



Children's MARS Policy and Procedures Child Death Reviews

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Introduction

The death of a child is a devastating loss that profoundly affects all those involved. The process of systematically reviewing the deaths of children is grounded in respect for the rights of children and their families¹, with the intention of learning what happened and why, and preventing future child deaths.

The majority of child deaths in England arise from medical causes. Enquiries should keep an appropriate balance between forensic and medical requirements and supporting the family at a difficult time. This policy and procedure provides guidance to child death review partners in light of their statutory responsibilities.

Child death review partners are local authorities and any clinical commissioning groups for the local area as set out in the Children Act 2004 (the Act), as amended by the Children and Social Work Act 2017². The statutory responsibilities for child death review partners are set out in the table below, and the boundaries for child death review partners are decided locally.

In the immediate aftermath of a child's death, a copy of *When a Child Dies – a guide for families and carers*³ should be offered to all bereaved families or carers in order to support them through the child death review process. In addition to supporting families and carers, staff involved in the care of the child should also be considered and offered appropriate support.

Further guidance [Child Death Review Statutory and Operational Guidance \(England\)](#) has been issued by the government. It should be referred to in conjunction with this guidance.

Local Child Death Review Partner Arrangements

Local authority areas must transition from LSCBs to child death review partner arrangements within 12 months of 29 June 2018 and have up to three months to implement the arrangements by 29 September 2019. Child death review partners should publish their arrangements, and should notify NHS England when they have done so. In North Lincolnshire, we are working to publish and implement the local child death review partner arrangements in April 2019.

Until the new child death review partner arrangements are published, the [LSCB Policy and Procedures Child Death Review Process and Child Death Overview Panel](#) remain in place.

After new child death review partner arrangements are set up, LSCBs in the area have a statutory 'grace' period of up to four months to complete outstanding child death reviews, which must be completed by 29 January 2020. Child death review partners should consider any incomplete child death reviews passed to them by former Child Death Overview Panels, and take appropriate action.

¹ [United Nations Convention on the Rights of the Child](#)

² Sections 16Q

³ [When a Child Dies – a guide for families and carers](#)

Statutory Requirements⁴

When a child dies, in any circumstances, it is important for parents and families to understand what has happened and whether there are any lessons to be learned.

The responsibility for ensuring child death reviews are carried out is held by 'child death review partners,' who, in relation to a local authority area in England, are defined as the local authority for that area and any clinical commissioning groups operating in the local authority area.

Child death review partners must make arrangements to review all deaths of children normally resident in the local area⁵ and, if they consider it appropriate, for any non-resident child who has died in their area.

Child death review partners for two or more local authority areas may combine and agree that their areas be treated as a single area for the purpose of undertaking child death reviews.

Child death review partners must make arrangements for the analysis of information from all deaths reviewed.

The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If child death review partners find action should be taken by a person or organisation, they must inform them. In addition, child death review partners:

- must, at such times as they consider appropriate, prepare and publish reports on:
 - what they have done as a result of the child death review arrangements in their area, and
 - how effective the arrangements have been in practice;
- may request information from a person or organisation for the purposes of enabling or assisting the review and/or analysis process - the person or organisation must comply with the request, and if they do not, the child death review partners may take legal action to seek enforcement: and
- may make payments directly towards expenditure incurred in connection with arrangements made for child death reviews or analysis of information about deaths reviewed, or by contributing to a fund out of which payments may be made; and may provide staff, goods, services, accommodation or other resources to any person for purposes connected with the child death review or analysis process.

⁴ The guidance in this chapter is issued under section 16Q of the Children Act 2004. Further guidance on child death review procedures will be issued by the government. While the contents of this chapter will be duplicated within that document, child death review partners should also have regard to that guidance to assist in their understanding of the steps taken by others prior to the child death reviews and analysis they carry out.

⁵ For the purposes of child death reviews, a local area is the area within the remit of a local authority (referred to in the Act as a "local authority area").

Responsibilities of Child Death Review Partners

The child death review process covers children: a child is defined in the Act as a person under 18 years of age⁶, regardless of the cause of death⁷.

In making arrangements to review child deaths, child death review partners should establish a structure and process to review all deaths of children normally resident in their area and, if appropriate and agreed between child death review partners, the deaths of children not normally resident in their area but who have died there. Child death review partners may, if they consider it appropriate, model their child death review structures and processes on the current Child Death Overview Panel (CDOP) framework⁸.

The child death review partners should consider the core representation of any panel or structure they set up to conduct reviews and this would ideally include: public health; the designated⁹ doctor for child deaths for the local area; social services; police; the designated doctor or nurse for safeguarding; primary care (GP or health visitor); nursing and/or midwifery; lay representation; and other professionals that child death review partners consider should be involved. It is for child death review partners to determine what representation they have in any structure reviewing child deaths.

Child death review partners should agree locally how the child death review process will be funded in their area.

The geographical and population 'footprint' of child death review partners should be locally agreed, but must extend to at least one local authority area. This footprint should take into account networks of NHS care, and agency and organisational boundaries in order to reflect the integrated care and social networks of the local area. These may overlap with more than one local authority area or clinical commissioning group. They should cover a child population such that they typically review at least 60 child deaths per year. Child death review partners should come together to develop clear plans outlining the administrative and logistical processes for these new review arrangements.

Child death review partners should ensure that a designated doctor for child deaths is appointed to any multi-agency panel (or structure in place to review deaths). The designated doctor for child deaths should be a senior paediatrician who can take a lead role in the review process. Child death review partners should ensure a process is in place whereby the designated doctor for child deaths is notified of each child death and is sent relevant information.

Child death review partners may request a person or organisation to provide information to enable or assist the reviewing and/or analysing of a child's death. The person or organisation to whom a request is made must comply with such a request and if they do not do so, the child death review

⁶ Section 65 of the Children Act 2004.

⁷ This will include the death of any new-born baby (of any gestation) who shows signs of life following birth, or where the birth was unattended, but does not include those (of any gestation) who are stillborn or where there was medical attendance, or planned terminations of pregnancy carried out within the law.

⁸ The CDOP frameworks were established and are currently used by Local Safeguarding Children Boards to review the deaths of children in their areas.

⁹ Within that part of the health system that supports child safeguarding and protection services, the word "designated" means a dedicated professional with specific roles and responsibilities that are centred on the provision of clinical expertise and strategic advice.

partners may instigate legal action to enforce.

Child death review partners for the local authority area where a child who has died was normally resident are responsible for ensuring the death is reviewed. However, they may also choose to review the death of a child in their local area even if that child is not normally resident there. Child death review partners may wish to consider this for the deaths of looked-after children in their area who were not normally resident there. The review process should seek to involve child death review partners for another local authority area who had an interest in the child or any other person or agencies, as appropriate.

Child death review partners should publicise information on the arrangements for child death reviews in their area. This should include who the accountable officials are (the local authority chief executive and the accountable officer of the clinical commissioning group), which local authority and clinical commissioning group partners are involved, what geographical area is covered and who the designated doctor for child deaths is.

Responsibilities of other organisations and agencies

All local organisations or individual practitioners that have had involvement in the case should cooperate, as appropriate, in the child death review process carried out by child death review partners. All local organisations or individual practitioners should also have regard to any guidance on child death reviews issued by the government.

Specific responsibilities of relevant bodies in relation to child deaths	
Registrars of Births and Deaths (Section 31 of the Children and Young Persons Act 2008)	<p>Requirement on registrars of births and deaths to supply child death review partners with the particulars of the death entered in the register in relation to any person who was or may have been under the age of 18 at the time of death. A similar requirement exists where the registrar corrects an entry in the register.</p> <p>The registrar must also notify child death review partners if they issue a Certificate of No Liability to Register (where a death is not required by law to be registered in England or Wales) where it appears that the deceased was or may have been under the age of 18 at the time of death.</p> <p>The information must be provided to the appropriate child death review partners (which cover the sub- district in which the register is kept) no later than seven days from either the date the death was registered, the date the correction was made or the date the certificate was issued¹⁰.</p>

¹⁰ Amendments have been made to the Children and Young Persons Act. It should be noted that while these

<p>Coroners and Justice Act 2009</p> <p>Coroners (Investigations) Regulations 2013</p>	<p>Duty to investigate and hold an inquest. Powers to request a post-mortem and for evidence to be given or produced.</p> <p>Coroner's duty to notify the child death review partners¹¹ for the area in which the child died or where the child's body was found within three working days of deciding to investigate a death or commission a post-mortem.</p> <p>Coroner's duty to share information with the relevant child death review partners¹².</p>
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amendments came into force on 29th June 2018, they will not have effect in a local authority area until the date that area implements its new safeguarding partnership arrangements.

¹¹ Amendments will be made to the Coroners (Investigations) Regulations 2013 to require the Coroner to notify the relevant safeguarding partners and child death review partners instead of LSCBs. Until such time as these amendments are made, where a local area has implemented its new safeguarding partnership arrangements, Coroners are asked to also notify relevant child death review partners.

¹² Amendments will be made to the (Investigations) Regulations 2013 to require the Coroner to share information with the relevant safeguarding partners and child death review partners instead of LSCBs. Until such time as these amendments are made, where a local area has implemented its new safeguarding partnership arrangements, Coroners are asked to also share information with the relevant child death review partners.

Responding to the death of a child: the child death review process

Flow Chart: Process to follow when a child dies

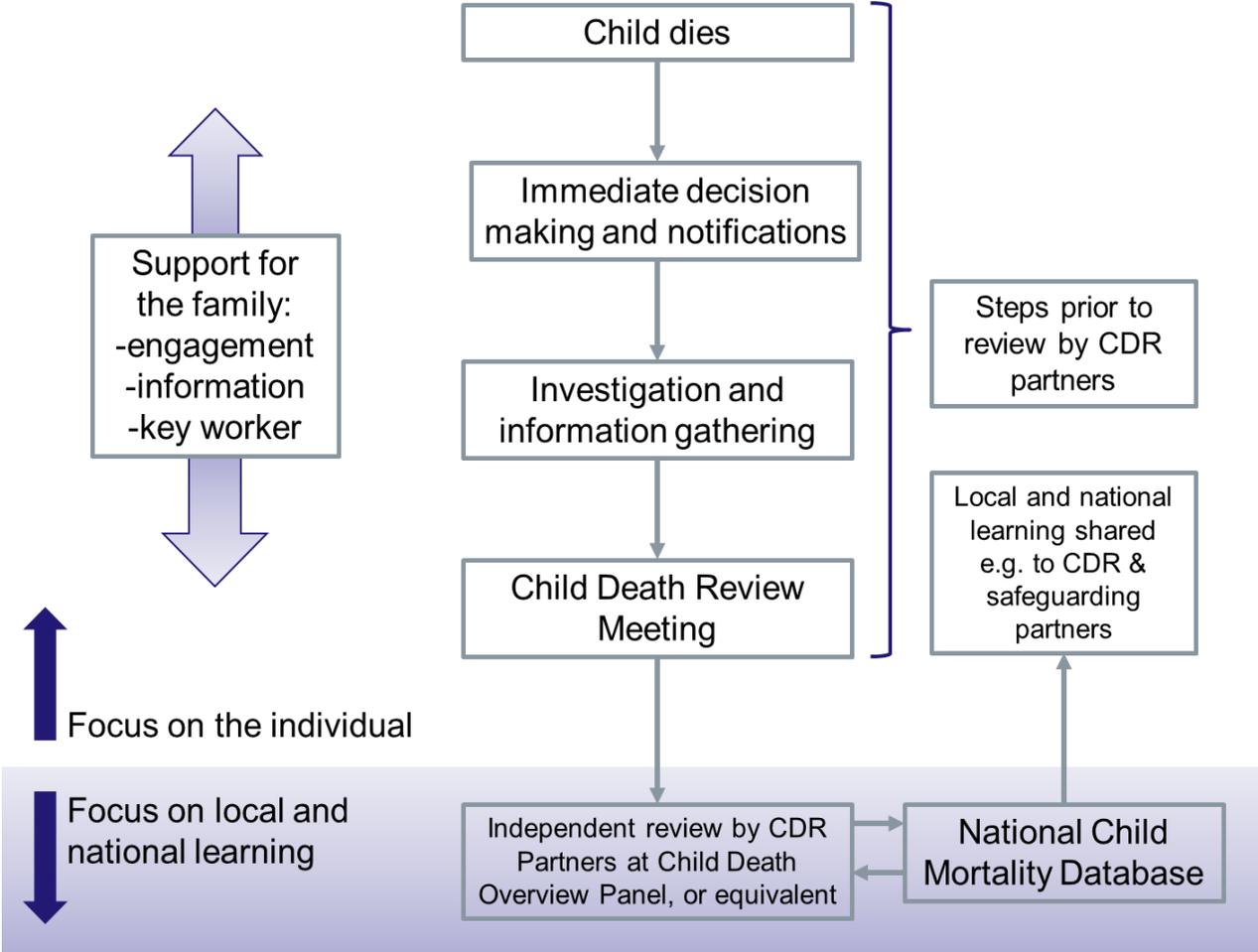


Figure 1. Chart illustrating the full process of a child death review. This includes both the statutory responsibilities of Child Death Review partners to review the deaths of children (described here as review at CDOP or equivalent), and the processes that precede or follow this independent review. Further explanation is below.

The *steps that precede* the child death review partners' independent review (figure 1), commence in the immediate aftermath of a child's death. These include the immediate decisions, notifications and parallel investigations, and the local case review by those directly involved with the care of the child or involved in the investigation after death, at the Child Death Review Meeting. The information gathered throughout this process should be fed into the partners' review.

The learning from all child death reviews should be shared with the National Child Mortality Database, once operational, which may in addition take into account information from other reviews in order to identify any trends or similarities with deaths. Information from the database may be able to inform systematic or local changes to prevent future deaths.

The processes that should be followed by all those involved when responding to, investigating, and reviewing all child deaths is set out in the further guidance on child death reviews issued by the government.

All practitioners participating in the child death review process should notify, report, and scrutinise child deaths using the North Lincolnshire ECDOP system. These should be submitted to North Lincolnshire's CDOP. The mechanism for collecting this data will evolve as the National Child Mortality Database becomes operational.

The child death review process

A child dies

Practitioners in all agencies should notify the local child death review partners, via the local CDOP coordinator of the death of any child of which they become aware by using the ECDOP form.

Immediate decision making and notifications & Investigation and information gathering

Whenever a child dies, practitioners should work together in responding to that death in a thorough, sensitive and supportive manner. The aims of this response are to

- establish, as far as is possible, the cause of the child's death
- identify any modifiable contributory factors¹³
- provide ongoing support to the family
- learn lessons in order to reduce the risk of future child deaths and promote the health, safety and wellbeing of other children
- ensure that all statutory obligations are met

Where a Joint Agency Response is required, practitioners should follow the process set out in *Sudden and Unexpected Death in Infancy and Childhood: multiagency guidelines for care and investigation (2016)*. A Joint Agency Response is required if a child's death:

- is or could be due to external causes
- is sudden and there is no immediately apparent cause (including sudden unexpected death in infancy/childhood)
- occurs in custody, or where the child was detained under the Mental Health Act
- occurs where the initial circumstances raise any suspicions that the death may not have been natural
- occurs in the case of a stillbirth where no healthcare professional was in attendance

If there is an unexplained death of a child at home or in the community, the child should normally be taken to an emergency department rather than a mortuary. In some cases when a child dies at home or in the community, the police may decide that it is not appropriate to move the child's body immediately, for example, because forensic examinations are needed.

In a criminal investigation, the police are responsible for collecting and collating all relevant information pertaining to the child's death. Practitioners should consult the lead police investigator and the Crown Prosecution Service to ensure that their enquiries do not prejudice any criminal proceedings.

If the results of any investigations suggest evidence of abuse or neglect as a possible cause of death, the paediatrician should inform relevant safeguarding partners and the Child Safeguarding Practice Review Panel immediately.

¹³ These are defined as factors which may have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future deaths.

Child Death Review Meeting

This is the multi-professional meeting that takes place prior to the child death review partners review. At the meeting, all matters relating to an individual child's death are discussed by professionals involved with the case. The child death review meeting should be attended by professionals who were directly involved in the care of that child during his or her life and in the investigation into his or her death, and should not be limited to medical staff. A [draft analysis](#) form of each individual case should be sent from the child death review meeting to child death review partners to inform the independent review at a CDOP, or equivalent.

Review of death by child death review partners

The review by the child death review partners (at CDOP, or equivalent), is intended to be the final, independent scrutiny of a child's death by professionals with no responsibility for the child during their life. The information gathered using all the standardised templates may help child death review partners to identify modifiable factors that could be altered to prevent future deaths.

In addition to the statutory purposes set out above, the review should also provide data¹⁴ to NHS Digital and then, once established, to the National Child Mortality Database.

Child death review partners for a local authority area in England must prepare and publish a report as set out in the statutory responsibilities above. They may therefore wish to ask the CDOP (or equivalent) to produce an annual report for child death review partners on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process in order to assist child death review partners to prepare their report.

¹⁴ Specified data to NHS Digital for the transitional period will be notified to Child Death Review partners separately. The mechanism for collecting, and the content of, this data will evolve as the National Child Mortality Database becomes operational.