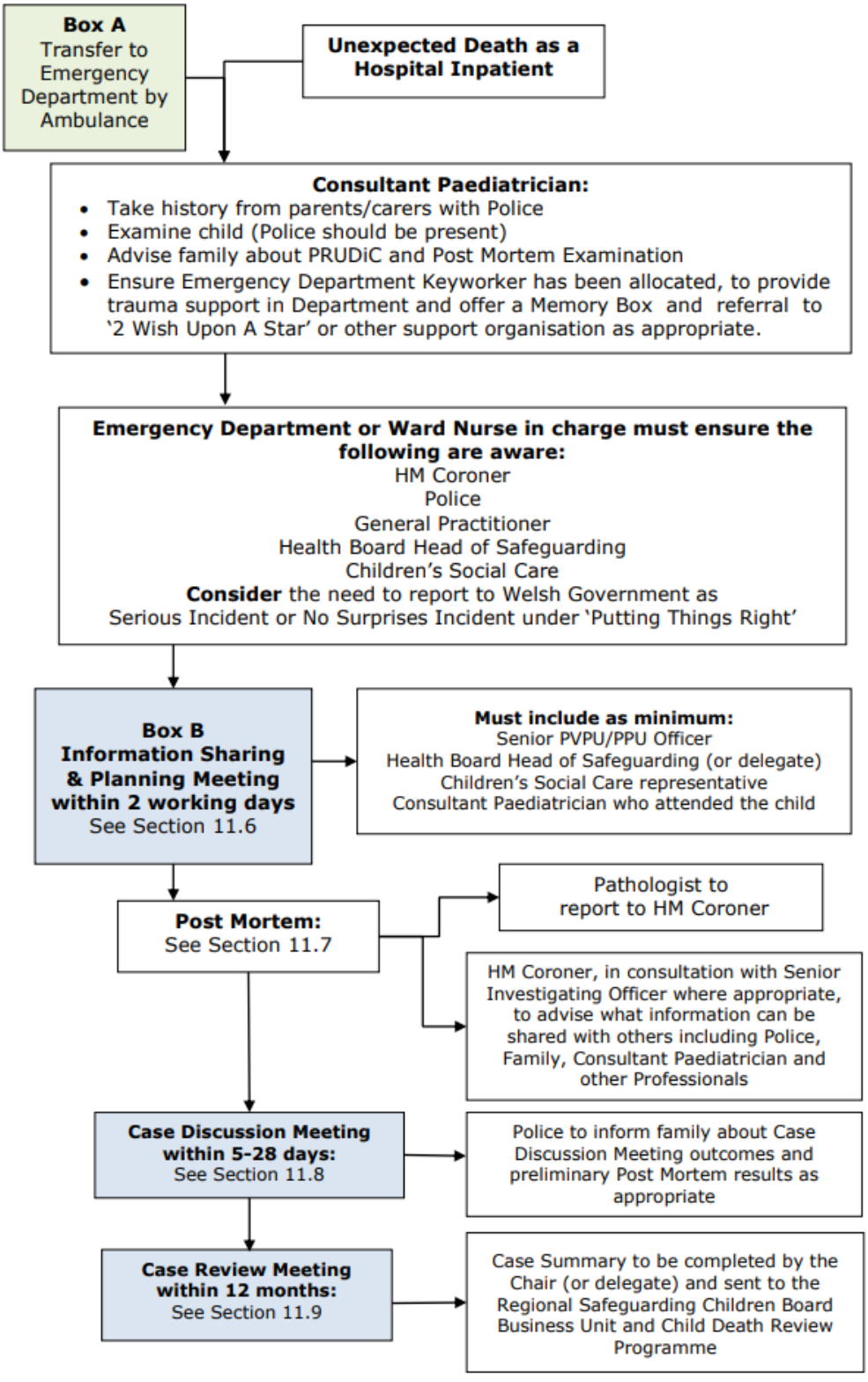
PRUDiC sets out a structure within which reasoned judgements can be made when evaluating an unexpected child death on the basis of all available information. It is important therefore that all staff remain open-minded when considering any death and avoid reaching conclusions inappropriately outside the agreed processes.

[7] Royal College of Pathologists. *National Medical Examiner's Good Practice Series No.2 – How medical examiners can facilitate urgent release of a body*. 2021. Available at: www.rcpath.org/uploads/assets/3590bf7f-a43e-4248-980640c5c12354c4/Good-Practice-Series-Urgent-release-of-a-bodyFor-Publication.pdf

Figure 3: Procedural Response to Unexpected Deaths in Childhood in Wales.[8]



[8] Public Health Wales. *Procedural Response to Unexpected Deaths in Childhood (PRUDiC) 2018*. Available at: www.wales.nhs.uk/sitesplus/documents/888/PRUDiC%202018%20Final.pdf


Box A
Transfer to Emergency Department by Ambulance
Unexpected Death as a Hospital Inpatient
Consultant Paediatrician:
Take history from parents/carers with Police
Examine child (Police should be present)
Advise family about PRUDiC and Post Mortem Examination
Ensure Emergency Department Keyworker has been allocated, to provide trauma support in Department and offer a Memory Box and referral to '2 Wish Upon A Star' or other support organisation as appropriate.
Emergency Department or Ward Nurse in charge must ensure the following are aware:
HM Coroner
Police
General Practitioner
Health Board Head of Safeguarding
Children's Social Care
Consider the need to report to Welsh Government as Serious Incident or No Surprises Incident under 'Putting Things Right'
Box B
Information Sharing & Planning Meeting within 2 working days
See Section 11.6
Must include as minimum:
Senior PVPU/PPU Officer
Health Board Head of Safeguarding (or delegate)
Children's Social Care representative
Consultant Paediatrician who attended the child
Post Mortem:
See Section 11.7
Pathologist to report to HM Coroner
HM Coroner, in consultation with Senior Investigating Officer where appropriate, to advise what information can be shared with others including Police, Family, Consultant Paediatrician and other Professionals
Case Discussion Meeting within 5-28 days:
See Section 11.8
Police to inform family about Case Discussion Meeting outcomes and preliminary Post Mortem results as appropriate
Case Review Meeting within 12 months:
See Section 11.9
Case Summary to be completed by the Chair (or delegate) and sent to the Regional Safeguarding Children Board Business Unit and Child Death Review Programme

Find out more

- Bereavement support standards for children's hospitals
- Child Bereavement UK
- Child Death Review Programme (Wales)
- Child Death Review: Statutory and operational guidance (England)
- Consultation on coronial investigations of stillbirths
- Early notification scheme – NHS Resolution
- Implementing a revised perinatal quality surveillance model (England)
- Independent Investigation into East Kent maternity services
- Maternity investigations | HSIB
- MBRRACE-UK signs of life guidance
- National Child Mortality Database (England)
- National Medical Examiner's Good Practice Guidelines
- 'Perinatal mortality − are we learning?' Royal College of Pathologists' *Bulletin*
- Perinatal Mortality Review Tool | Oxford Population Health, NPEU
- Procedural Response to Unexpected Deaths in Childhood (PRUDiC) (Wales)
- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
- Report of the Morecambe Bay Investigation
- Ockenden Review of maternity services at Shrewsbury and Telford Hospital NHS Trust

Acknowledgments

This document was drafted following circulation to and input from the following people. The National Medical Examiner is grateful to all for their participation and support:

- Dr Alan Fletcher, National Medical Examiner (Chair)
- Ann Marie Aherne, Deputy Head of the Chief Coroner's Office
- Margaret Butler, North West Regional Medical Examiner Officer, NHS England and NHS Improvement
- Stuart Cella, Joint Head of Policy, Civil Registration Directorate, General Register Office
- Ann Chalmers, Chief Executive, Child Bereavement UK
- Jane Crossley, Team Leader – Death Certification Reform, DHSC
- Nick Day, Policy and Programme Lead, National Medical Examiner System, NHS England and NHS Improvement
- Professor Jacqueline Dunkley-Bent OBE, Chief Midwifery Officer, NHS England and NHS Improvement
- Douglas Findlay, Lay representative
- Dr James Fraser, Consultant in Paediatric Intensive Care, University Hospitals Bristol NHS Foundation Trust
- Myer Glickman, Head of Methods, Quality and International, Health Analysis and Life Events Division, Office for National Statistics
- Natalie Harris, Healthcare Standards and Governance Lead, Welsh Government
- Austin Hayes, Senior Policy Advisor, General Register Office
- Matthew Jolly, National Clinical Director for Maternity and Women's Health, NHS England and NHS Improvement
- Dr Chris Jones, Deputy Chief Medical Officer for Wales
- Nita Kabaria, Business Support Officer, Maternity and Neonatal Policy, DHSC
- Professor Simon Kenny, National Clinical Director – Children and Young People, NHS England and NHS Improvement
- Camilla Kingdon, President, Royal College of Paediatrics and Child Health
- Dr Su Laurent, Medical Education Advisor, Child Bereavement UK
- Dr Suzy Lishman, Royal College of Pathologists
- Helen Mactier, President, British Association of Perinatal Medicine
- Edward Morris, President, Royal College of Obstetricians and Gynaecologists
- Pat O'Brien, Vice President for Membership, Royal College of Obstetricians and Gynaecologists

- Jane Pawson, DHSC
- Graham Prestwich, Lay representative
- Anna Rajakumar, Children and Young People Senior Policy Manager, NHS England and NHS Improvement
- Dr Rosalind Reilly, Consultant in Public Health – Child Death Review Programme, Public Health Wales
- Dr Mette Rodgers, Regional Medical Examiner (London), NHS England and NHS Improvement
- Vicky Sleap, National Child Mortality Database Manager, University Hospitals Bristol NHS Foundation Trust
- Dr Claire Thomas, National Safeguarding Team, NHS Wales
- Ian Thomas, Welsh Government
- Michele Upton, Head of Maternity and Neonatal Safety, NHS England and NHS Improvement
- Becky Wilson-Crellin, Programme Lead – Safety, NHS England and NHS Improvement.

Annex

Deaths of children – frequently asked questions

1. Do medical examiners provide scrutiny of the deaths of children and neonates?

Medical examiners should scrutinise non-coronial deaths of neonates and children in the same way as they do for adults, so that families bereaved after the death of a child have equal access to a discussion with an independent person. Medical examiners complete scrutiny rapidly in the short time (5 days) before the death must be registered. They provide independent scrutiny as they will not have been involved in care of the child prior to death. This is particularly important given the findings of a number of independent healthcare investigations. Medical examiners are likely to provide valuable support to child/neonatal death reviews, which will usually take place later.

2. What information should the doctor completing the MCCD give to the medical examiner?

The medical examiner will need access to the patient record.

In England Chapter 2 of the national child death review statutory and operational guidance sets out the immediate decisions that should be taken following a child's death and what notifications should take place. It gives guidance as to which deaths require a joint agency response, when a referral to the coroner is mandated, and required notifications. Where the doctor completing the MCCD believes the certificate can be issued, they should notify the medical examiner of the proposed cause of death, and in England, provide details of the family's key worker to the medical examiner. In cases where the consultant paediatrician is uncertain whether a MCCD can be issued, they should discuss the case with the medical examiner or medical examiner officer.

3. What should the medical examiner do if they have concerns about emerging patterns and trends relating to the deaths of children?

See recommendation 8. Medical examiners should escalate concerns to regional medical examiners in England and the lead medical examiner in Wales, as set out in the National Medical Examiner's Good Practice Guidelines; or in England, to the regional chief midwife and regional lead obstetrician, who will be members of regional-level quality oversight committees.

4. What happens if the child dies in the community?

When medical examiners provide independent scrutiny of the death of a child in a non-acute setting, the interactions between medical examiners and the child death review processes will be the same as or very similar to those for deaths in hospital. Children whose deaths trigger a joint agency response in England, or a PRUDiC in Wales, are likely to be notified to the coroner (if the coroner takes the death for investigation, the medical examiner will not provide independent scrutiny).