

The Review we have to do when a child dies

Information for Parents, Families
and Carers

North Yorkshire and City of York Safeguarding Children Boards

www.safeguardingchildren.co.uk

www.saferchildrenyork.co.uk

The death of a child is always tragic. Talking and thinking about a child's death is a sensitive and painful subject which is particularly upsetting for parents, families and carers.

What is a Review and why is it needed?

Government legislation now requires every Local Safeguarding Children Board to review the death of every child (up to the age of 18 years), in their area. This is because the government believes that it may help other children and families in the future.

How does a Review happen?

Information about each child and the circumstances of their death must be collected and summarised into a short report from records held by hospitals, local health services, schools, police, children's services and other agencies whose staff knew the child and their family.

A small Child Death Overview Panel of doctors, other health specialists and child care professionals must consider the report to be clear what caused the child's death and what support and treatment was offered to the child and their family up to the death; and also what support was offered to the family after that time.

The Child Death Overview Panel must consider whether they can make any recommendations to improve how things are done for children and their families. These recommendations must be shared with the local health trusts, children's services and the police, as well as specialist agencies such as the fire service or traffic authorities, as appropriate.

What does this mean for you?

As part of this process the Local Safeguarding Children Board has been informed of your child's death. Our first concern is that you and your family are offered any support we are able to give you. We also want to ensure that you know that we are required to do a Review and will plan for the circumstances of your child's death to be included at a future meeting of a Child Death Overview Panel.

It may take several months as we cannot do this until all other enquiries are completed, such as the work of the pathologist and coroner, or any legal processes.

It is not possible for parents or family representatives to attend the Panel meetings. This is because the information presented is anonymous and the panel looks only at generalised issues.

Where the panel decides that a more detailed report is needed, it will arrange for a "In-depth

Review" to take place. If this were the case, your view would be sought and feedback given.

All the information we gather will be treated with the deepest respect and in strictest confidence. None of our findings, recommendations or reports will name your child or family.

North Yorkshire and City of York Local Safeguarding Children Boards have agreed with our local hospitals, health trusts, children's services, police and the coroner to have a joint Review Panel.

The North Yorkshire and City of York Child Death Overview Panel can be contacted at Room 171, County Hall, Racecourse Lane, Northallerton, DL7 8AE (Tel **(01609) 535182**).

Please ask for the Child Death Overview Panel Administrator or Manager.

Further information about the role of Child Death Overview Panels can be found on the North Yorkshire Safeguarding Board website

(www.safeguardingchildren.co.uk) or the City of York Safeguarding Board website (www.saferchildrenyork.org.uk);

Government guidance is contained in Chapter 7, Working Together to Safeguard Children from Harm 2006.

If you would like this information in another language or format such as Braille, large print or audio, please ask us.

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