	RSD Internal Guidance	RIG-2015-04
Local Safeguarding Children Boards and Child Death Overview Panels		

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Keywords	Child death review; investigation; coroner; child death overview panel, child death review team.
Summary	This document gives guidance to those who may investigate the death of a child about the role of the Child Death Overview Panel, in England or a Child Death Review Team in Wales. The current position in Scotland is described.
Original consultation	Legal Services
Subsequent consultation (reviews only)	

* Delete as appropriate

Summary

This guidance advises inspectors about the existence of a body responsible for looking into deaths of children i.e. persons under the age of 18 years in England and Wales.

In Scotland, a governmental short life working group recommended in 2014 that a similar system of child's death reviews should be established. A steering group has been established to implement the arrangements.

Background

The Local Safeguarding Children Boards (LSCBs) in England and Wales have a responsibility under the Children Act 2004 to conduct child death reviews for all children and young people under 18 who die and who were normally resident in their area.

LSCB Membership includes representatives of local authorities, the NHS, probation service, police, and youth offending teams. Its functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under the Children Act 2004.

Among their functions, the LSCB is responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken.

The review is undertaken by a Child Death Overview Panel in England and in Wales by a Child Death Review Team. These will have a membership drawn from organisations represented on the LSCB.

Coroners

Coroners must notify the LSCBs for their area of a child death if the coroner decides to hold an inquest or to conduct a post mortem.

Disclosure: Rule 57 of the Coroners Rules 1984 concerns the disclosure of information. However, it provides only for the disclosure of information at the end of an inquest and only to those people who were, in the opinion of the coroner, a properly interested person. There is no power to enable a coroner to disclose material to a LSCB, unless the coroner considers the LSCB to be an interested person.

Coroner's Rule 57A has been introduced that allows coroners to supply information, at an appropriate time, rather than after the inquest. This will enable LSCBs to meet their obligation to conduct child death reviews and to fulfil their statutory obligations more generally. Therefore information about our investigation findings, supplied to the Coroner by ORR, could be passed to an LSCB or review team body member.

It is also possible that inspectors investigating a child death may be approached by the LSCB direct.

Action	Inspectors investigating the death of a child or young person under the age of 18 years should be aware that the coroner may intend to pass information contained in our report on to a child's death review body of an LSCB before an inquest. If we are likely to take a prosecution arising from the fatality, then inspectors should explain this to the coroner and specifically ask them not to pass our investigation report to other parties such as an LCSB either before or after the inquest without prior discussion with ORR. Inspectors should then advise the coroner if any part of the investigation report can be disclosed or otherwise furnish a short factual description of events for the LCSB. The same applies if the inspector is approached directly by a child death review body. If no prosecution is intended, and our investigation is complete, then relevant factual parts of the investigation report can be disclosed whilst observing the usual constraints of HSWA S28 (8).