

Safeguarding Children Briefing



CHILD DEATH REVIEW PROCESS

INTRODUCTION

The purpose of this briefing is to update agencies about the Child Death Review Process which has been in place since 1st April 2008.

From 1st April 2008, it became a statutory responsibility for all Local Safeguarding Children Boards (LSCB's) to review the deaths of all children in the local authority's area, from birth (excluding those babies who are stillborn) up to the age of 18. This is as stated in [Working Together to Safeguard Children 2006](#), and [Regulation 5\(1\) \(e\) of the Local Safeguarding Children Board Guidance \(DCSF, 2006\)](#).

BACKGROUND

There are two interrelated processes for reviewing child deaths.

1. A rapid response by a team of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child in the area of the County of Kent.
2. An overview of all child deaths (birth up to 18th birthday, excluding babies stillborn) in the Kent Safeguarding Children Board area undertaken by a panel. There were approximately 120 such deaths in Kent in 2007.

An unexpected child death is defined as the death of a child that was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death. This includes children and young people with disabilities or life limiting illnesses, children and young people who die in road traffic accidents, by drowning etc and children who are admitted to a hospital ward and subsequently die unexpectedly in hospital.

Each unexpected death of a child is a tragedy for his or her family and subsequent enquiries/investigations will seek an appropriate balance between forensic and medical requirements and the family's need for support. 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 must be made 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 to safeguard and promote children's welfare in the future.

RESPONDING RAPIDLY TO THE DEATH OF A CHILD

- When a child dies unexpectedly health care professionals will share information with lead agencies (i.e. police, health and children's social services) to decide what should happen next and who will do what.
- Contact will be made with any other agencies that 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.
- The police will begin an investigation into the sudden or unexpected death of a child on behalf of the Coroner. When a child dies unexpectedly in a non-hospital setting the senior investigating officer and senior health care professional will make a decision about whether a visit to the place where the child died should be undertaken.
- A further multi-agency meeting should be convened shortly after the initial post mortem results are available – usually five to seven days after the death - to review any further information that has come to light and that may raise additional concerns about safeguarding issues.
- A case discussion meeting will be held as soon as the final post-mortem result is available. The timing of this discussion varies according to the circumstances of death from immediately after the post-mortem to eight to twelve weeks after the death. The main purpose of this 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. There will be an explicit discussion about whether abuse or neglect was the cause of death or a contributory factor and the core data set will be completed.
- Records and reports will be sent to the Coroner who in turn will share appropriate information with the Kent Safeguarding Children Board.

REVIEWING DEATHS OF CHILDREN IN KENT

The Kent Child Death Overview Panel (CDOP) with support from the Expert Advisory Group (EAG) conducts paper reviews of all deaths of children in the Kent area. This is based on information available from those involved in the care of that child both before and immediately after the death. The CDOP and EAG are:

- Subgroups of the KSCB
- Have a fixed membership but co-opt other relevant professionals as appropriate e.g. Highways in events of road traffic accidents and Kent Fire & Rescue Service for those children who die as a result of fire or smoke inhalation.
- Meet at regular intervals to ensure deaths are discussed in a timely manner
- Collect and collate an agreed national dataset
- Review the appropriateness of the professional responses to each unexpected death of a child.
- Identify any patterns or trends and reports to the KSCB any recommendation to prevent such deaths occurring where possible.

WHAT DO I DO IF I BECOME AWARE OF THE DEATH OF A CHILD?

If you become aware of the death of a child, there is now a statutory requirement for the Kent Safeguarding Children Board to be notified on the contact details below within 24 hours using the "Form A" - Notification of Child Death Form. This is available at http://www.clusterweb.org.uk/new_kscb/kscb_about_subgroups_cdop.cfm

FURTHER INFORMATION

Kent Safeguarding Children Board Website www.kscb.org.uk

Working Together to Safeguard Children 2006 HM Government
<http://www.everychildmatters.gov.uk/socialcare/safeguarding/childdeathreview/>

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For further information



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