Responding to the Death or Serious Injury of a Child Procedure

ALL SERVICES

Procedure Overview

The purpose of this procedure is to detail what staff need to do in the event of responding to the death of a child or a serious injury to a child.

It sets out the internal agency requirements and external statutory requirements for the notification of events. All deaths and serious injuries must be notified to the external agencies as appropriate, but not all serious injuries would require this procedure to be enacted. For the purposes of this procedure, we are referring to serious injuries which are:

- Life threatening
- Life changing
- Life limiting
- Those that have or could result in a disability

As part of Polaris community, the term 'foster parent'" is preferred but it is recognised that 'foster carer' is also used in legislation and within the community. The term *'Adopters'*" is used throughout the document, but depending on the context, it may refer to potential adopters, prospective adopters, or those adopters for whom an adoption order has already been granted.

This procedure forms part of the Polaris Community Quality Management System in line with ISO-9001:2015 standards and applies to all companies within the Community unless stated otherwise.

All group companies are detailed in the current legal structure.

Procedure Owner:	Quality Assurance & Safeguarding Team
Approved by:	Head of Safeguarding
Date approved:	30th September 2025
Next review date:	September 2028
Version No:	01
Supporting documents:	Safeguarding Policy and all associated Procedures

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Procedure Details

Following the death or serious injury of a child, , the manager for the agency must inform their line manager, the Managing and/or Operational Director, Director of Quality and Learning, Head of Safeguarding, and the CEO as appropriate.

Notifications to Managers must be made immediately by telephone and followed up in writing within 24 hours. Where relevant, the Social Worker for any other children in placement must be informed of the incident. Information must then be recorded using the Incident Portal.

The Registered Manager/ Head of Service/or equivalent should be the central point for information, send all notifications, inform staff, provide support/general coordination as needs arise and consultation with the Responsible Authorities/Trusts of any other children in placement.

Notification Requirements

The Registered Manager/Head of Service (or equivalent) is responsible for all notifications and will co-ordinate and direct notifications to other agencies as appropriate**.** In the absence of the Registered Manager/ Head of Service, a suitable individual such as another manager should deputise. Thie notification requirement for all Polaris agencies ensures that relevant authorities are informed of such events and can take appropriate action.

Polaris Children's Services (PCS) will always contact the Local Authority responsible for the child, and it will be the responsibility of that Local Authority to inform other agencies.

BFSWS will in addition to this procedure also follow the MOD guidance in line with Joint Service Publication (JSP) 834 and will also inform Senior Managers as outlined in this procedure.

Fostering

Regulation 36 and Schedule 7 of the Fostering Services Regulations 2011 will apply.

Adoption

Schedule 4 of the Voluntary Adoption Agencies and the Adoption Agencies (Miscellaneous Amendments) Regulations 2003 will apply.

Residential Care

Regulation 40 (The Protection of Children Standard) primarily refers to a provision within the Children's homes (England) Regulations 2015 will apply.

Supported Accommodation

Regulation 27 Supported Accommodation (England) Regulations 2023 will apply.

External Notifications:	Death of Child	Serious Injury of child	Further Information/Websites/ useful links
Responsible Local Authority/Trust	YES	YES	Local Safeguarding Partnerships
Area Local Authority/Trust	YES	NO	Local Safeguarding Partnerships
Responsible Local Authority/Trust for children placed alongside	YES	YES	Local Safeguarding Partnerships

Ofsted – England	YES	YES	**https://www.gov.uk/guidance/tell-ofsted-about-an-incident-childrens-social-care-notification**
Child Death Overview Panel – England	YES	NO	**https://www.gov.uk/government/publications/child-death-overview-panels-contacts**
TCIW – Wales	YES	YES	https://www.careinspectorate.com/
Public Health – Wales	YES	NO	**phw.nhs.wales**
Safeguarding Board – Northern Ireland	YES	NO	**www.safeguardingni.org**
Health – Integrated Care Boards or equivalent Health Board (the HOST ICG/Health Board)	YES	NO	**Local ICG/health board website**
Care Inspectorate Scotland	YES	YES	**Care Inspectorate Scotland**
Healthcare Improvement Scotland	NO *	NO*	**https://www.healthcareimprovementscotland.org/**
Public Health Agency – Scotland	NO**	NO	**Local Health and Social Care Partnerships /health board website**
Scottish Ministers	NO**	NO	

Scotland only-:

*See Appendix note 01

** See Appendix note 02

NB All agencies for England & Wales no longer make external contact with the Secretary of State. The agency should make the relevant local authority aware of all deaths of looked after children and the local authority will then make the notification. By advising the Local Authority of the death, enabling them to notify the Department for Education, Ofsted, and the National Panel, the agency will have fulfilled their duty to inform the Secretary of State.

It is vital that a written record is kept of all events, communication, and decisions. This record must be detailed and accurately written and all staff that have any involvement must contribute to this record. Copies of the notifications must be uploaded to Charms or equivalent.

*In **Scotland,** the **Duty of Candour procedure** also needs to be followed in relation to notifications to the Care Inspectorate and the process to follow. The duty of candour procedure sets out what organisations providing social work services in Scotland are required by law to follow when there has been an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm).*

Responding to a Serious Significant Event

The **Serious Significant Event Learning Review procedure** may be enacted following the death of a child / young person and / or a child who has suffered a significant injury, i.e., one that is defined as being;

- Life threatening
- Life changing
- Life limiting
- Those that have or could result in a disability

The Polaris definition of a Serious Significant Event (SSE) is one that has;

The potential or has caused actual significant harm to a child, young person or adult including death and near miss events, where the incident is attributable to the care given or lack of care given to a child, young person, or adult. The definition also extends to any event that has the potential or has resulted in significant reputational risk, either due to intelligence received or the risk is assessed to be significant.

This includes incidents that may warrant a Safeguarding Practice Review (or equivalent), a Domestic Abuse Related Death review (formerly known as a Domestic Homicide Review), or a Safeguarding Adults Review.

The full criteria for when the Serious and Significant Event Learning Procedure is enacted can be found within the Procedure. It is likely that all deaths will be reviewed in line with this procedure.

It is important that the agency, the manager, and the reviewer, consider changes to practice on a continuous basis and implement them promptly once identified. Any changes that have the potential to positively impact children, young people and families should be made without delay. The Registered Manager/Responsible Individual/Head of Service are responsible for ensuring that practice changes are communicated to teams and that changes are embedded.

Consideration will be given to any immediate action that may need to be undertaken across the Polaris Community. This decision will be undertaken in conjunction with the Director for Quality and Learning, Head of Safeguarding and the Managing Director.

Escalation & Crisis Communication Procedure

The death or serious injury of a child / young person in the context of this procedure will be a red incident and the Escalation and Crisis Communications Procedure should be followed.

Red incident – Line Manager notifies Registered Manager, Head of Service, Managing Director, CEO, Director of Quality and Learning / Head of Safeguarding /Marketing Director. The Marketing Director agrees approach to responding to media and internal enquiries.

The Registered Manager/ Head of Service should ensure that staff and anyone involved in caring for a child does not to enter into any communication with media organisations in the event of media interest. The Registered Manager/ Head of Service and all staff should follow the protocols and processes set out in the **Escalation & Crisis Communication Procedure.** The senior team and Managing Director of the service should liaise with the Internal Comms as required, to manage media enquiries.

The Registered Manager/ Head of Service or their designated deputy will need to be available to attend any meetings with the Responsible Authority/Trust, Police, and/or Rapid Response Process. This includes Sudden Unexpected Death in Childhood (SUDIC) meetings or Child Safeguarding Practice Reviews learning events (CSPRs in England, equivalent reviews exist for Wales/NI/ Scotland).

In The Event of the Sudden Death (SUDIC) of a Child

A SUDIC can be defined as *'The death of an infant or child whose death was 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 which lead to the death'*.

The first notification will be to the Authority/Trust with responsibility for the child; it must be established at this time who will take responsibility for notifying the child's parent(s) and the Police.

The child's personal belongings must also be immediately secured, including any medications, valuables, and financial items. These should be safely stored to preserve the integrity of the environment and prevent loss or tampering. A full inventory should be recorded, and access restricted to designated personnel until further direction is given by the appropriate authorities.

If the death has occurred outside of the child's home i.e., in public, the Authority/Trust with responsibility for the child may be aware of the death first and contact the agency to notify the relevant people.

The child's birth parents, family and/or the Responsible Authority/Trust will take responsibility for funeral arrangements and may sometimes seek support and assistance from agency staff. Those working within the agency, who wish to attend the funeral, should be supported to do so although the wishes and feeling of the birth family must be taken into consideration.

The Responsible Authority/Trust will also need to confirm the child's religious and cultural requirements concerning death. For example, a Muslim burial may be required within 24 hours of the death, or the body may need to be prepared in line with Jewish rituals. The Responsible Authority/Trust may consult the agency to assist in establishing this information as well as any needs/wishes expressed by the parent(s). It is important to note that the Coroner may order a post-mortem to be carried out. In these circumstances the post-mortem takes priority over any religious or cultural norms, and this should be dealt with in a sensitive manner. Funeral arrangements should not be communicated to parent(s) without confirmation that a post-mortem is not required.

In the case of fostering placements/adoptive placements the child's Social Worker will discuss with the parents the arrangements they wish to make about the funeral. Following the death of a child, any legal order on that child is no longer in place and the responsibility returns to the parents. This is a distressing time and sometimes parents and foster parents/ adopters can disagree about funeral arrangements. It is the parents' right to make decisions on these matters.

For Fostering - In the event of the death of a child with a terminal illness or severe physical disabilities:

Foster Parents who are caring for a child with a terminal illness or severe physical disabilities which are associated with life threatening medical episodes will have regular appointments with their GP, hospital doctor or consultant. In these circumstances if the child has been seen by a doctor in the previous 14 days, then that doctor should be contacted as it is them who will normally be involved in medically certificating the cause of death. The arrangements for who is responsible for contacting the GP in this scenario and for 'End of Life Care Plan' should have been agreed as part of the Child Specific Safer Caring Plan or Individual Safeguarding Risk Assessment and Management Plan.

In the case of terminally ill children it may have been agreed that the foster parent will inform the parent(s) of approaching end of life to ensure that arrangements can include the parent(s) attending the home or hospital with the foster parent, or that the parent(s) resume care of the child's end of life care. Any such arrangements must be clearly documented and agreed in the Child's Care Plan and Placement Agreement.

Foster Parents who are caring for a child with terminal illness/severe disabilities may have been issued with 'no resuscitation' consent by the persons with Parental Responsibility. This means that if the child is in a critical condition, it has been agreed by the medical practitioner responsible for the child and the person(s) holding Parental Responsibility that on emergency admission to hospital the medical team will not actively prolong life. In this case the foster parent must carry the written consent at all times when attending hospital in an emergency.

Support after the Death of a Child – (Fostering/Adoption)

Foster Parents/Adopters/Staff must report the death immediately to either their Supervising/ Assessing Social Worker, the Registered Manager, Head of Service, or equivalent or via the Out of Hours Service (OOH).

It is vital that a Supervising Social Worker/SW is dispatched immediately to be with the foster parent/ adopter for support. Ideally this should be the SW/SSW with an established relationship with the foster parent/adopter and knowledge of the child. In the event that they are not available, the senior manager (or OOH Team) will decide the most appropriate person to attend. If the child has been taken to hospital it may be suitable for a member of agency management (e.g., the RM) to attend for the purpose of supporting the Foster Parent(s), Adopter (s), and staff.

The SSW/SW supporting the foster parent/adopter will need to establish what support is required at the home e.g., the needs of other children in the home. This information will be reported to the 'dedicated' staff member in the regional office for an appropriate response to be arranged.

The SSW/SW must support them through any interviews that may be required e.g., with health professionals and police. If necessary, foster parents can access free independent advice, including legal advice via FosterTalk.

Do not assume that the Responsible Authority/Trust will dispatch a staff member to attend the hospital; as this may not happen. Ensure there is regular liaison and discussion with the LA/Trust SW to co-ordinate roles.

The staff involved with the death will need to have all the necessary information regarding the child: their health information, legal status, and the names and contact details of those holding parental responsibility for example. Communication between the staff member in attendance and the 'dedicated' staff member in the office should be at agreed intervals.

Any sudden death will involve unique circumstances. Guidance on the process, provided later in this document, is a general overview of what may happen, so that staff and foster

parents/adopters/ birth parents have some preparation on what may seem to them alarming but is routine procedure for professionals when dealing with a sudden death.

Foster Parents/adopters/birth parents/those with parental responsibility and their family will need ongoing support after the death. They may have established support networks that they consider their first choice such as family, friends, and other Foster Parents/ adopters. The regional Therapist may provide advice and guidance on accessing counselling for them and their family and the offer of counselling should be open-ended so that the Foster Parent/ prospective adopters/birth parent/those with parental responsibility can decide if and when they are ready to use this service.

For Fostering - Registered Managers can agree financial support for the Foster Parent(s). For example, a minimum of 28 days placement fee and consideration to extending payments after this period.

For birth parents of children in foster/adoptive care it has also proved helpful to provide the birth parent(s) with Life Story materials and other personal possessions of the child. All of these decisions should be made on a needs led basis and considering the wishes and feelings of those with parental responsibility.

Support for All Staff

Staff directly involved should have regular welfare checks and have regular debriefs throughout. All staff affected by the death will find it helpful to have an open-door session with managers and the regional/team therapist where possible. These sessions allow staff to attend and talk about what has happened and to share how they are feeling.

It is important that staff are given open conversation forums to come together to discuss events that can have a significant impact upon the whole region/team. Managers should also speak individually to all the staff who knew the young person and those who dealt with the incident via OOH's to check how they are feeling and refer them to the services that can be accessed via the Exchange (Employee Assist Programme).

It is also important to communicate with all relevant staff as soon as possible following the event and signpost them to their manager for support.

The Polaris Employee Assist Programme provides confidential emotional health and wellbeing support services. The EAP service is a confidential 24/7, 365 days a year service. Accredited counsellors and experienced information specialists offer support and signposting across a range of personal legal, medical, health and wellbeing issues, as well as a telephone counselling service. Any employees who wish to access EAP can contact: 0800 756 0834 and staff just need to quote 'Polaris'. Further information can be found here: https://theexchange.rewardgateway.co.uk/SmartPage/EAP

In the Event of a Serious Injury to a Child

The first notification will be to the Local Authority/Trust with responsibility for the child; it must be established at this time who will take responsibility for notifying the child's parent(s), fostering/adoption services and if they need assistance attending the hospital. Although it is not required that agency staff assist parents and family members to attend hospital it is in the best interest of the child to ensure their parents and family members are informed and can be with them if appropriate.

Support for Foster Parents/ Adopters:

The foster parent/adopters will need to be supported in staying with the child whilst they are in hospital.

They may require another foster parent to take responsibility for other children in placement to allow them to stay for long periods or overnight.

Providing the circumstances regarding the injury are clear, there may be no need for police involvement; each case will be assessed at the time of admission to hospital by the Senior Doctor on duty and the relevant Local Authorities/Trusts. On discharge from hospital the child may be referred for follow up consultation, particularly in the case of an attempted suicide or a continuing health problem.

Support for other children

In the event of a child's death, it is crucial to provide compassionate and sensitive support to the other children affected. Such a loss can be deeply traumatic, and each child may process grief in their own way. Creating a safe space where children feel comfortable expressing their emotions—whether through talking, creative activities, or simply being quiet—is essential. Adults should offer reassurance, validate the children's feelings, and answer questions honestly but age-appropriately. It may also be helpful to involve trained professionals, such as counselors or therapists, to guide children through the grieving process. Ongoing support, routine, and open communication can help children feel secure and understood during this profoundly difficult time.

Restricting Access to Records

The case files will need to be restricted if the criteria has been met.

These instances include situations such as -:

- Where a Safeguarding Practice Review is to be carried out
- The death of a child where child protection concerns exist that require investigation
- Where the Senior Manager makes a decision that information must be protected because of the sensitive nature of the case. E.g. Safeguarding Adult Review or a Domestic Abuse Related Death

- Where a Senior Manager is investigating potential disciplinary issues in relation to a member of staff

The Incident Portal

The Incident Portal is a system built for the reporting of incidents by staff and managers. Incidents are sent automatically to relevant Central Staff for review and management.

Reporting and tracking progress is undertaken centrally, with ongoing communications, notes, documentation, and status updates held in one place under the incident's unique reference number. The portal provides leadership with a succinct high level view of incidents and high risk operational situations. See the **Incident Reporting Procedure** for further guidance.

External Agencies – Procedures following the Death of a Child

Child Safeguarding Practice Reviews (or equivalent)

Child Safeguarding Practice Reviews (SPR's) are undertaken when a child dies (including death by suspected suicide), and abuse or neglect is known or suspected.

Initially a Rapid Review will be undertaken to ascertain whether a local Child Safeguarding Practice Review is appropriate, or whether the case may raise issues which are complex or of national importance that such a national review may be appropriate.

The Rapid Review process will decide whether the case meets the criteria for a Child Safeguarding Practice Review (or equivalent as below) and send this recommendation to the national Child Safeguarding Practice Review Panel.

Each UK nation has its own terminology and guidance for carrying out and sharing the learning from the reviews by multi-agency panels:

- child safeguarding practice reviews in **England**
- case management reviews in **Northern Ireland**
- learning reviews in **Scotland**
- child practice reviews in **Wales**

Frontline professionals may be asked to attend learning events. Representatives from the agency should attend and any attendees must be agreed by the Managing Director or Senior Manager.

Police

In all cases of sudden death of a child the Police must be informed. The Police will interview any individuals present at the time of the death (including Foster Parents/adopters/ birth parents and household members/staff) to establish the facts and circumstances. They may also interview foster parents/adopters /birth parents or staff members not present at the time of the death as part of their enquiries.

The Police will also examine the place where the death occurred, which may involve the home being forensically examined. As part of this process photographs may be taken and items such as bedding removed for forensic purposes. Foster Parents/adopters/birth parents/staff will need to be supported throughout this process.

The Police will be following their normal procedures regarding a 'Sudden Death,' but Foster Parents/adopters may feel that they are 'suspects' and be alarmed that Scene of Crime Officers are examining their home if the death occurred there. They will need to be reassured that this practice is routine and purely to establish the facts surrounding the death.

Health Professionals, Death Certificates and Coroners/Procurator Fiscal

NB: In Scotland there is no system of coroners' inquests unlike England, Wales, and Northern Ireland. Accidental, unexpected, unexplained, sudden, or suspicious deaths are investigated privately for the local crown agent, an official called the **Procurator Fiscal**. In Scotland, the Police will act on the requests of the Procurator Fiscal in the event of a sudden death. Our role in investigating deaths | COPFS

In the event of a sudden death or serious injury of a child, it is likely that the first questions/interview for the foster parent will be by a health professional. Their aim will be to establish the cause of death or injury; therefore, the Foster Parent/staff may be asked a series of questions regarding the child's medical history, when they last saw their G.P, attended hospital etc. If a G.P or Hospital Doctor has been treating the child and seen him/her in the previous 14 days, then in most cases they can establish and certify the medical cause of death.

For **England, Wales, and Northern Ireland** if the child has not been seen or treated then the Coroner will be notified by the relevant Doctor or Police Officer and a Postmortem examination may take place. The child's body will usually be released directly after the post-mortem so that funeral arrangements can be made.

In **Scotland,** the Postmortem is performed by a qualified pathologist.

In certain circumstances even when a medical certificate concerning cause of death has been issued, a hospital medical Registrar or G.P. must also report deaths to the Coroner/ Procurator Fiscal; for example, if the death occurred under "unusual circumstances."

The decision of whether a child's death meets the SUDIC criteria is made by the Designated Paediatrician for SUDIC and throughout the process the child remains under the jurisdiction of HM Coroner/ Procurator Fiscal.

A Coroner/Procurator Fiscal will decide whether to hold an inquest when a death has occurred in unusual circumstances. An inquest is an inquiry into who has died, and how, when and

where the death occurred. An inquest is usually opened primarily to record that a death has occurred and to identify the dead person and will be adjourned until any police enquiries and Coroner's/Procurator Fiscal investigations are completed. If a full inquest is held staff members and/or foster parents/may be asked to attend as witnesses and give evidence. In such circumstances foster parents/should be offered help from staff in compiling their account of the events leading to the death and support attending the inquest.

Responsible Authority/Trust

The Responsible Authority/Trust for the child must be notified immediately, in the first instance through contact by telephone by either the Registered Manager/Head of Service or their delegated Senior Manager. This notification will be followed up in writing at the earliest opportunity. It needs to be agreed with the Responsible Authority/Trust who will inform the child's parent(s) or next of kin (fostering services).

A meeting should take place on the day the death occurs or within 24 hours, between the Registered Manager/Head of Service and the Responsible Authority/Trust Senior Management. This meeting will include information sharing about the circumstances and any outstanding arrangements regarding the child's parents and funeral arrangements. The Responsible Authority/Trust will have its own internal procedures to follow; they will also be working with the Police in relation to any enquiries being made. This process could potentially take several weeks, therefore the Registered Manager/Head of Service/Delegated Senior Manager will need to be available for further enquiries and meetings.

Child Death Review Partners

Child Death Review (CDR) partners are Local Authorities/Trusts and any Clinical Commissioning Groups (CCGs) for the local areas (England). CPC (Scotland). CMR Panel (NI). CDRP (Wales).

Child Death Review partners (or equivalent as above) must make arrangements to review all deaths of children normally resident in the local area and, if they consider it appropriate, for any non-resident child who has died in their area. Child Death Review partners for two or more local authority/trust areas may combine and agree that their areas be treated as a single area for the purpose of undertaking child death reviews. Child Death Review partners must make arrangements for the analysis of information from all deaths reviewed.

All agencies, including those within the Polaris community, have a duty to provide any required information about the child for the purpose of reviewing the child's death. Therefore contact should always be made with the local Child Death Review Partners (or equivalent) whenever any child dies to ensure information held by the agency is shared.

Local Safeguarding Children Partnerships

In **England** the Local Authority, Integrated Care Boards (ICG's) and the Police make up the Local Safeguarding Children Partnerships (LSCP) replacing the former Safeguarding Boards. Safeguarding Children's Partnerships consider whether to conduct a *Child Safeguarding Practice Review* (CSPR's) in cases where abuse or neglect of a child is known or suspected and the child has died or been seriously harmed and where a child is seriously harmed or dies while in the care of a local authority, or while on (or recently removed from) a child protection plan.

Locally, safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken. There is an emerging theme of learning lessons events being organised as part of these reviews, that frontline practitioners are asked to attend. This could involve agency members being asked to attend and where possible, this should be facilitated and encouraged.

In **Wales** the Public Health Wales Procedural Response to Unexpected Deaths in Childhood (PRUDIC) aims to identify and describe patterns and causes of child death including any trends, and to recommend actions to reduce the risk of avoidable factors contributing to child deaths in Wales. The notification form for a child death in Wales is available on Public Health Wales website. This panel operates in a similar way to the process in England, and information should be shared accordingly.

A Child Practice Review (CPR) takes place after a child dies or is seriously injured, and abuse or neglect is thought to be involved. An extended CPR takes place when the child was on the child protection register and/or was a looked after child (including a person who has turned 18 years of age, but who was a looked after child) on any date during the 6 months preceding.

It aims to identify lessons that can help prevent similar incidents from happening in the future, and information and involvement from FCA may be required.

Northern Ireland also operates a child death review process in a similar way to England and Wales, and information should be provided for this process.

Additionally, the Safeguarding Board Northern Ireland (SBNI) will undertake a Case Management Review when where a child has died or has been significantly harmed and when any of the following apply:
1. Abuse or neglect of the child is known or suspected;
2. The child or a sibling of the child is or has been on the child protection register and is subject to a plan to safeguard that child from further harm and promote his health and

development;

3. The child or a sibling of the child is or has been looked after by an authority within the meaning of Article 25 of the Children (Northern Ireland) Order and the SBNI has concerns about the effectiveness in safeguarding and promoting the welfare of children of any of the persons or bodies represented on the Safeguarding board by virtue of section 1(2)(b) and (4) of the Act.

In **Scotland,** a learning review is a multi-agency process initiated by child protection committees. They are intended to establish the facts of, and lessons from, a situation where a child has died or been significantly harmed. Learning reviews focus on learning and reflect on day-to-day practices and systems within which those practices operate. A Learning Review takes place when abuse or neglect is known or suspected to be a factor in the child's death, the child is on or has been on the Child Protection Register or a sibling is or was on the Child Protection Register. The child was Looked After by the Local Authority. The death is by suicide or accidental death. The death is by alleged murder, culpable homicide, reckless conduct, or an act of violence. A learning review can also be carried out when a child has not died but has sustained significant harm or is at risk of significant harm.

The purpose of a Learning Review is to: -

- Establish the full circumstances of the death/serious harm of the individual.
- Examine and assess the role of all relevant services.
- Explore any key practice issues and why they may have arisen.
- Establish whether there are lessons to be learned or good practice to be shared about the way in which agencies work individually and collectively to protect individuals.
- Identify areas for development, how they are to be acted on and what is expected to change as a result.
- Consider whether there are gaps in the system and whether services should be reviewed or developed to address those gaps.
- Establish findings which will allow the committee to consider what recommendations need to be made to improve the quality of services.

Review Dates

N/A

Scotland - Appendix Note 01

*Healthcare Improvement Scotland in collaboration with the Care Inspectorate, co-host the national hub for reviewing and learning from the deaths of children and young people. These reviews will be conducted into the deaths of all live born children up to the date of their 18th birthday, or 26th birthday for care leavers who are in receipt of continuing care or aftercare at the time of their death. The National Hub will operate in the context of existing review arrangements, rather than replace or duplicate. In conjunction with the Expert Advisory Group, the National Hub developed National guidance when a child or young person dies. It sets out the process NHS boards, and local authorities should follow when responding to, and reviewing, the death of a child or young person.

The relevant Registered Manager/ Head of Service is responsible for making the required notifications both internally and externally. Any required notifications to regulatory bodies must be completed immediately (see Monitoring & Notifiable Events Procedure).

Appendix Note 02

This is the Responsibility of LA in Scotland as part of their initial report, submitted to Care Inspectorate Scotland within 28 days for their review. It is the responsibility of Care Inspectorate Scotland to inform Scottish Ministers. It is also the responsibility of the LA and Care Inspectorate Scotland to inform the Child Protection Committee (CPC) who will determine whether a learning review is instigated. **The agency in Scotland must ensure that the notifications to the Scottish Ministers and Child Protection Committee have been made.