NHS
Central East
Integrated Care Board

Child Death Review Protocol 2026-2027

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1.0	1.4.2026	ICB Board	Approved
1.1	10.4.2026	Governance Team	Minor formatting amendments

Contents

1. Introduction

1.1 This policy sets out the responsibilities and accountabilities for child death reviews (CDR) within Central East Integrated Care Board as part of chapter six of Working together to safeguard children 2023: statutory guidance and Child Death Review Statutory and Operational Guidance (England). It aims to ensure a consistent and effective approach that supports the organisation's objectives, complies with statutory and regulatory requirements and promotes best practice.

2. Purpose and Scope

2.1 The purpose of this protocol is to define the key responsibilities of Central East ICB to ensure the safe and effective management of the statutory child death review process.

2.2 This policy applies to Central East ICB Board members, safeguarding teams, CDOP teams, and others involved in, and/or accountable for, the statutory child death review process.

3. Definitions

3.1 Child Death Overview Panel (CDOP) – a group of independent professionals responsible for reviewing the deaths of children from birth up to the age of 18. The purpose of CDOP is to conduct comprehensive and independent reviews of child deaths to identify patterns and improve services, ultimately aiming to prevent future deaths.

3.2 Child Death Review (CDR) – a structured process in which multidisciplinary teams review the circumstances surround the death of a child to understand why it occurred and identify ways to prevent similar deaths in the future. These reviews are conducted at a Provider and commissioning level and involve professionals from healthcare, social care, police, education and public health.

3.3 Joint Agency Response (JAR) – a coordinated multi-agency effort triggered when a child dies unexpectedly or in specific situations such as, stillbirths without healthcare attendance or when a child is brought to the hospital near death but is expected to die shortly thereafter. The primary aim of the JAR is to ensure that all relevant agencies work together effectively to investigate the circumstances surrounding a child's death and to provide necessary support to the family.

3.4 Neonatal Intensive Care Unit (NICU) – a specialised hospital unit that provides advanced medical care for premature or critically ill newborns.

3.5 Paediatric Intensive Care Unit (PICU) – a specialised hospital unit that provides intensive care to critically ill infants, children and adolescents.

3.6 Local Maternity and Neonatal Systems (LMNS) – a collaborative partnership aimed at improving maternity and neonatal services. It involves various stakeholders, including care providers, commissioners, and service users, working together to enhance the safety, personalisation, and quality of care for those using these services.

3.7 Sudden Unexplained Death in Childhood (SUDC) – the sudden and unexpected death of a child aged 12 months or older, where no clear cause of death is determined despite thorough investigation and post mortem.

3.8 Sudden Unexpected Deaths of Infants (SUDI) – the sudden and unexpected death of a baby under one year old, often during sleep, with no immediate cause. This includes conditions such as sudden infant death syndrome (SIDS) and fatal sleep accidents.

4. Policy Statement

4.1 Central East ICB is committed to ensuring compliance with the statutory child death review legislation, with the aim to improve the experience of bereaved families, and professionals involved in caring for children, and ensuring that information from the child death review process is systemically captured in every case to enable learning to prevent future deaths.

All staff are expected to adhere to the requirements set out in this policy.

5. Roles and Responsibilities

5.1 The following have specific responsibilities in relation to this policy:

5.2 To ensure that any responsibilities for safeguarding that are delegated by the ICB Board to individuals or committees are appropriately reflected in the ICB's scheme of reservation and delegation Executive Lead Guidance (May 2023).

5.3 ICBs are also required to have a Board level executive lead for statutory safeguarding.
5.4 For the purposes of CDR, it is advised that in line with statutory guidance:

5.4.1 ICBs are expected to jointly resource and manage all local CDOP or equivalent via the multiagency CDR partnerships with local authorities as their CDR partner.

5.4.2 The ICB Director for Safeguarding and Complex Care has executive lead responsibility to ensure the effective discharge of statutory safeguarding responsibilities for the CDOP. The governance structure related to this includes clinically led forums through which oversight is sought including the Local Safeguarding Children Partnership, the NHS England Regional Quality Board. The

Regional Chief Nurses carry out assurance reviews of ICBs using the SAAF with the support of the Regional Safeguarding Lead. The NSSG annual review process is assisted by NHS England's regional safeguarding teams.

5.4.3 The ICB Executive Clinical Director Utilisation Management / Medical Director has executive lead responsibility for the clinical content, the quality improvement approaches and the patient safety governance within all CDRs and CDOP reports.

5.4.4 The Designated Doctors for Child Death, the local CDOP Chairs, the CDR Nurses and the CDOP team take responsibility for co-ordinating meeting dates, panel agenda, the CDOP action plan, and the production of an annual report, as per statutory guidance.

5.4.5 The statutory role of the Designated Doctor for Child Deaths is a funded post and is accountable to the ICB Executive Clinical Director Utilisation Management / Medical Director.

5.4.6 ICBs and statutory CDR partnerships must also ensure that:

- All provider trusts are reviewing deaths as per the statutory guidance, holding holistic CDR meetings, and not traditional morbidity and mortality meetings.

- All provider trusts are expected to allocate bereaved families a keyworker to act as a main point of contact and support for a CDR, including obtaining feedback and questions from parents for CDR meetings and signposting to suitable bereavement support services. The allocation of a keyworker is individual to the circumstances of the death and the family. There is an expectation that if a child dies outside their home area, the keyworker in the organisation where the death was certified liaises with the child's home area to identify the most appropriate key worker service for the family.

- The Joint Agency Response (JAR) team is appropriately commissioned, and provided, with trained healthcare professionals able to conduct joint home visits with police when necessary, noting when a nurse led JAR model is used, that expert clinical supervision and advice is readily available to support.

- Within integrated care systems, as executive lead for statutory safeguarding assurance the ICB Director of Safeguarding and Complex Care are expected to have a lead role on behalf of ICB Boards in ensuring that ICBs meet their functions relating to those CDRs. This includes the CDOP for children who are being statutorily safeguarded or those deaths that might have been impacted by neglect, harm, abuse or violence.

5.5 ICB Director of Safeguarding and Complex Care are required to have oversight of child safeguarding rapid reviews under Working Together to Safeguard Children (2023) to assure that all child deaths are reviewed with a safeguarding context.

5.6 ICBs and statutory CDR partnerships are required to collaborate with local providers to supportively manage parent and family complaints about any JAR, CDOP process and timeline delays. Providers will investigate their own complaints, but ICB and CDR partnerships may need to own process complaints.

5.7 ICBs and statutory CDR partnerships will recognise an increasing need for analysing quality metrics, relevant patient safety key lines of enquiry through the Patient Safety Incident Response Framework (PSIRF), safeguarding risks and extreme and criminal transgressive behaviours or egregious acts for unit, provider and system early alerts and learning for all health provider settings.

5.8 ICBs and statutory CDR partnerships will be required to have regard to all Neonatal Intensive Care Units (NICUs) and Paediatric Intensive Care Units (PICUs), noting these services come under the commissioning of Local Maternity and Neonatal Systems (LMNS) and ICBs from April 2025 as per NHS England » Annex 1: Services suitable for delegation in 2024/25.

5.9 All NICUs and some PICUs use BadgerNet as their clinical record system. CDR partnerships should consider requesting providers to audit the clinical systems for evidence of sudden collapse, episodes of de-oxygenation, glucose abnormalities, and any indicators of inflicted injury or non-accidental head injury. These findings can be reviewed through the multi-agency SUDI/SUDC process, aligned with the 2016 Kennedy Guidelines.

5.10 ICBs and statutory CDR partnerships have regard to allegations against adults who work with children in relation to extreme and criminal transgressive behaviours or egregious acts by staff or volunteers. NHS system leaders (providers and commissioners) are expected to ensure all necessary investigations regarding allegations of harm, abuse or wilful neglect are referred to the Local Area Designated Officer (LADO) and any professional regulator as set out in the statutory guidance Working Together to Safeguard Children 2023 (chapter 4) and per the Safeguarding Accountability and Assurance Framework (page 12, paragraph 3.5.6) and NHS England Safeguarding policy and in line with local safeguarding children partnership board policies and procedures.

6. Processes and Procedures

6.1 The following processes must be followed to comply with this policy:

- Cambridgeshire and Peterborough Child Death Overview Panel Protocol (2024)
- Hertfordshire Child Death Overview Panel Procedures (2025)
- Bedfordshire Child Death Overview Panel Policy and Guidance (2024)
- Milton Keynes Child Death Review Arrangements (2024)

7. Statutory and National Guidance

7.1 This policy has been developed with reference to the following statutory and national guidance:

- *Working Together to Safeguard Children (2023)*
- *Child Death Review: Statutory and Operational Guidance (2018)*
- *Sudden Unexpected death in infancy and childhood (2016)*
- *Safeguarding Accountability and Assurance Framework (2024)*

8. Stakeholder Engagement Record

8.1 The following stakeholders were engaged in the development / of this policy:

Role/Group	Date of Engagement	Summary of Feedback
[Safeguarding team subject matter experts]	[N/A]	[This policy has been developed by merging the MCA policies from the three formal ICBs. The three formal ICBs' policies were developed with stakeholders' engagement from their various locality therefore from implication, this policy has been developed with stakeholder engagement.]

Accessibility Statement

This policy is available in alternative formats upon request, including large print, Braille and translated versions, to ensure accessibility for all staff and stakeholders.

Implementation Plan

Development and Consultation: [this protocol was developed by the Child Death Review team at Cambridge and Peterborough ICB place-based team]
Dissemination: [The protocol will be available on the ICB intranet site and will be available to key stakeholders including local population. Access and accessibility to the policy are outlined above.
Training: The specific training requirements for targeted staff groups are explicit within the protocol and aligned to job role and responsibilities.
Monitoring: ongoing monitoring unless indicated by local, national or legislative changes.
Review: The protocol will be formally reviewed initially after 1 year thereafter unless indicated by national, statutory, changes, local learning or revised commissioning arrangements.
Equality, Diversity, and Privacy: See Appendices, CEICB recognise the diversity of the local

community and those in its employment. This protocol is supported by the auditable EQIA standards contained in this document and will be monitored for impact. The policy also acknowledges specific vulnerable groups where susceptibility to child death might be linked to complex health and social inequalities.

Associated Documents: A list of all the associate policies including links to relevant web pages is contained within the document

References: References are contained within the document and will be updated in line with changes to national policies and statutory changes see also section 7 for references and statutory guidance]

Appendix 1: Equality Impact Assessment

Please answer the questions against each of the protected characteristic and inclusion health groups. If there are significant impacts and issues identified a full Equality / Quality Impact Assessment (EQIA) must be undertaken. It is against the law to discriminate against someone because of these protected characteristics. For support and advice on undertaking EQIAs please contact: agcsu.equalities@nhs.net

Name of Policy:	Child Death Review Protocol
Date of assessment:	10/02/2026
Screening undertaken by:	Eleanor Weller, Child Death Review Manager

Protected characteristic and inclusion health groups. **Find out more about the Equality Act 2010, which provides the legal framework to tackle disadvantage and discrimination:** **https://www.equalityhumanrights.com/en/equality-act/protected-characteristics**	**Could the policy create a disadvantage for some groups in application or access?** **(Give brief summary)**	**If Yes - are there any mechanisms already in place to mitigate the potential adverse impacts identified?** **If not, please detail additional actions that could help.** **If this is not possible, please explain why**
Age A person belonging to a particular age (for example 32 year olds) or range of ages (for example 18 to 30 year olds).	No	
Disability A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.	No	
Gender reassignment The process of transitioning from one gender to another.	No	
Marriage and civil partnership Marriage is a union between a man and a woman or between a same-sex	No	

couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'.	
Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.	No
Race Refers to the protected characteristic of race. It refers to a group of people defined by their race, colour and nationality (including citizenship) ethnic or national origins.	No
Religion or belief Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	No
Sex A man or a woman.	No
Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex, to both sexes or none.	No
Carers Individuals within the ICB which may have carer responsibilities.	No
Please summarise the improvements which this policy offers compared to the previous version or position.	
This protocol is an amalgamation of NHS England child death review guidance/protocols, Cambridgeshire and Peterborough CDOP, Hertfordshire CDOP, and Bedfordshire, Luton and Milton Keynes CDOP protocols/processes. This protocol aligns the three ICB's to form a unitary protocol for Central East ICB.	

Has potential disadvantage for some groups been identified which require mitigation?

No

Appendix 2: Data Protection Impact Assessment

Data protection is the fair and proper use of information about people. Before completing this form, please refer to the Data Protection Impact Assessment (DPIA) Guidance in the Information Governance (IG) section on the staff Intranet or contact the Data Protection Officer for support via ***(insert email address once confirmed)***

A DPIA is a process to help you identify and minimise the data protection risks. You must do a DPIA for processing that is likely to result in a high risk to individuals. You can use our screening checklist below to help you decide when to do one. If you have answered 'Yes' to any of the 10 screening questions, you must then carry out a full DPIA using the Stage 2 form, which is also available on the Intranet in the IG section.

Name of Policy:	Child Death Review Protocol
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Stage 1 – DPIA form **please answer 'Yes' or 'No'**

1.	**Will the policy result in the processing of personal identifiable information / data?** This includes information about living or deceased individuals, including their name, address postcode, email address, telephone number, payroll number etc.	Yes
2.	**Will the policy result in the processing of sensitive information / data?** This includes for living or deceased individuals, including their physical health, mental health, sexuality, sexual orientation, religious belief, National Insurance No., political interest etc.	Yes
3.	**Will the policy involve the sharing of identifiers which are unique to an individual or household?** e.g., Hospital Number, NHS Number, National Insurance Number, Payroll Number etc.	Yes
4.	**Will the policy result in the processing of pseudonymised information by organisations who have the key / ability to reidentify the information?** **Pseudonymised data -** where all identifiers have been removed and replaced with alternative identifiers that do not identify any individual. Re-identification can only be achieved with knowledge of the re-identification key. **Anonymised data -** data where all identifiers have been removed and data left does not identify any patients. Re-identification is remotely possible, but very unlikely.	Yes
5.	**Will the policy result in organisations or people having access to information they do not currently have access to?**	No
6.	**Will the policy result in an organisation using information it already holds or has access to, but for a different purpose?**	No
7.	**Does the policy result in the use of technology which might be perceived as being privacy intruding?** e.g., biometrics, facial recognition, CCTV, audio recording etc.	No
8.	**Will the policy result in decisions being made or action being taken against individuals in ways which could have a significant impact on them?** Including profiling and automated decision making. (This is automated processing of personal data to evaluate certain things about an individual i.e., diagnosis and then making a decision solely by automated means - without any human involvement)	No
9.	**Will the policy result in the collection of additional information about individuals in addition to what is already collected / held?**	No

10. Will the policy require individuals to be contacted in ways which they may not be aware of and may find intrusive? e.g., personal email, text message etc.	No

Appendix 3: Process Flow Diagram

Visual summary of key multi-agency processes for child death review, taken from the Child death review: statutory and operational guidance (2018).

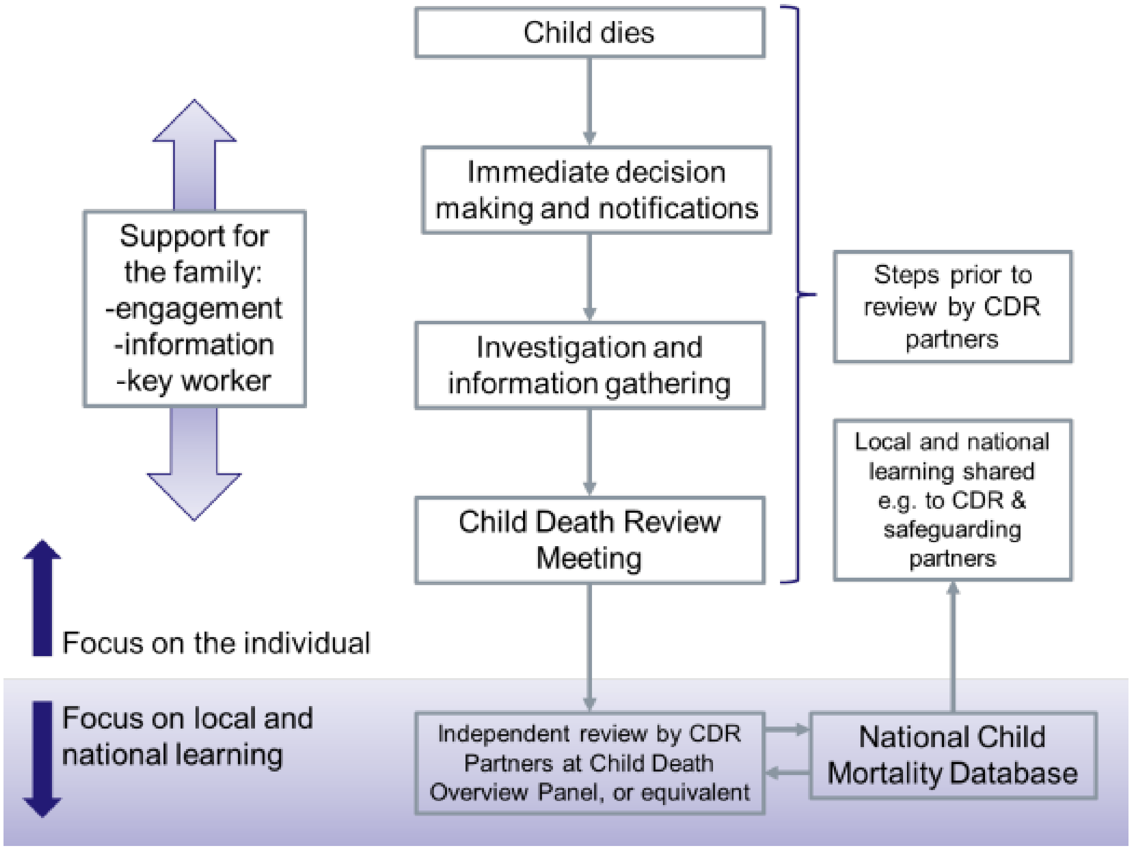

Figure 1 Chart illustrating the full process of a child death review. This includes both the statutory responsibilities of CDR partners to review the deaths of children at an independent multi-agency panel (described here, and throughout, as review at CDOP or equivalent), and the processes that precede or follow this independent review.

Central East child death review/CDOP team contact details:

Bedfordshire, Luton and Milton Keynes: blmkicb.cdopmanager@nhs.net

Cambridgeshire and Peterborough: cpicb.cdop@nhs.net

Hertfordshire: hct.hertscdr@nhs.net