## Chapter 5: Child death reviews

Chapter 5 provides guidance for child death review partners. Child death review partners consist of local authorities and any clinical commissioning groups for the local area (as set out in the Children Act 2004, amended by the Children and Social Work Act 2017.) 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. 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 must make arrangements for the analysis of information from all deaths reviewed.

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) framework

It is for child death review partners to determine what representation they have in any structure reviewing child deaths. 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 designated doctor for child deaths for the local area; children's social care police; the designated doctor or nurse for safeguarding; primary care (GP or health visitor); nursing and/or midwifery; lay representation; and any other professionals that child death review partners consider should be involved.

Child death review partners should agree locally how the child death review process will be funded in their area. 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 information on designated doctor for child deaths.

Child death review partners should publish their arrangements for reviewing child deaths, and should notify NHS England when they have done so, at England.cypalignment@nhs.net.

All practitioners participating in the child death review process should notify, report, and scrutinise child deaths using the standardised templates. These should be forwarded to the relevant CDOP (or other structure child death review partners have put in place to help review child deaths). The mechanism for collecting this data will evolve as the National Child Mortality Database becomes operational.

The purpose of a review and/or analysis is to identify any matters relating to child 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 of this.

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) .

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. Child death review partners for a local authority area in England must prepare and publish a report, and . 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.

**Transition**

From 29th June 2018, local authority areas must begin their transition from LSCBs to child death review partner arrangements. The transition must be completed by 29 September 2019.

LSCBs must continue to ensure that the review of each death of a child normally resident in the LSCB area, is undertaken by the established child death overview panel (CDOP), until the point at which new child death review partner arrangements are in place.

After new safeguarding partner and child death review partner arrangements are set up, LSCBs in the area have a statutory ‘grace’ period of up to 4 months to complete any outstanding child death reviews. Any CDOP set up under LSCB arrangements may not undertake any new child death reviews during this 4-month period.

The latest date for completion of any review is 29th January 2020, where a review has not been completed, the LSCB must pass the information to the child death review partners. Child death review partners should consider any incomplete child death reviews passed to them by former CDOPs, and take appropriate action.

If the child death review partner arrangements are in place and ready to operate before the safeguarding partner arrangements for a local area, the child death review partners may begin child death reviews and their analysis of information from them, without waiting for the safeguarding partner arrangements to begin.