



SOUTH WALES CHILD PROTECTION FORUM

# THE CORONERS PROTOCOL

Protocol between the seven within the South Wales  
Police area and  
The Coroners Association of South Wales

In relation to the commissioning, preparation and  
publication of case reviews whereby the death of a  
child is subject to a Coroners Inquest.

## **Introduction**

When a child dies the impact on a parent is traumatic. It is acknowledged that all professionals who are involved in the investigation of the death of a child, that the parents of the child are treated sympathetically and that whenever possible are kept informed of the course of actions that professionals must take.

This protocol has been agreed by the seven Local Safeguarding Children Boards, within the South Wales Police area Forum and The Coroners Association of South Wales. It sets out an agreed process for co-ordinating the commissioning, preparation and publication of Serious Case Reviews by the Local Safeguarding Children Board in relation to:

- the death of a child under 18 years
- which occurs in the area co-terminus with the South Wales Police Authority

and

- Is subject to a Coroners Inquest.

## **Purpose of the Protocol**

It is recommended ( Ref: *Luce Review* (2003) that there should be a protocol which takes into account the characteristics of the area and the configuration of the relevant children's health and social services and child protection networks. This will include :-

- National Care Standards Commission

The Coroner working with the Statutory Medical Assessor should retain the responsibility for investigating and reporting on cases. Where any criminal behaviour needs investigation, the prime responsibility is with the police.

The objectives of these arrangements should be to ;

- Provide the Coroner with information on risks to children to assist the Coroner in the selection of cases for investigation and the avenues of investigation that should be chosen
- Enable the Coroner quickly to find out whether, when a child dies there are family or other social circumstances relevant to the investigation, in particular any aspects of the family situation that trigger the reporting provisions above
- Provide such specialist support to the Coroner and his staff as they may need
- Set out arrangements for visiting the scene of death, and interviewing the family *Ref: SUDI Sudden Unexplained Death of Infants 2003. Please note: The Coroner should be notified of date and time of Strategy Meeting prior to this taking place*
- Set out arrangements under which the Coroner's Office will provide the children's and child protection services with information on the outcomes of investigations to help with their work
- Summarise policy in the area for the support of families who lose very young children

### **Commencement, Duration and Amendment of the Protocol**

This protocol will take effect from March 2008 and will continue unless cancelled or amended in accordance with the following provisions.

Where any party to this protocol wishes to withdraw from the protocol or withdraw any services or standards for which it has responsibility under this protocol the party is required to give:

- Not less than one month's written notice to the other parties to permit time for discussion relating to the reason for withdrawal.
- Detail of the standard or service to be withdrawn.
- The reason for the withdrawal.

## **Serious Case Reviews**

Under section 32(2) of the Children Act 2004, a Local Safeguarding Children Board is to have such functions as the Assembly may prescribe by regulation which may include functions of review and investigation. The Local Safeguarding Children Boards (Wales) Regulations 2005 require that where abuse or neglect of a child is known or suspected and

- A child dies or
- A child sustains a potentially life threatening injury or serious and permanent impairment of health or development, this may include cases where a child has been subjected to particular serious sexual abuse

The Local Safeguarding Children Board must conduct a Serious Case Review. Additionally, LSCBs should always undertake a serious case review where

- A child has committed suicide, or
- The child has been killed by a parent with mental illness.

*(Ref: Safeguarding Children: Working Together under the Children Act 2004, Sect 10.1)*

## **The Purpose of the Review**

“The purpose of case reviews carried out under this guidance is to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children.
- Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence
- To improve inter-agency working and better safeguard children.
- Identify examples of good practice

## **Process**

“Case reviews are not enquiries into how a child dies or who is culpable; that is a matter for the Coroner’s and Criminal Courts respectively to determine, as appropriate.” *Ref: Para 10.9 Safeguarding Children: Working Together Under the Children Act 2004*

When the death of a child occurs and the Local Safeguarding Children Board commissions a serious case review then:

- The police representative from the Public Protection Bureau on the Serious Case Review Panel will take the lead in any liaison with the Coroners Office. The representative will undertake enquiries with the coroner to identify whether an inquest will be held. If there is police investigation the representative from Public Protection will liaise with the SIO (Senior Investigating Officer).
- If an Inquest is to be held the Chair of the ACPC / LSCB will notify (in writing) the coroner in whose area the death occurs that a serious case review under Part 8 of *Working Together to Safeguard Children (2000)* is being undertaken.
- The terms of reference of the Case Review Panel should bear cognisance to this protocol.
- When the terms of reference of the review have been agreed by the LSCB, the Chair will forward them to the Coroner in whose area the death occurred and invite comments from the coroner as to any conflicts between the two separate processes.
- Should a conflict be identified then a meeting may be held between representatives of the LSCB Serious Case Review Panel and the Coroner in attempt to resolve the issues
- The police representatives from Public Protection Bureau attending the Serious Case Review Panel will liaise between the Coroner and the LSCB to identify Inquest timescales.
- Should the review be completed prior to the Inquest being held the Chair of the LSCB will forward the Executive summary to the coroner

prior to the report being published, and invite comments in relation to any conflicts between the two separate processes.

- Should a conflict be identified then a meeting may be held between representatives of the LSCB Serious Case Review Committee and the Coroner in attempt to resolve the issues
- Should there be a need to delay publishing the Serious Case review report in order that the Inquest is not compromised, then the Chair of the LSCB will notify the Welsh Assembly Government of the facts surrounding the delay.
- The Coroner would not be involved once the Inquest had taken place but would provide any necessary transcripts to the Serious Case Review Panel.

### Monitor and Review

This protocol will be reviewed by the signatories (annually) following its commencement.

On behalf of the Coroners Association of South Wales

Phillip Walters

Signed.....Date .....

On behalf of the Director of Social Services and / or Integrated Services

Signed.....Date.....Director of Cardiff

Signed.....Date.....Director of Neath Port  
Port Talbot

Signed.....Date..... Director of Bridgend

Signed.....Date .....Director of Merthyr  
Tydfil

Signed.....Date..... Director of RCT

Signed.....Date..... Director of Vale of

Glam

Signed.....Date..... Director of Swansea