

# **Child Death Review in the Eastern part of the Netherlands; a comparison with current practice in the management of childhood deaths**

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## **Background**

Child mortality in the Netherlands declines gradually (source [www.fomat.nl](http://www.fomat.nl)). In total 1.275 children and youth aged 0 to 19 years died in 2009. In 8 out of 10 cases the death was classified as due to a natural cause.

Child Death Review has been introduced in the United States of America, Canada, Australia, New Zealand and the United Kingdom. All child deaths are examined in a systematic way through a multidisciplinary approach with the objective to improve cause of death statistics, to identify risk factors for generating preventive interventions, and to enhance support of families and professionals.

Since January 2011 the pilot implementation of Child Death Review in children 0-2 years of age in the Eastern part of the Netherlands has started. Until August, 7 children have been included.

## **Objective**

The objective of this study is to measure the benefit of the Child Death Review process, which contains the Rapid Response in case of a sudden and unexpected death of a child and the Child Death Overview in all childhood deaths.

## **Method**

Protocols, guidelines and a variety of other papers were retrieved from professionals and organizations in child and family care to compare the Child Death Review process with the current procedures in the management of childhood deaths. Information of relevant professionals who do not have any documents has been obtained through interviews. A scorecard based on the Child Death Review protocol used in the United Kingdom and in the Eastern part of the Netherlands has been developed to measure the Child Death Review process. By analyzing the current procedures with this scorecard a comparison can be made between the Child Death Review process and the current procedures.

## **Results**

In total 22 protocols and interview reports were analyzed. Protocols which pay attention to improve death statistics correspond with the Rapid Response, especially the manual to report deceased minors, the protocol for Sudden Infant Death Syndrome and the procedures of the police and the Public Prosecutor. No other protocol primarily aims at gaining insight into avoidable factors except the protocol for perinatal audits and to a limited extent the protocol for Sudden Infant Death Syndrome. The Dutch Safety First Association, the Dutch Consumer and Safety Foundation, the Dutch Safety Board and the Dutch Perinatal Audit Foundation are focused on long term prevention. With regard to the support of the families only the protocol which is used when a child dies at the Emergency Department corresponds most with the Child Death Review process.

## **Conclusions**

The current procedures in the Netherlands are fragmented and none of them corresponds completely with the Child Death Review process. The protocol for Sudden Infant Death Syndrome and for perinatal audits contain many aspects of the Child Death Review in the Eastern part of the Netherlands.

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