Child Death Review Process (including Unexpected Death of a Child

Contents

1. Introduction

1.1 Regulation 6 of the Local Safeguarding Children Board Regulations 2006 places a statutory duty on LSCBs in relation to the deaths of any children normally resident in their area and guidance is provided in Working Together to Safeguard Children 2015. This function became a statutory requirement from 1st April 2008. This chapter will set out the principles relating to when a child dies in Sunderland Safeguarding Children Board (SSCB) area.

1.2 The guidance in this chapter relates to the deaths of all children and young people from birth (excluding those babies who are stillborn *or planned terminations that are within the law but including children with life-long or life limiting conditions*) up to the age of 18 years.

1.3 There are two related processes for reviewing child deaths (either of which can trigger a **Serious Case Reviews Procedure**).

a. A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child;

b. An overview of child deaths in SSCB area undertaken by the Child Death Review Panel.

1.4 Overall Principles

1.5 Each unexpected death of a child is a tragedy for the family and subsequent enquiries/investigations should keep an appropriate balance between forensic and medical requirements and the family's need for support. Children with a known disability or a medical condition should be responded to in the same manner as other children. A minority

of unexpected deaths are the consequence of abuse or neglect, or are found to have abuse or neglect as an associated factor. In all cases enquiries should seek to understand the reasons for the child's death, address the possible needs of other children in the household, the needs of all family members and also consider any lessons to be learnt about how best to safeguard and promote children's welfare in the future.

1.6 Families should be treated with sensitivity, discretion and respect at all times and professionals should approach their enquiries with an open mind.

2. The Regulations Relating to Child Deaths

2.1 Regulation 6 requires the collection and analysis of information about each child death in their area with a view to identifying:

i. Any case giving rise for the need for a **Serious Case Review**;

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.

2.2 And putting in place procedures for ensuring that there is a co-coordinated response by the authority, their LSCB partners and other relevant persons to an unexpected death.

3. Definition of an Unexpected Death of a Child

3.1 An unexpected death is defined as the death of a child (less than 18 years old) that was not anticipated as a significant possibility, for example 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events that led to the death.
The Designated Paediatrician responsible for unexpected deaths in childhood should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt these procedures should be followed until the available evidence enables a different decision to be made.

4. SSCB Responsibilities for the Child Death Review Processes

4.1 The Local Child Death Review Panel is responsible for reviewing information on all child deaths and is accountable to the SSCB Independent Chair. The disclosure of information about a deceased child enables the SSCB to carry out its statutory functions relating to child deaths. SSCB uses the aggregated findings from all child deaths collected according to a nationally agreed minimum data set, to inform local strategic planning on how best to safeguard and promote the welfare of the children in their area.

4.2 SSCB shares a Child Death Overview Panel with Gateshead and South Tyneside LSCB's covering a population greater than 500,000. This South of Tyne Overview Panel is chaired by a member of one of the LSCBs. However, the processes for reviewing child deaths in each local area will be managed separately but use common procedures and tools in order to support the shared overview process. The three authorities have commissioned a Child Death Review Co-ordinator to support and administer the child death review process.

4.3 In each partner agency of SSCB, a senior person with relevant expertise has responsibility for advising on the implementation of the local procedures on responding to child deaths within their agency. Each agency should expect to be involved in a child's death at some time.

4.4 The CCG has a Consultant Paediatrician who is the Designated Doctor with responsibility for unexpected deaths in childhood. Their role includes providing advice on:

- The commissioning of Paediatric Services from paediatricians with expertise in undertaking enquiries into unexpected deaths in childhood and the medical investigative services such as radiology, laboratory and histopathology services; and
- The organisation of such services.

4.5 The Designated Paediatrician for unexpected deaths in childhood is a member of the Child Death Overview Panel. This is a separate role to the Designated Doctor for Child Protection.

4.6 The South of Tyne Child Death Overview Panel is responsible for ensuring that appropriate single and inter-agency training is available to ensure successful implementation of these procedures. LSCB partner agencies should ensure that relevant staff have access to this training.

4.7 When a child dies unexpectedly, several investigative processes may be instigated, particularly when abuse or neglect is a factor. This guidance intends that the relevant professionals and organisations work together in a co-coordinated way, in order to minimise duplication and ensure that the lessons learnt contribute to safeguarding and protecting the welfare of children in the future.

5. Other Related Processes

5.1 Where there is an ongoing criminal investigation, the Crown Prosecution Service must be consulted as to what is appropriate for the professionals to be doing, and what actions to take in order not to prejudice any criminal proceedings.

5.2 Where a child dies unexpectedly, all Trusts including CCGs should follow their locally agreed procedures for reporting and handling serious patient safety incidents.

5.3 If it is thought at any time that the criteria for a Serious Case Review might apply, the Chairperson of the SSCB should be contacted through the SSCB Business Manager and the **Serious Case Reviews Procedure** should be followed.

5.4 If during the enquiries concerns are expressed in relation to the needs of surviving children in the family, discussions should take place with Children's Safeguarding. It may be decided to initiate a Child in Need Assessment. If concerns are raised at any stage about the possibility of surviving children in the household being abused or neglected the procedures set out in Child Protection Referrals and Responses Procedure should be followed. Children's Safeguarding has lead responsibility for safeguarding and promoting the welfare of children. The Police will be the lead agency for any criminal investigation. The Police must be informed immediately that there is a suspicion of a crime, to ensure that the evidence is properly secured and that any further interviews with family members and other relevant people accord with the requirements of the Police and Criminal Evidence Act 1984.

6. Roles and Responsibilities when Responding Rapidly to an Unexpected Death of a Child

6.1 It is intended that those professionals involved (before or after the death) with a child who dies unexpectedly should come together to enquire into and evaluate the child's death. This means that some roles may require an on call rota for responding to unexpected child deaths in their area. The work of the team convened in response to each child's death should be co-coordinated, usually by a local Designated Paediatrician responsible for unexpected deaths in childhood. LSCBs may choose to designate particular professionals to be standby members of a team because of their roles and particular expertise. The professionals who come together as a team will carry out their normal functions i.e. as a Paediatrician, GP, Nurse, Health Visitor, Midwife, Mental Health Professional, Social Worker, Probation or Police Officer in response to the unexpected death of a child. They should also work according to a protocol agreed with the local Coronial Service.

6.2 The joint responsibilities of those professionals include:

- Responding quickly to the unexpected death of a child;
- Making immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the Coroner;
- Undertaking the types of enquiries/investigations that relate to the current responsibilities of their respective organisations when a child dies unexpectedly. This includes liaising with those who have ongoing responsibilities for other family members;
- Collecting information in a standard, nationally agreed manner;
- Following the death through maintaining contact at regular intervals with family members and other professionals who have ongoing responsibilities for other family members to ensure they are informed and kept up to date with information about the child's death.

6.3 Procedures for a Rapid Response from Professionals to All Unexpected Deaths of Children

6.4 Care of Parents/Family Members

6.4.1 When a child has died in, or been taken to, a hospital their parents/carers should be allocated a member of the hospital staff to remain with and support them throughout the process. The parents should normally be given the opportunity to hold and spend time with their baby or child. During this time the allocated member of staff should maintain a discreet presence.

6.4.2 There should be provision within local procedures for an identified professional to provide similar support to families where the child has died and not been taken to hospital.

6.4.3 Where a child is living in England but their parents live abroad, careful consideration should be given to how best to contact and support the bereaved family members.

6.4.4 Parents/carers should be kept up to date with information about their child's death and the involvement of each professional, unless such sharing of information would jeopardise Police investigations or other criminal processes.

6.5 Responding to the Unexpected Death of a Child

6.5.1 The type of response to each child's unexpected death will depend to a certain extent on the age of the child but there are some key elements that underpin all subsequent work. Supplementary information is required for making enquiries into, for example, infant deaths, deaths that are as a result of traumas, death in hospital and suicides.

6.5.2 Once the death of a child has been referred to the Coroner and s/he has accepted it, the

Coroner has jurisdiction over the body and all that pertains to it. Coroners must therefore be consulted over the local implementation of national procedures and protocols and should be asked to give general approval for the measures agreed to reduce the need to obtain specific approval on each occasion.

6.5.3 A multi-professional approach is required to ensure collaboration among all involved including ambulance staff, A & E staff, Coroner's Officers, Police, GPs, Health Visitors, School Nurses, Midwives, Paediatricians, mental health professionals, hospital bereavement staff, voluntary agencies, Coroners, Pathologists, Forensic Medical examiners, Children's Safeguarding, Probation, school and any others who may find themselves with a contribution to make in an individual case e.g. fire fighters or faith leaders.

6.5.4 Babies who die suddenly and unexpectedly at home should be taken to an A & E Department rather than a mortuary and resuscitation should always be initiated unless clearly inappropriate. Resuscitation, once commenced, should be continued according to the UK Resuscitation Guidelines (2005) until an experienced doctor (usually the Consultant Paediatrician on call) has made a decision to stop further efforts. Older children must also be taken to A & E unless this is inappropriate, for example the circumstances of the death require the body to remain at the scene for forensic examination.

6.5.5 As soon as practicable after arrival at a hospital the baby or child should be examined by the Consultant Paediatrician on call (in some cases this might be together with a consultant in Emergency Medicine, or for some young people over 16, the consultant in Emergency Medicine may be more appropriate than the paediatrician). A detailed and careful history of events leading up to and following the discovery of the child's collapse should be taken from the parents/carers. This should begin the process of collecting a nationally agreed data set. The purpose of obtaining high quality information at this stage is to understand the cause of the death where appropriate and to identify anything suspicious about it.

6.5.6 When the cause of death or factors contributing to it are uncertain, investigative samples should be taken immediately on arrival and after the death is confirmed. These need to be agreed in advance with the Coroner and should include the standard set for SUDI (Royal College of Pathologists, and Royal College of Paediatricians and Child Health 2004) and standards set for other types of death presentation as they are developed. Consideration should always be given to undertaking a full skeletal survey and, where appropriate, it should be made before the autopsy starts as this may significantly alter the required investigations.

6.5.7 Where the baby or child is pronounced dead the consultant clinician should inform the parents having first reviewed all the available information. He should explain future Police and Coroner involvement including the Coroner's authority to order a post mortem examination. This may involve particular tissue blocks and slides to ascertain the cause of death. Consent from those with **Parental Responsibility** for the child is required for tissue to be retained beyond the period required by the Coroner (for example for use in research or for possible future review).

6.5.8 The Consultant Clinician who has seen the child should inform the Designated Paediatrician with responsibility for unexpected deaths in childhood immediately after the Coroner is informed.

6.5.9 The same processes apply to a child who is admitted to a hospital ward and subsequently dies unexpectedly in hospital.

6.6 Immediate Response to the Unexpected Death of a Child in the Community

6.6.1 Where a child is not taken immediately to A & E the professional confirming the fact of death should inform the Designated Paediatrician with responsibility for unexpected

deaths in childhood at the same time as the Coroner is informed.

6.6.2 The Police will be involved and may decide it is not appropriate to move the child's body. This may typically occur if there are clear signs that lead to suspicion. In most cases, however, it is expected that the child's body will already have been held or moved by the carer and therefore removal to A & E will not normally jeopardise an investigation.

6.7 Whenever and Wherever an Unexpected Death of a Child has Occurred

6.7.1 The professional confirming the fact of death should consult the designated paediatrician with responsibility for unexpected deaths in childhood who will ensure that relevant professionals (i.e. the Coroner, the Police and Children's Safeguarding) are informed of the death. This task may be undertaken by a person on behalf of the Designated Paediatrician. Contact may be required with more than one Local Authority if the child dies away from home. Any relevant information identified by Children's Safeguarding should be shared promptly with the Police and on-call Paediatrician. The Health Visitor or School Nurse and GP should also be informed as a matter of routine and relevant information should be shared.

6.7.2 When a child dies unexpectedly a paediatrician (on call or designated) should initiate an immediate information sharing and planning discussion between the lead agencies (i.e. Health, Police and Children's Safeguarding) to decide what should happen next and who will do what. This will also include the Coroner's Officer and Consultant Paediatrician on call and any others who are involved (for example the GP if called out by the family or for older children the professional certifying the fact of death if they have already been involved in the child's care/death). The agreed plan should include a commitment to collaborate closely and communicate as often as necessary, often by telephone. Where the death occurred in a hospital, the plan should also address the actions required by the Trust's serious incidents protocol. Where the death occurred in a custodial setting, the plan should ensure appropriate liaison with the investigator from the Prisons and Probation Ombudsman.

6.7.3 For all unexpected deaths of children (including those not seen in A & E) urgent contact should be made with any other agencies who know or are involved with the child (including CAMHS, school or early years) to inform them of the child's death and to obtain information on the history of the child, the family and other members of the household. If a young person is under the supervision of the Youth Offending Services (YOS) then the YOS should also be approached.

6.7.4 The Police will begin an investigation into the sudden or unexpected death of a child on behalf of the Coroner. They will carry this out in accordance with relevant ACPO guidelines.

6.7.5 When a baby or older child dies unexpectedly in a non-hospital setting, the senior investigating officer and senior health care processional should make a decision about whether a visit to the place where the child died should be undertaken. This should almost always take place for infants who die unexpectedly in line with the recommendations of the Kennedy Report (2004). As well as deciding if the visit should take place, it should be decided how soon, within 24 hours, and who should attend. It is likely to be a senior investigating Police officer and a healthcare professional who is experienced in responding to unexpected child deaths and who may be a paediatrician, who will visit, talk with the parents and inspect the scene. They may make this visit together, or they may visit separately and then confer. After this visit, the senior investigating Police officer, visiting healthcare processional, GP, Health Visitor or School Nurse and Children's Safeguarding representative should review whether there is any additional information that could raise concerns about the possibility of abuse or neglect having contributed to the child's death. If there are concerns about the safety and/or well being of the surviving children in the household consideration should be given to the need to follow the Services to Children in Need Procedure or whether the threshold for a Child Protection referral are met - see Thresholds for Child Protection Referrals Procedure. If there are grounds for considering initiating a **Serious Case Review**, the process set out

in **Serious Case Reviews Procedure** should be followed.

7. Involvement of Coroner and Pathologist

See also: **Section 11.3, The coroner may supply information to the SSCB**.

7.1 In Sunderland the coroner requires all child deaths to be notified to him. The coroner will then decide if there is to be an investigation. On receipt of notification of a death, the coroner issues a safeguarding notice.

7.2 If the Coroner deems it necessary (and in almost all cases of an unexpected child death it will be) the Coroner will order a post mortem examination to be carried out as soon as possible by the most appropriate pathologist available (this may be a Paediatric Pathologist, Forensic Pathologist or both) who will perform the examination according to the guidelines and protocols laid down by the Royal College of Pathologists. The Designated Paediatrician should collate information collected by those involved in responding to the child's death and share it with the pathologist conducting the post-mortem in order to inform this process. Where the death may be unnatural, or the cause of death has not yet been determined, the Coroner will in due course hold an inquest.

7.3 All information collected relating to the circumstances of the death including a review of all relevant medical, social and educational records must be included in a report for the Coroner. This report should be delivered to the Coroner within 28 days of the death, unless some crucial information is not yet available.

8. Case Discussion Following the Preliminary Results of the Post-Mortem Examination Being Available

8.1 The preliminary results of the post-mortem examination belong to the commissioning Coroner. In most cases it is possible for these to be discussed by the Paediatrician and Pathologist, together with the senior investigating Police officer as soon as possible, and the Coroner should be informed immediately of the initial results. At this stage the core data set should be updated and if necessary, previous information corrected to enable this change to be audited. If the initial post-mortem findings or findings from the child's history suggest evidence of abuse or neglect as a possible cause of death, the Police, and Children's Safeguarding should be informed immediately and the **Serious Case Reviews Procedure** should be followed. If there are any concerns about the safety and/or well being of the surviving children being in the household consideration should be given to the need to follow the Services to Children in Need Procedure or whether the threshold for a Child Protection referral are met - see Thresholds for Child Protection Referrals Procedure.

8.2 In all cases, the Designated Paediatrician for unexpected child deaths should convene a further multi-agency discussion (usually on the telephone) very shortly after the initial post-mortem results are available. This discussion usually takes place 3-5 days after the death and should involve the pathologist, Police, Children's Safeguarding and the Paediatrician, plus any other relevant healthcare professional, to review any further information that has come to light and that may raise additional concerns about safeguarding issues.

8.3 Case Discussion Following the Final Results of Post-Mortem Examination Becoming Available

8.4 A case discussion meeting should be held as soon as the final post-mortem result is available. The timing of this discussion varies according to the circumstances of the death.

This may range from immediately after the post-mortem to 8-12 weeks after the death. The type of professionals involved in this meeting depends on the age of the child. The meeting should include those who knew the child and the family and those involved in investigating the death, i.e. the GP, Health Visitor or School Nurse, Paediatrician, Pathologist, Senior Investigating Police Officers and where appropriate, Social Workers.

8.5 The Designated Paediatrician for unexpected deaths in childhood should convene and chair this meeting. At this stage, the collection of core data set should be completed and if necessary previous information corrected to enable this change to the information to be audited.

8.6 The main purpose of the case discussion is to share information to identify the cause of death and/or those factors that may have contributed to the death, and then to plan future care for the family. Potential lessons to be learnt may also be identified by this process and the purpose is to inform the inquest.

8.7 There should be an explicit discussion of the possibility of abuse or neglect either causing or contributing to the death. If no evidence is identified to suggest maltreatment this should be documented as part of the minutes of the meeting.

8.8 It should be agreed how details about the cause of the child's death will be shared, and by whom, with the parents, and who will offer the parents ongoing support.

8.9 The results of the post-mortem examination should be discussed with the parents at the earliest opportunity except in those cases where abuse is suspected and/or the Police are conducting a criminal investigation. In those situations, the paediatrician should discuss with Children's Safeguarding, the Police and the Pathologist what information should be shared with the parents and when. This discussion with the parents is usually part of the role of the Paediatrician responsible for the child's care and they will have a responsibility for initiating and leading the meeting. A member of the primary healthcare team should usually attend this meeting.

8.10 An agreed record of the case discussion meeting and all reports should be sent to the Coroner, to take into consideration in the conduct of the inquest and in the cause of death notified to the Registrar of Births and Deaths. The record of the case discussions and the record of the core data set should also be made available to the Child Death Overview Panel when the child dies away from their residential area. This information can then be analysed and decisions can be made about what actions should be taken to prevent similar deaths in the future.

9. Reviewing Deaths of All Children

9.1 An overview of all child deaths in the Sunderland, Gateshead and South Tyneside LSCB areas considered by the South of Tyne Child Death Overview Panel is undertaken. This a paper exercise based on information available from those who were involved in the care of the child, both before and immediately after the death, and other sources including, perhaps the Coroner. The Panel:

- Has a fixed core membership to review these cases, with flexibility to co-opt other professionals as and when appropriate;
- Holds meetings bi-monthly to enable each child's case to be discussed in a timely manner;
- Reviews the appropriateness of the professionals responses to each unexpected death of a child, their involvement before the death and relevant environmental, social, health and cultural aspects of each death, to ensure a thorough

consideration of how such deaths might be prevented in the future; and

- Identifies any patterns or trends in the local data and reports these to the individual relevant LSCB.

10. Procedures to be followed by the Local Child Death Overview Panel for all Child Deaths

10.1 The SSCB has responsibility for reviewing the deaths of all children in Sunderland. In order to fulfil its responsibilities, it is informed of all deaths of children normally resident in its geographical area. The single point of contact for child death notifications for the South of Tyne Child Death Overview Panel is the Child Death Review Co-ordinator. S/he is the designated person to whom the death notification and other data on each death is sent. The Chairperson of the Overview Panel is responsible for ensuring that this process operates effectively. The Child Death Review Co-ordinator is responsible for circulating the information by secure email to the SSCB Business Manager, SSCB Support Officer, Police, Children's Safeguarding and the Health Lead.

10.2 Deaths should be notified by the professional confirming the fact of the child's death. For unexpected deaths this will be at the same time as they inform the Coroner and the Child Death Review Co-ordinator. If this is not the area in which the child is usually resident, the designated person should inform their opposite number in the area where the child normally resides. In these situations, the LSCB where the child resides will take responsibility for gathering the necessary information for their Panel's consideration. The Registrar and ONS respectively send a notification of each death to the local CCG, and this provides a check to ensure that all child deaths have been notified to the LSCB Chairperson. Any professional (or member of the public) hearing of a local child death in circumstances that mean it may not yet be known about (for example a death occurring abroad) can inform the Chair of the SSCB via the Business Manager.

10.3 The Child Death Overview Panel has a permanent core membership drawn from the key organisations represented on the LSCB although not all core members are necessarily involved in discussing all cases. The Panel includes a professional from public health as well as child health. Other members can be co-opted either as permanent members to reflect the characteristics of the local population (for example a representative of a large local ethnic or religious community), to provide a perspective from the independent or voluntary sector or to contribute to the discussion of certain types of death when they occur (for example fire fighters for house fires). The Panel is chaired by a representative member of the LSCB. The Panel Chairperson is not involved in providing direct services to children and families in the area.

10.4 The functions of the Child Death Overview Panel include:

- Implementing in consultation with the local Coroner, local procedures and protocols that are in line with Working Together to Safeguard Children 2015 on enquiring into unexpected deaths, and evaluating these together with information about all deaths in childhood;

- Collecting and collating an agreed minimum data set and, where relevant, seeking information from professionals and family members;

- Meeting bi-monthly to evaluate the routinely collected data on the deaths of all children, and thereby identify lessons to be learnt on issues of concern with a particular focus on effective inter-agency working to safeguard and promote the welfare of children;

- Having a mechanism to evaluate specific cases in depth, where necessary, at

subsequent meetings;

- Monitoring the appropriateness of the response of professionals to an unexpected death of a child, reviewing the reports produced by the Rapid Response Team on each unexpected death of a child, making a full record of this discussion and providing the professionals with feedback on their work. Where there is ongoing criminal investigation, the Crown Prosecution Service must be consulted as to what is appropriate for the Panel to consider and what actions it might take in order not to prejudice any criminal proceedings;

- Referring to the Chair of the LSCB any deaths where, on evaluating the available information, the Panel considers there may be grounds to undertake further enquiries, investigations or a **Serious Case Review** and explore why this has not previously been recognised;

- Informing the Chair of the LSCB when specific new information should be passed to the Coroner or other appropriate authorities;

- Providing relevant information to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family;

- Monitoring the support and assessment services offered to families of children who have died;

- Monitoring and advising the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths;

- Organising and monitoring the collection of data for the nationally agreed minimum data set, and making recommendations (to be approved by the LSCB) for any additional data to be collected locally;

- Identifying any public health issues and considering, with the Director of Public Health, how best to address these and their implications for both the provision of services and for training;

- Co-operating with regional and national initiatives, for example the Confidential Enquiry into Maternal and Child Health (CEMACH) to identify lessons on the prevention of unexpected child deaths.

The Local Child Death Overview Panel is responsible for developing its work plan which should be approved by the LSCB. It will prepare an annual report for the LSCB, which are responsible for publishing relevant, anonymised information.

10.5 The LSCB are responsible for disseminating the lessons to be learnt to all relevant organisations, ensures that relevant findings inform the Children and Young People's Plan and acts on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children. The LSCB are also required to supply data regularly on every child death to bodies commissioned by the Department for Education and Skills, so that the Department can commission bodies to undertake and publish nationally comparable, anonymised analyses of these deaths.

11. Sunderland Local Child Death Review Panel

The Local Child Death Review Panel meets bi-monthly to review child deaths. Its function is to take an overview of all child deaths in Sunderland. Each meeting will consider the death of any child about whom a completed child death review report has been submitted. It will also consider the status/progress of reviews not completed within the expected timescales (6 months).

The Panel has a core membership (see Membership at **Sunderland SCB website**) but will have the option of inviting others to attend as required.

The Panel's main purpose will be to consider and evaluate the individual response to child death and to identify any actions required to be taken locally. It will also seek to identify any local trends, patterns or themes that might be of interest in terms of public health and safety. Its work should be focused on improving local services, procedures and practices that in turn will improve outcomes for children and young people and reduce the number of preventable deaths. The Panel will finalise reports for the Overview Panel.

11.1 Child Death Review Co-ordinator

The Co-ordinator provides administrative support to the local review processes in each of the three LSCB areas and to the Child Death Overview Panel. The role involves:

- Receiving child death notifications;
- Informing named individuals about child deaths;
- Requesting information from agencies/professionals for the purpose of completing child death reviews;
- Arranging and administrating Child Death Overview Panel meetings;
- Gathering and distributing reports;
- Maintaining records;
- Completing reports on child death data.

11.2 Notification to the SSCB of the death of a child by the Coroner

The Coroner is required to notify the SSCB of the death of a child if an inquest is to be held into the death of the deceased child or a post mortem examination is to be held and the Coroner has reason to believe the deceased was or may have been under the age of 18 at the time of death.

The Coroner must ensure that the LSCB in their area is notified within 3 working days, beginning with the date in which the Coroner makes a decision to hold an inquest into the death or to request a post mortem examination. The details of the child who has died should be conveyed in writing.

Deaths that are not within the jurisdiction of the Coroner. Where the death of a child is reported to a Coroner and there are no circumstances that require the Coroner to exercise their jurisdiction, then the coroner is not required to notify the SSCB of the death. However, where the death occurred in England or Wales, the SSCB will be notified of the death by the Local Registrar for the area in which that child's death is registered. The Local Registrar advises the Child Death Review Co-ordinator of all child deaths via secure email on a weekly basis (including a nil return).

The Coroner must notify the appropriate LSCB of the death of a child, normally the LSCB within whose area the body of the deceased child is lying. The LSCB with responsibility for reviewing the death is the LSCB within whose area the child normally resides. In some cases, the LSCB within whose area the body of the deceased child is lying and the LSCB within whose area that child normally resides will be different. In these cases the Coroner should notify the LSCB within their

district of the death of the child. It will then be the responsibility of the LSCB who receives the notification to identify and pass on the information to the LSCB for the area in which the child normally resides so that the statutory duty to conduct a child death review can be fulfilled and the other LSCB can be effectively discharged. If the coroner is aware of where the child normally resided then they may chose additionally to inform the LSCB for that area.

In some cases the LSCB for the area in which the child died may have a significant contribution to the child death review even if it is not the area in which the child normally resided.

On receipt of the initial report of a death the LSCB with an interest should inform the Coroner of the address (including secure email address) to which future information can be supplied.

11.3 The coroner may supply information to the SSCB

The Coroners (Investigations) Regulations 2013 Coroners Rules 1984 as amended by the Coroners (Amendment) Rules 2008 place a duty on coroners to inform the LSCB, for the area in which the child died or the child's body was found, where the coroner decides to conduct an investigation or of the fact of an inquest or directs that a post mortem should take place. The coroner must provide to the LSCB all information held by the coroner relating to the child's death. It also gives coroners powers to share information with LSCBs for the purposes of carrying out their functions, which include reviewing child deaths and undertaking SCRs.

Where the coroner makes a report to prevent other deaths, a copy must be sent to SSCB.

11.4 The SSCB providing information to the coroner

If any information comes to the attention of the SSCB which they believe should be drawn to the attention of the relevant coroner, then the SSCB should consider supplying it to the coroner as a matter of urgency

11.5 Notifications

The person confirming death must notify the Child Death Review Co-ordinator. The role of the co-ordinator is explained in **Section 11.1, Child Death Review Co-ordinator**. Notification will be by means of a minimum dataset to the Child Death Review Co-ordinator. The Co-ordinator must then ensure that the lead contacts are aware of the death in order for them to begin any necessary review procedure.

11.6 Neonatal Deaths

CEMACH reviews the deaths of all children in the North East region who are aged up to 28 days. These procedures do not alter this 'CEMACH' arrangement. Reports completed by CEMACH will be sent to the Child Death Review Co-ordinator for consideration at the Local Child Death Review Panel. RMSO will notify the Child Death Co-ordinator of all such deaths and s/he will be responsible for gathering these reports and making them available to the Local Child Death Review Panel and the Child Death Overview Panel. The Local Child Death Review Panel and Overview Panel will be responsible for ensuring these reviews take place, are of sufficient quality and that all recommendations from these reports are acted upon and any lessons to be learnt from the deaths shared with relevant agencies. Where abuse and/or neglect are suspected to have been a factor in a

death the matter will be subject to police investigation and will require consideration for a Serious Case Review.

Appendix 1: Child Death Review and Overview Process Flowchart

Click here to view Appendix 1: Child Death Review and Overview Process Flowchart.

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