Child Death Reviews

The Regulations relating to child death reviews

The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

a) *collecting and analysing information about each death with a view to identifying—*

   (i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);
   (ii) *any matters of concern affecting the safety and welfare of children in the area of the authority;*
   (iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

b) *putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.*

1. Each death of a child is a tragedy and enquiries should keep an appropriate balance between forensic and medical requirements and supporting the family at a difficult time. Professionals supporting parents and family members should assure them that the objective of the child death review process is not to allocate blame, but to learn lessons. The purpose of the child death review is to help prevent further such child deaths, and families may find it helpful to read the child death review leaflet.

2. The responsibility for determining the cause of death rests with the coroner or the doctor who signs the medical certificate of the cause of death (and therefore is not the responsibility of the Child Death Overview Panel (CDOP)).

Responsibilities of the Sheffield Safeguarding Children Board (SSCB)

3. The SSCB is responsible for ensuring that a review of each death of a child (defined as from birth up to the 18th birthday) normally resident in the SSCB's area is undertaken by CDOP. The CDOP will have a fixed core membership drawn from organisations represented on the SSCB with flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate. The CDOP should include a professional from public health as well as child health. It should be chaired by the SSCB Chair's representative. That individual should not be involved directly in providing services to children and families in the area. CDOP should meet at least four times each year.

4. The standing membership will consist of the following agencies:

- Legal Advisor, SCC
- Consultant pathologist (SCH)
- Designated paediatrician (SCH)

- Lay people
- Public Health (Chair)
- Sheffield Children's Social Care
- Sheffield Children's Safeguarding Service
- South Yorkshire Police
- Midwifery
- Clinical Commissioning Group (CCG)
- GPs
- Multi-Agency Support Teams (MAST)
- Schools

Agencies listed should agree who is the most appropriate member of staff to represent them on CDOP. They should also agree a deputy. When it is not possible for the agreed representative to attend, the deputy should attend on their behalf.

5. All members of the CDOP should adhere to the Terms of Reference and confidentiality agreement.

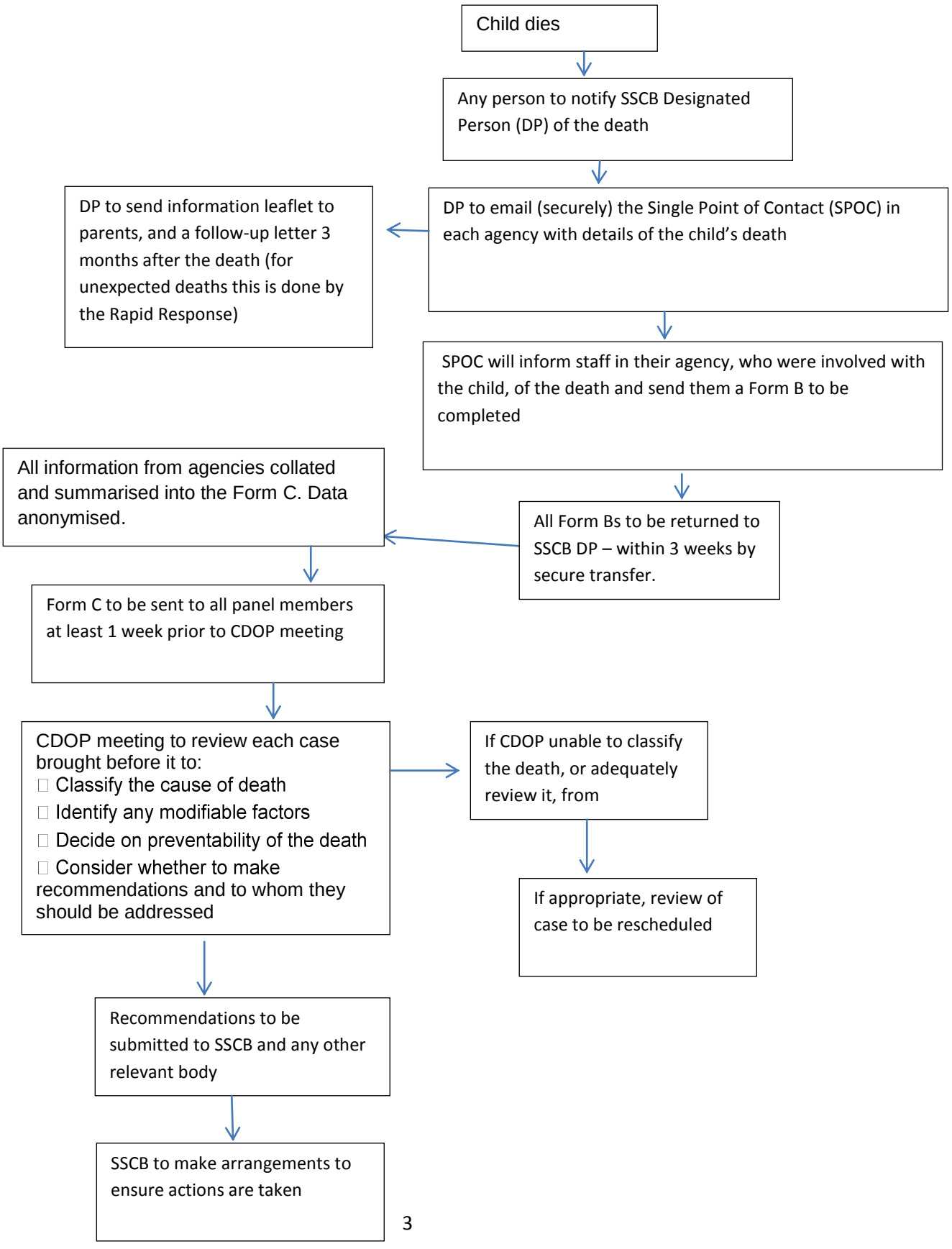
6. In Sheffield the designated person to whom the death notification and other data on each death should be sent is the Business Support Manager (BSM) for CDOP, based within the SSCB. A list of designated people for CDOPs in England and Wales is available on the Department of Education website. SSCB should use sources available, such as professional contacts or the media, to find out about cases when a child who is normally resident in their area dies abroad. The SSCB should inform the CDOP of such cases so that the deaths of these children can be reviewed.

7. Other Local Safeguarding Children Boards (LSCBs) or local organisations which have had involvement in the case should cooperate in jointly planning and undertaking the child death review. In the case of a looked after child, the LSCB for the area of the local authority responsible for the looked after child should exercise the lead for conducting the child death review, involving other LSCBs with an interest or whose lead agencies have had involvement.

8. All forms and templates to be used for reporting child deaths can be obtained by emailing cdop@sheffield.gov.uk.

9. A summary of the child death processes to be followed when reviewing all child deaths is set out in the flow chart below. The processes for undertaking a rapid response when a child dies unexpectedly are set out later in this procedure.

Process to be followed for all child deaths



Responsibilities of Child Death Overview Panels

10. The functions of the CDOP include:

- Reviewing all child deaths (up to the 18th birthday), excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
- Collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
- Discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;
- Determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
- Making recommendations to the sscb or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
- Identifying patterns or trends in local data and reporting these to the sscb;
- Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the sscb chair for consideration of whether a serious case review (scr), case review (cr) or learning lessons review (llr) is required;
- Agreeing local procedures for responding to unexpected deaths of children;
- Supply annual data return to the department of education; and
- Cooperating with regional and national initiatives – for example, with the national clinical outcome review programme – to identify lessons on the prevention of child deaths.

11. In reviewing the death of each child, the CDOP should consider modifiable factors, for example, in the family environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level.

12. The aggregated findings from all child deaths should inform local strategic planning, including the local Joint Strategic Needs Assessment, on how to best safeguard and promote the welfare of children in the area. CDOP should prepare an annual report of relevant information for the SSCB and provide 6 monthly updates to the SSCB Operational Board. A public version of the annual report should also be produced and made available on the SSCB website. This information should in turn inform the SSCB annual report.

13. CDOP should work to an annually agreed Work Plan.

Specific responsibilities of relevant bodies in relation to child deaths

Registrars of Births and Deaths (Children and Young Persons	Requirement to supply the LSCB with information which they have about the death of persons under 18 they have registered or re-registered.

Act 2008)	Notify LSCBs if they issue a *Certificate of No Liability to Register* where it appears that the deceased was or may have been under the age of 18 at the time of death. Requirement to send the information to the appropriate LSCB (the one which covers the sub-district in which the register is kept) no later than seven days from the date of registration.
Coroners (Coroners Rules 1984 (as amended by the Coroners (Amendment) Rules 2008))	Duty to inquire and may require evidence. Duty to inform the LSCB for the area in which the child died within three working days of the fact of an inquest or post mortem. Powers to share information with LSCBs for the purposes of carrying out their functions, including reviewing child deaths and undertaking SCRs.
Registrar General (section 32 of the Children and Young Persons Act 2008)	Power to share child death information with the Secretary of State, including about children who die abroad.
Clinical Commissioning Groups (Health and Social Care Act 2012)	Employ, or have arrangements in place to secure the expertise of, consultant paediatricians whose designated responsibilities are to provide advice on: • commissioning paediatric services from paediatricians with expertise in undertaking enquiries into unexpected deaths in childhood, and from medical investigative services; and • the organisation of such services.
Health & Safety Executive (HSE)	Where a young person dies at work, the Health and Safety Executive should be informed.
Youth Justice Service	Should review the deaths of children under their supervision. Finding from this review should feed into the CDOP child death processes.