

# The review we have to do when a child dies –

## Information for families and carers



Thurrock  
**Safeguarding  
Children  
Board**

**We would like to express our sincere condolences at this very sad time.**

**Under the law Local Safeguarding Children Boards are now required to do two things.**

**First, to ensure that you are supported.**

**Second, to run a process called Child Death Review. This process is to help us understand as much as possible about why your child has died and why other children are dying in Essex. We will use this information to help support you and to improve services for children in our area.**

**We need to tell you about this process and what it will mean for you.**

## Introduction

**The law now requires that Local Safeguarding Children Boards review the death of every child that lives in their area up to the age of 18 years.**

Through this process we will try to identify if there are any similarities between the deaths that are happening in Essex and elsewhere.

Reviewing all child deaths may help organisations working with children to improve their practice and the services they offer. Reviewing your child's death will help us to ensure that you understand as much as possible about why your child has died and that you are supported in the right way.

Depending on the circumstances of your child's death the review will be conducted in one of two ways, which are explained on the next pages. The professionals with whom you are working will let you know which review will happen and when.

## What is a Local Safeguarding Children Board?

A Local Safeguarding Children Board (LSCB) is an organisation which brings together agencies that have a role to play in keeping children safe and well locally. This includes local authority children's services, health services, the police and district councils. For this area there are three Safeguarding Boards – one each for Southend, Essex and Thurrock. Boards do a range of different things such as writing policies and procedures, checking that people are properly trained to work with children, and giving advice to people about how to keep children safe. From April 2008 we were asked to start collecting and reviewing information about children's deaths in our area. To do this we have set up five local child death review panels covering different parts of Essex.

## The review of unexpected deaths

If your child's death is unexpected, you will be contacted by a professional rapid response team including a specialist doctor or nurse, a specialist police officer and, in some circumstances, someone from social care. This team will gather and review information about your child and the circumstances that led to their death. This includes information held by hospitals, local health services, schools, police and children's services.

This team will need to talk to you and they may ask to visit the place where your child died. This visit is an opportunity to collect further information about what happened, for you to talk through the events leading up to your child's death and for you to ask any questions that you may have.

Once all the information has been collected, which may take several months, the Local Child Death Review Panel for your area will meet to look at what the team has found out. Members of the team will also offer to meet with you to share this information.

The panel is made up of specialist doctors and nurses, police and social care professionals. They will agree what caused your child's death and whether you have been offered the right support and services. They will then decide whether anything could have been done differently which could prevent similar deaths in future.

The Child Death Review Panel may make recommendations about improving services for children and are asked to identify any patterns in the deaths they have reviewed. Any recommendations made will be looked at by the Local Safeguarding Children Boards. Where agreed, the Boards will put into place the recommendations.

## The review of expected deaths

If your child had been ill for some time and their death had been expected, the professionals you are working with will provide support to you and your family. Local Safeguarding Children Boards are requested to undertake a review of your child's death and will do this by gathering information from the organisations you have been working with. These may include hospitals, local health services, schools, police and children's services. We will do this by writing to these organisations and they will supply written responses.

Once we have received responses from the organisations, the Local Child Death Review Panel in your area will meet to look at the information we have. The panel is made up of specialist doctors and nurses, police and social care professionals. The panel will agree, based on the information they have been provided with, what caused your child's death and whether you have been offered the right support and services. They will then decide whether anything could have been done differently which would prevent similar deaths in future.

The Child Death Review Panel may make recommendations about improving services for children and are asked to identify any patterns in the deaths they have reviewed. Any recommendations made will be looked at by the Local Safeguarding Children Boards. Where agreed, the Board will put into place the recommendations.

For expected deaths there will not be a specialist professional rapid response team formed or a visit made to the place where your child died as is the case with unexpected deaths.

## Frequently asked questions

### **How will parents and family be involved in the review process?**

Following the death of your child you will be in contact with a range of different professionals, including, if the death is unexpected, a professional rapid response team. You will be able to discuss your child's death with them and they will be able to pass on your views to the Local Panel. Unfortunately it is not possible for parents or family representatives to be present at the Child Death Review Panel Meeting but if you have specific information that you would like to let them know please let any professional or the LSCBs know this.

During the course of a review the professional team reviewing the death or the local panel may identify information about the factors that contributed to your child's death that they feel it is important for you to know. If this is the case this information will be explained to you by one of the professionals you have been working with. In most cases the review will be routine and is unlikely to identify anything that you do not already know.

### **I've been told that there will be a Coroner's Inquest into my child's death, how does this process link to that?**

These are two separate processes. However, if there is an inquest the child death review team will work closely with the Coroner's Officer and will share information with them.

### **Does this review process affect any other investigation that is being undertaken?**

It is possible that other agencies, such as the Police or social care, may also be investigating your child's death. We will be told about these investigations and their outcome but our review remains separate.

### **How will the Panel report on its findings?**

The Local Safeguarding Children Boards are required to publish an annual report on the findings of their child death review process. This will focus on statistical information and any recommendations that have been made. Nothing within this report will name or identify your child. A copy of this report can be made available to you if you let us know that you would like a copy.

## Confidentiality

We would like to assure you that the Boards have established secure systems for gathering information and all information held is kept strictly confidential. All information provided to the Local Safeguarding Children Boards from the Local Panels is anonymised. Any information published by the Boards about this process will not identify individual children.

## Where can I find further information on this process?

- The Essex Safeguarding Children Board website:  
**[www.escb.co.uk](http://www.escb.co.uk)**
- The Southend, Essex and Thurrock Child Death Review Officer: Tel: **01245 506645** or email:  
**[cdr@essex.gov.uk](mailto:cdr@essex.gov.uk)**
- From the Government Guidance 'Working Together to Safeguard Children' available at  
**[www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk)**
- From any professional with whom you are in contact following the death of your child

## **Support and resources for bereaved parents and families:**

The Child Bereavement Trust  
Helpline:  
01494 446648 (office hours)  
[www.childbereavement.org.uk](http://www.childbereavement.org.uk)

The Compassionate Friends  
Helpline: 0845 123 2304  
(10.00am–4.00pm/6.30pm–10.30pm)  
[www.tcf.org.uk](http://www.tcf.org.uk)

## **Support and counselling for all bereaved persons:**

Cruse (Bereavement Care)  
Helpline: 0870 167 1677  
(9.30am–5.00pm)  
[www.crusebereavementcare.org.uk](http://www.crusebereavementcare.org.uk)

## **Support for families bereaved through a sudden infant death (cot death)**

Foundation for the Study of Infant Death (FSID) Helpline:  
0808 802 6868  
(9.00am–11.00pm Mon-Fri;  
6.00pm–11.00pm weekends)  
[www.sids.org.uk](http://www.sids.org.uk)

Sands (Stillbirth and Neonatal Death Society) Helpline:  
020 7436 5881  
(09.30am –05.30pm Mon–Fri)  
[uk-sands.org](http://uk-sands.org)

The Child Death Helpline  
08200282935  
[www.childdeathhelpline.org.uk](http://www.childdeathhelpline.org.uk)

The information contained in this folder can be translated, and/or made available in alternative formats, on request.

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