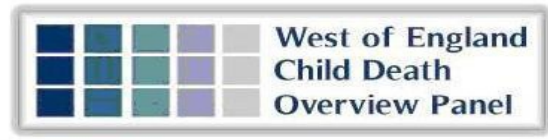


# Death in childhood



The information contained in this section outlines the procedures to be followed in the event of an 'Unexpected death of a child'.

If you are seeking support following the loss of a child there are links on this page to organisations and charities that can provide specialist advice and support.

## Child Death Review Process

Since 1 April 2008, Local Safeguarding Children Boards have had a statutory responsibility to review all deaths of children resident in their area. In the West of England (WoE), the LSCBs of Bristol, North Somerset, South Gloucestershire, Bath & North East Somerset have come together to form a single Child Death Overview Panel (West of England Child Death Overview Panel).

The relevant legislature is enshrined within the Children's Act 2004, and applies to all young people under the age of 18 years. The processes to be followed when a child dies are outlined within Working Together to Safeguard Children 2010: Chapter 7, Child Death Review Process. Very useful guidance has also been published by the Royal College of Paediatrics and Child Health: Child Death Review Processes – RCPCH.

The overall purpose of the child death review processes is to understand why children die, put in place interventions to protect other children, and to prevent future deaths. It is intended that these processes will:

- Document and accurately establish causation of death in an individual child.
- Identify patterns of death in a community so that preventable factors can be recognised and reduced.
- Contribute to the improved collection of forensic evidence in the small proportion of deaths where there may have been an act of maltreatment.

Working Together (2010) outlines two inter-related processes:

1. A **Rapid Response** where a group of key professionals come together for the purpose of evaluating the cause of death in an individual child, where the death of that individual child is unexpected. "Unexpected" in this context is defined as a "Death not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death". The process to be followed in Bristol is attached.
2. A **Child Death Overview Panel (CDOP)** that comes together to undertake an overview of all child deaths under the age of 18 years in a defined LSCB area. the activities of WoE CDOP are outlined in the attached annual report.

An annual report is produced by the WoE CDOP should you be seeking a copy please contact Adam Bond: [adam.bond@bristol.gov.uk](mailto:adam.bond@bristol.gov.uk)

## related links

- [Child Bereavement Trust](#) - Charity that supports families and educates professionals both when a child dies and when a child is bereaved.
- [Child Bereavement Network](#) - The Childhood Bereavement Network (CBN) is a national, multi-professional federation of organisations and individuals working with bereaved children and young people. It involves and is actively supported by all the major bereavement care providers in the UK.
- [The Foundation for the Study of Infant Deaths](#) - The Foundation for the Study of Infant Deaths (FSID) is the UK's leading baby charity working to prevent sudden deaths and promote health. FSID funds research, supports bereaved families and promotes safe baby care advice.
- [SANDS - Stillbirth and Neonatal death charity](#) - Sands is an organisation which can offer you support when your baby dies during pregnancy or after birth.
- [West of England Child Death Overview Panel: Annual Reports](#) - Annual reports from 2008-2009 and 2009-2010