

## **Assisting Statutory Investigations**

Schools need to be aware that a critical incident such as the sudden death of a pupil or member of staff can trigger an investigation that may involve a number of statutory agencies.

The sudden death of a pupil or member of staff is an extremely difficult and emotionally charged time for all concerned. Schools should be aware that alongside a coroner's inquest there may be other officially established reviews, such as serious case reviews (SCRs) or inquiries into the pupil's or member of staff's death and the circumstances surrounding it.

It is important that schools anticipate being asked to contribute information about the pupil to any such review or inquiry and ensure that all relevant records relating to the pupil are secured. It is important to stress that the purpose of such reviews is not to inquire into how a child or adult died or who is culpable. It is to learn from the experience on how best to protect children and staff in the future and if there are ways of improving the practice of all professionals working with children particularly in relation to multi-disciplinary and inter-agency working.

### **Child Death Overview Panel (CDOP)**

The death of a child is always tragic. Talking and thinking about a child's death is a sensitive and painful subject which is particularly upsetting for parents, families and carers. The reviewing of Child Deaths became mandatory for Local safeguarding Children Boards (LSCBs) in England on 1st April 2008. Child Death Overview Panels (CDOPs) are also a statutory requirement of Working Together 2010.

All LSCBs are required to have suitable CDOP arrangements in place. These arrangements include: A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child.

The purpose of the processes is to try to understand why children die and then put in place interventions to protect other children and prevent future deaths wherever possible. It is intended that these processes will:

Document and try to understand the cause of death so that parents can come to terms with the death of their child.

Enable parents and professionals to take steps to prevent the deaths of any other children where possible.

Identify patterns of deaths in a community so that preventable or avoidable hazards that may contribute to deaths can be recognised and reduced.

Contribute to the improved collection of forensic evidence in the very small proportion of deaths where there might be concerns about the cause of death being non-accidental.

All families should be treated with sensitivity, discretion and respect at all times, and professionals should approach their enquiry with an open mind.

Contact details of the people in child death overview panels (CDOPs) who are responsible for receiving child death notifications. Can be found at:

<https://www.gov.uk/government/publications/child-death-overview-panels-contacts>

### **Metropolitan Police**

In the case of a sudden death the Metropolitan Police will assist the school in any way that they can. However in a situation whereby the death is immediately unknown or sudden and unexplained e.g. where there is no evidence of a previous illness or working with equipment which may have contributed to the cause of death. Then the area will be treated as a crime scene.

In all cases the police will require statements from those that were present at the time of death or linked to the incident.

Whilst the police are investigating the incident they may also call upon the Health and Safety Executive who will attend site to inspect the crime scene. They may also be accompanied by representative professionals such as mechanical or electrical inspectors. The school will be required to provide statutory documentation on request e.g. electrical test and inspection certificates, maintenance records etc.

### **Corners Service**

Doctors or the Police must report deaths to a coroner in certain circumstances. These include where it appears that:

- no doctor saw the deceased during his or her last illness;
- the cause of death is unknown;
- the death occurred at work;
- the death was sudden and unexplained;
- the death was in other suspicious circumstances etc.

The coroner's office will be contacted by the police and they have three hours in which to attend to the deceased. In the case of adults, the deceased can only be dealt with by the coroner's office.

The police may not allow next of kin to attend the deceased until the coroner is in attendance.

When a death is investigated by a coroner, the coroner's office will contact the next of kin, where known, and where possible, within one working day of the death being

reported, to explain why the death has been reported and what actions are likely to follow.

A guide to the coroner's service can be found at:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/363879/guide-to-coroner-service.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/363879/guide-to-coroner-service.pdf)