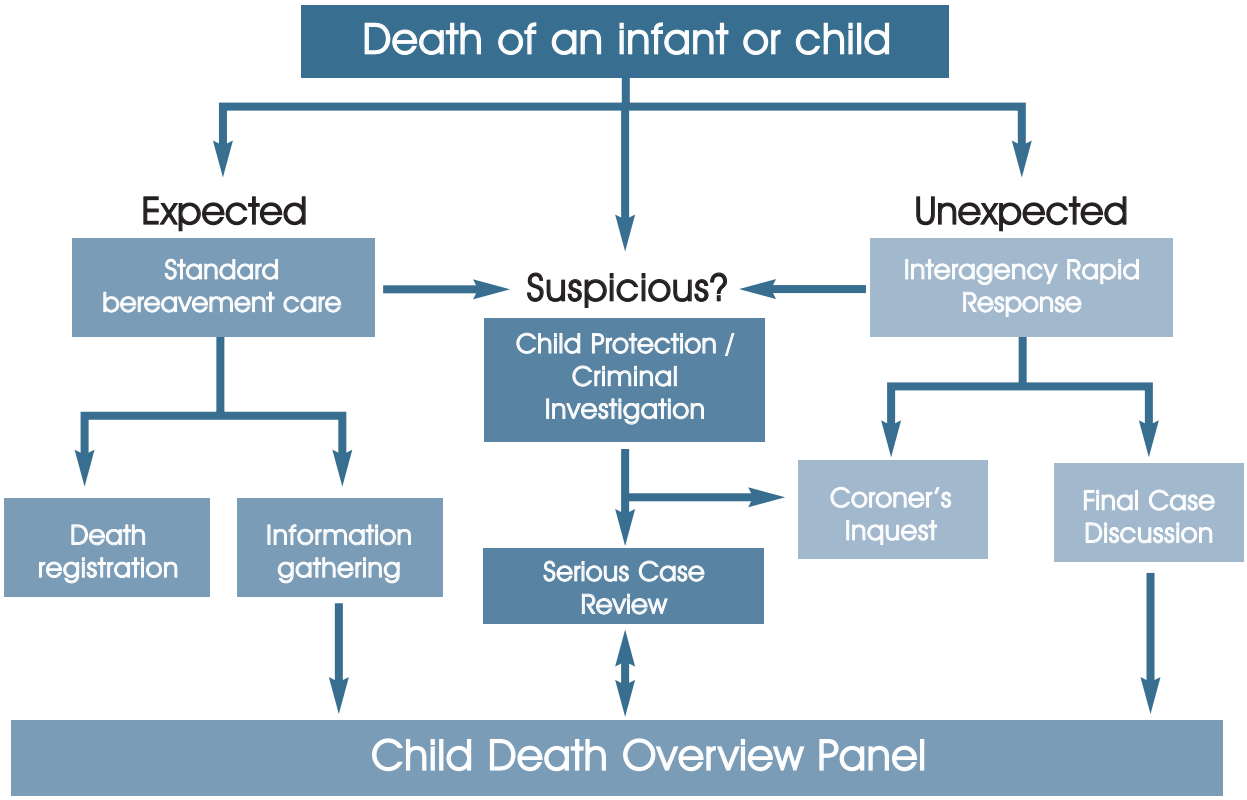
department for
children, schools and families

Information Sheet

Responding when a Child Dies

Working Together to Safeguard Children (HM Government, 2006) sets out the responsibilities of Local Safeguarding Children Boards in England (LSCBs, formerly Area Child Protection Committees) to put in place procedures, both to respond rapidly to individual unexpected childhood deaths, and to review all childhood deaths in a systematic way. In addition there is an ongoing requirement to undertake a serious case review where a child has died and abuse or neglect are considered to be a factor in the death. These processes sit alongside other processes when a child dies, including the requirement to register the death, and for certain deaths, for the coroner to undertake an inquiry into the cause and manner of death.

Figure: child death review processes



Overview of all child deaths

The LSCB has a responsibility for reviewing the deaths of all children from birth to 18 years (excluding stillbirths) who would normally be resident in their local authority area. This requires gathering information on all deaths with a view to a multi-agency team reviewing the deaths in order to:

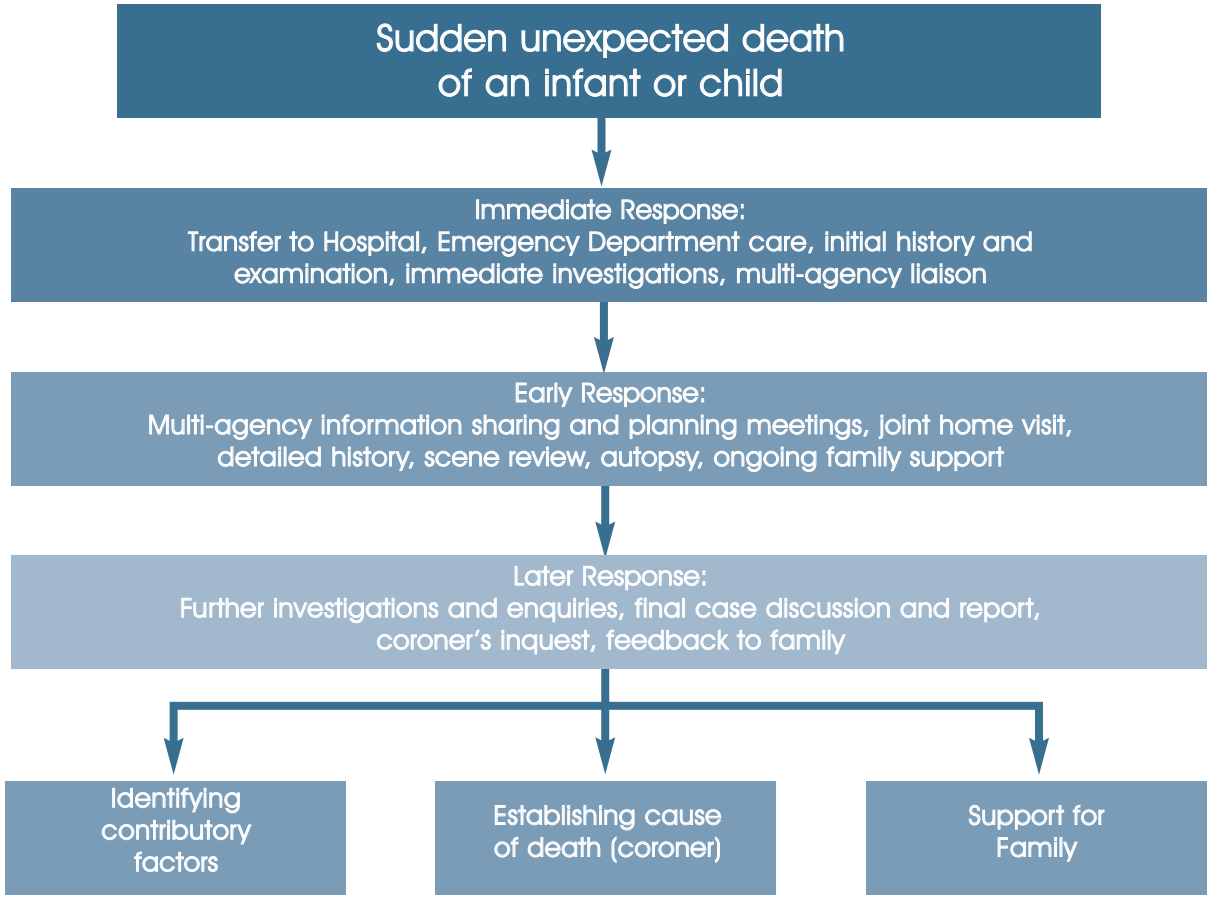
a) identify any death giving rise to the need for a serious case review;

b) identify any matters of concern affecting the safety and welfare of children in their area; and

c) identify any wider public health or safety concerns arising from a particular death or from a pattern of deaths in their area.

The child death overview panel will have a fixed core membership and will meet regularly to review all child deaths. The panel will be accountable to the LSCB and will have clear links to the LSCB and other relevant bodies to ensure that lessons learnt from child death reviews can lead to specific actions to prevent future child deaths and to promote the safety and welfare of children.

Figure: The rapid response to an unexpected death



Rapid Response to an Unexpected Death

The rapid response is a coordinated multi-agency approach to investigating the unexpected death of a child and supporting the bereaved family. It has 3 primary outcomes: to establish where possible, in conjunction with the coroner, a cause of death; to identify any contributory factors; and to provide ongoing support to the family.

There are three distinct but overlapping phases: immediate responses carried out in the first 2-3 hours after a child dies (the "golden hour"); early responses occurring over the next 24-48 hours; and later responses which can take 3-4 months or more to complete. In responding in this joint-agency manner, the different professionals involved will be carrying out their normal functions in relation to a child's death, but doing so in a coordinated fashion in which the varied skills and knowledge of different professionals complement each other. There is thus the need for regular liaison between the different professionals involved. The final case discussion gives the opportunity to collate and interpret all the information gathered through the investigation. The outcomes of this review will be fed back to the coroner, the family and the child death overview panel.

If, at any stage in the rapid response process, concerns are raised of a possible child protection nature, the police and social care professionals will lead in a criminal and section 47 child protection investigation, and there will subsequently be the need for a Serious Case Review.

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