SANDWELL SAFEGUARDING CHILDREN'S BOARD

7 Minute Briefing – Child Death Review Guidance 2018

01

Working Together 2018

New guidance was released in October 2018 outlining the duties of the new Child Death Review (CDR) partners who are defined in section 16Q of the Children Act 2004 as:

- The Local Authority

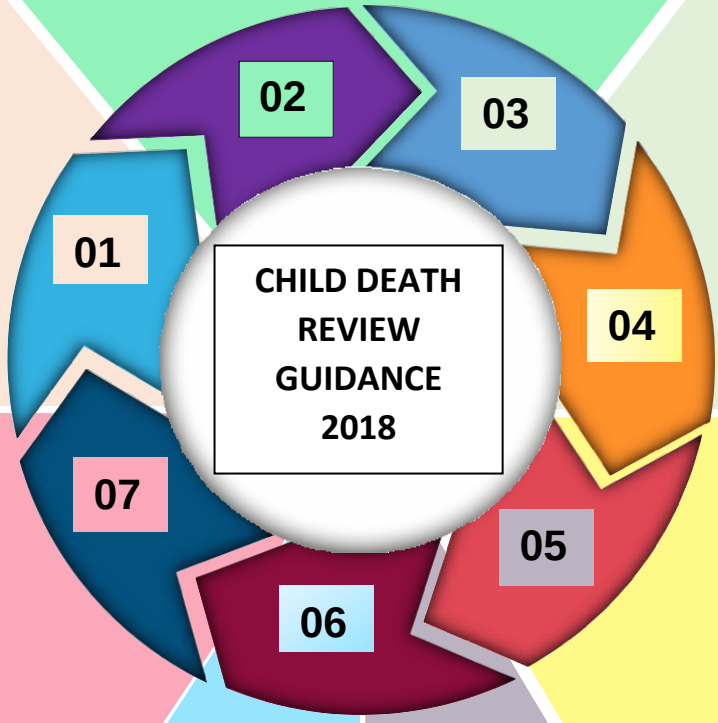
- Clinical Commissioning Group (CCG)

The guidance aims to set out the processes to be followed when responding to, investigating, and reviewing the death of any child, from any cause.

02

Process

Child Dies
↓
Immediate Decision Making & Notification (where child dies)
↓
Investigation & Information Gathering
↓
Child Death Review Meeting
↓
Independent Review by CDR Partners



03

Similarities

All deaths will continue to be reviewed up to the age of 18 years (not stillbirths or planned terminations).

A multi-agency panel will review all deaths to determine any modifiable factors.

Learning will be widely disseminated locally, regionally and nationally.

A Joint Area response will be triggered in the case of unexpected deaths.

04

Differences

The geographical area footprint for CDR partners should be large enough to typically review at least 60 deaths per year.

Reporting of annual data will shift from the Department for Education to the Department for Health.

Initial decision making, investigation and information gathering will be discussed at a child death review meeting by the professionals who were directly involved in the care of that child. This will normally take place within the clinical setting where the child died.

05

What Does This Mean?

Greater responsibility on the senior professional (with the responsibility for the child at the end of his/her life) to make immediate decisions.

Existing child death overview panels may need to merge with another panel to ensure they are compliant with the review requirements for reviewing 60 deaths.

Governance arrangements may need to change due to changes to Safeguarding Boards.

06

What's different for parents

Every family will have support through engagement, information, key worker provided by the most appropriate agency.

A National Bereavement Care Pathway is being developed.

A national database will ensure that learning from child deaths is analysed on a larger scale leading to greater information and advice for parents/carers.

07

What Happens Next

Child Death Review Partners should publicise information on the arrangements for child death reviews in their area including who the accountable officers are, which LA and CCG partners are involved, the geographical area and who the designated doctor for child deaths is.

LSCB's must continue to ensure the review of every child death in their area is undertaken until the child death review partners arrangements are in place.