STATEMENT ON TRANSITION ARRANGEMENTS FOR CHILD DEATH REVIEW

In October 2018, the Government published new statutory and operational guidance relating to Child Death Review, in partnership with health professionals involved in child death reviews. I am writing to you today regarding your statutory responsibilities in relation to transitioning to the new child death review processes. The majority of child deaths in England are the consequence of medical causes. Investigations should keep an appropriate balance between forensic and medical requirements, and supporting the family at a difficult time. Child Death Review partners are identified as Local Authorities and any Clinical Commissioning Groups for the local area as set out in the Children Act 2004 (the Act), as amended by the Children and Social Work Act 2017.

As stated in the Government's Working Together – transitional guidance (published July 2018), Child Death Review partners had **up to 12 months** from 29 June 2018 to agree arrangements for the review of each death of a child normally resident in their area[5], including arrangements for the analysis of information about deaths reviewed. At the end of this **12-month period**, or at any time before, Child Death Review partners then had **up to three months** to implement the arrangements. At the latest, new child death review arrangements must be in place by 29 September 2019.

It is requested that Child Death Review partners publish their arrangements by 29 June 2019, and notify NHS England at England.cypalignment@nhs.net when they have done so. Notification may take place either through sending a report that details the new arrangements, or through sending a link to the domain where the new arrangements are published. We also request that Child Death Review partners publicise their new arrangements as widely as possible to all agencies in their area who are commissioned to provide services for children.

Once new child death review arrangements are in place, Child Death Review partners should consider any outstanding reviews of children who died before the new arrangements were in place. If they identify matters relating to the deaths that are relevant to the welfare of children in the area, or to public health and safety, and they identify that it would be appropriate for anyone to take action (for example, the safeguarding partners), they must inform that person or organisation.

Earlier this year, NHS England held a series of implementation support activities that included workshops, webinars and a community of practice forum to support transitional arrangements. Should there be any concern that your local area will not be able to meet the timescales for transition, I would be grateful if you could notify us immediately atEngland.cypalignment@nhs.net. Failure to meet the timescales will mean your local area is in breach of the statutory requirements and operational guidelines.

NHS England has also had the opportunity to review the current collection of eCDOP reports which have been processed in the limited number of prototype sites. It has allowed us to audit the quality of these important reports and we can now pin-point some data quality improvements which will be highlighted as the system rolls out into other parts of England. It is also important to note that this aggregated data will support the systematic and consistent review of all child deaths. Through working with child death review partners, the intelligence gathered will help develop better informed policies for children. From 1st April 2019, CDOPs must submit information from local reviews to the National Child Mortality Database

Dr Jacqueline Cornish (National Clinical Director, Children, Young People and Transition to Adulthood) states:

“It is always a devastating and life changing event when a child dies, and I know that you will share my dedication to establishing robust processes for understanding and learning from the cause of every child's death. We want to ensure there is commitment to providing ongoing support to the family and ensure that all statutory obligations are met. To help parents, families and carers of a child who has recently died at this difficult time, a group of bereaved parents, support organisations and professionals put together a Guide, which explains the child death review processes and sign-posts them to support that is available. We all have a duty of care and must work collectively to ensure that we identify any modifiable contributory factors in any child’s death, learn lessons in order to reduce the risk of future child deaths and promote the health, safety and wellbeing of other children.”