



CHILD DEATH OVERVIEW PANEL PROCEDURES

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Acknowledgement

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1. Introduction

- 1.1 This Procedure sets a minimum standard for a Child Death Overview Panel (CDOP) as outlined in chapter 7 of the Government guidance [*Working Together to Safeguard Children \(DCSF, 2010\)*](#) (*Working Together*).
- 1.2 There are two inter-related processes for reviewing child deaths. Either process can trigger a serious case review.
- 1.3 The processes are:
 - A rapid response by a team of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child.
 - An overview of all child deaths (birth up to 18th birthday, excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) in the Buckinghamshire LSCB area, undertaken by a panel drawn from key organisations represented on the LSCB. This will include children who suffered with life limiting or life threatening conditions (LL/LT conditions), this Procedure applies.
- 1.4 The Buckinghamshire Safeguarding Children Board (BSCB) has a responsibility for convening and maintaining a CDOP.

2. Context

- 2.1 When a child dies within the area in which s/he normally resides, the LSCBs must collect and analyse information about each death with a view to identifying:
 - any case giving rise to the need for a review mentioned in Regulation 5(1) (e) of the Local Safeguarding Children Board Regulations 2006;
 - any matters of concern affecting the safety and welfare of children in the area of the authority.
 - any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area.
- 2.2 When a child dies outside of the area in which s/he normally resides, the two LSCBs may, in some cases, decide to conduct individual reviews (see paragraph 7.2).

Definitions

An unexpected death is defined as the death of an infant or child (less than 18 years old) which:

- was not anticipated as a significant possibility for example, 24 hours before the death; or
- where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death (DfES, 2010).

Preventable child deaths are defined as those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

3. Core Purpose

- 3.1 The CDOP will undertake an overview of all child deaths within the locality. This process uses a standard set of data (see <http://www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/childdeathreviewprocedures/childdeathreviewprocess/>) based on information available from those who were involved in the care of the child, both before and immediately after the death, and other sources such as:
 - Case summaries from health records;

- Case information from police, LA children's social care and education; and
 - Post mortem reports.
- 3.2 The CDOP has responsibility for reviewing the deaths of all children (excluding those deaths set out in paragraph 1.1), with priority given to those deaths that are both unexpected and unexplained.
- 3.3 If there is to be a serious case review, it will be undertaken by the LSCB where the child normally resides, with the decision taken by the LSCB Chair of that area.

4. Membership

- 4.1 The CDOP will be chaired by someone not involved with operational management of any service represented on the CDOP.
- 4.2 There will be a fixed core membership on the CDOP, which is drawn from the key organisations represented on the LSCB. There should be senior management representation from:
- Director of Public Health or representative
 - Coroner or Coroner's Officer
 - Consultant Paediatrician (SUDI paediatrician)
 - Children's Social Care
 - Police Child Abuse Investigation Unit
 - Child Health Nurse
 - Midwifery
 - Education
 - Ambulance/Paramedic services
 - Chair of Sub-Committee Serious case review
- 4.3 Other members will be co-opted as and when appropriate. This may be so that the membership of the CDOP better reflects the characteristics of the local population, to provide a perspective from the independent or voluntary sector or to contribute to the discussion of certain types of death e.g. Fire Brigade, adult mental health services, education / early years, bereavement services etc.
- Emergency Department medical/nursing staff
 - Primary Care
 - Other paediatric input, either hospital or community based, or relevant paediatric sub-specialties.
 - Obstetric staff
 - Other police representatives including accident investigators
 - Fire services
 - Social Services legal representative
 - Registrar of Births, Deaths and Marriage
 - Lay representative

5. Frequency of CDOP meetings

- 5.1 The CDOP should hold meetings on a regular basis to enable the circumstances of each child's case to be discussed in a timely manner. The frequency of the meetings should be every two to three months and reflect the number of cases.

6. Notification of child deaths

- 6.1 The CDOP Administrator (CDA) will be the single point of contact (SPOC) to be informed of all child deaths in the LSCB area, regardless of whether the child is resident in the area.

7. Deaths of children out of area

- 7.1 When a child dies in the area s/he is not permanently resident in, the SPOC for the area in which the child died will inform the SPOC in the area the child normally lived.
- 7.2 It should be decided on a case by case basis which Panel should take responsibility for gathering the necessary information for a Panel's consideration. In some cases this may be done jointly. The CDOP in the area where the death occurred will normally review the death and liaise with the area of permanent residency where appropriate. The two CDOPs may, in some cases, decide to conduct individual reviews. In these cases, the Chairs of both CDOPs must negotiate management of the two reviews to ensure that there is a uniform response.
- 7.3 Information sharing between two CDOPs when a child dies out of his / her normal residency area, is in addition to informing the coroner within 1 working day, and immediate notification of the designated paediatrician for unexpected deaths in childhood if the death was unexpected
- 7.4 If a child dies unexpectedly out of his/her normal residency area, the designated paediatricians for unexpected deaths in childhood from both areas will jointly decide on who will lead on the rapid response procedures.
- 7.5 The CDOP Chair is responsible for ensuring that this process operates effectively.
- 7.6 Children who die in hospital should be reviewed by the CDOP for the area in which they lived. The reviewing CDOP is responsible to inform the CDOP where the hospital is located.
- 7.7 The CDOP must review the circumstances of children who are normally resident in the area but who die abroad.

8. Key functions

8.1 The key functions of the CDOP are to:

- a) Receive notification on all child deaths occurring in the local area.
- b) Collect and collate an agreed national minimum data set.
- c) Seek information from professionals who had involvement with the child before and immediately following the death.
- d) Ensure that parents and family members are informed that their child's death will be reviewed and are given the opportunity to contribute to the review process.
- e) Evaluate the routinely collected data on the deaths of all children, and thereby identify lessons to be learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children.
- f) Assess all the cases with regard to the threshold criteria to enable specific cases to be reviewed in depth (see [Threshold criteria in appendix 2](#))
- g) Ensure that individual case discussions have taken place regarding unexpected child deaths.
- h) Monitor the appropriateness of the response of professionals to an unexpected death of a child, reviewing the reports produced by the rapid response team on each unexpected death of a child, making a full record of this discussion and providing the professionals with feedback on their work. Where there is an ongoing criminal investigation, the Crown Prosecution Service must be consulted as to what it is appropriate for the Panel to consider and what actions it might take in order not to prejudice any criminal proceedings.
- i) Scrutinise the recommendations from the reports compiled by the designated doctor for unexpected deaths.

- j) Identify any common themes from individual cases and consider these in more depth.
- k) Consider whether the death was avoidable, if so how such deaths might be prevented in the future.
- l) Identify any patterns or trends in the local data and reports these back to the LSCB.
- m) Consider the [*Framework for the Assessment of Children in Need and their Families \(Department of Health et al, 2000\)*](#) to assess any child, parent, social or environmental factors which could contribute to developing an understanding of the individual child's death (*Sidebotham and Fleming, 2007; p20-24*).
- n) Where a child either in custody or under the supervision of the Youth Offending Team (YOT) dies, the Local Management Review undertaken by the YOT in relation to this death should feed into the child death processes initiated by the CDOP.
- o) Alert the Chair of the LSCB about any deaths where, on evaluating the available information, the CDOP considers there may be grounds to undertake further enquiries, investigations or a serious case review and explore why this had not previously been recognised.
- p) Inform the Chair of the LSCB where specific new information should be passed to the coroner or other appropriate authorities.
- q) Provide relevant information to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family.
- r) Monitor the support and assessment services offered to families of children who have died.
- s) Monitor and advise the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths.
- t) Identify any public health issues and consider, with the Director of Public Health, how best to address these and their implications for both the provision of services and for training;
- u) Co-operate with regional and national initiatives to identify lessons on the prevention of unexpected child deaths e.g. the Confidential Enquiry into Maternal and Child Health (CMACE)¹
- v) Ensure each partner agency of the LSCB identifies a senior person with relevant expertise to have responsibility for advising on the implementation of the local procedures on responding to child deaths within their agency.

9. Consent and confidentiality

9.1 Information in CDOP meetings will not be anonymised.

9.2 Information will be shared in accordance with the Overarching Information Sharing Protocols in existence in each LSCB area. Parental consent is not required for this. It should only be shared with those who need to know as governed by the Caldicott Principles, the Data Protection Act and Working Together. Persons with parental responsibility (Children Act 1989) should be advised that the child's death will be subject to a review in order to learn any lessons that may help to prevent future deaths of children. This must be handled

¹ See CMACE Centre for Maternal and Child Enquiries (www.cemach.org.uk/)

sensitively. It should normally be done by the doctor confirming the child's death to the parents and followed up with a letter. (See [letter and leaflet for parents in appendix 5](#)).

- 9.3 All LSCB member agencies must be aware of the need to share information on all child deaths to enable the LSCB to carry out its statutory duty.
- 9.4 Members of the CDOP must sign a confidentiality agreement, including sharing and securely storing information (see [confidentiality statement in appendix 3](#)) when they join the CDOP. This agreement will be reviewed at each meeting.
- 9.5 In no case will any team member disclose any information regarding team discussion within the CDOP outside the meeting, other than pursuant to the mandated agency responsibilities of that individual. Public statements about the general purpose of the child death review process may be made, as long as they are not identified with any specific case.

10. Professional and family support

- 10.1 Before the CDOP meets, the Chair should consider what explanatory information is sent to the child's family (see [letter and leaflet for parents in appendix 5](#)).
- 10.2 The CDOP Chair should consider what feedback is given to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family.
- 10.3 The CDOP Chair should ensure that information is also received and evaluated by the CDOP regarding the services and immediate support offered to families of children who have died.

11. Learning from child deaths

- 11.1 The CDOP should monitor and advise the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths.
- 11.2 The CDOP should identify any public health issues and consider, with the Director of Public Health, how best to address these and their implications for both the provision of services and for training.
- 11.3 The CDOP should contribute to regional and national initiatives to identify lessons on the prevention of unexpected child deaths e.g. CMACE.

12. Reporting mechanisms

- 12.1 The CDOP must submit an annual report to Buckinghamshire LSCB each May. This information should include the total numbers of deaths reviewed, recommendations made by the panel about required future actions to prevent child deaths, and any further description of the deaths that the panel deems appropriate.
- 12.2 The LSCB is responsible for:
 - Disseminating the lessons to be learnt to all relevant organisations;
 - Ensuring that relevant findings inform the *Children and Young People's Plan*;
 - Acting on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children; and
 - Ensuring that data relating to child deaths is submitted to relevant regional and national initiatives to identify lessons on the prevention of unexpected child deaths.

Appendix 1: Terms of reference

Buckinghamshire Safeguarding Children Board Child Death Overview Panel

Terms of reference

1. Purpose

1.1 Through a comprehensive and multidisciplinary review of child deaths, the Buckinghamshire Safeguarding Children Board Child Death Overview Panel (CDOP) aims to better understand how and why children in Buckinghamshire die and use our findings to take action to prevent other deaths and improve the health and safety of our children.

1.2 In carrying out activities to pursue this purpose, the CDOP will meet the Local Safeguarding Children Board (LSCB) functions, as set out in paragraph 7.13 of Working Together to Safeguard Children (2010) (Working Together), in relation to the deaths of any children normally resident in the Buckinghamshire area:

(a) Namely collecting and analysing information about each death with a view to identifying –

- (i) any case giving rise to the need for a Serious Case Review
- (ii) any matters of concern affecting the safety and welfare of children in Buckinghamshire.
- (iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in Buckinghamshire.

(b) Establishing procedures for ensuring a coordinated response to an unexpected child death.

2. Objectives

Notification and data collection

2.1 The CDOP will seek to:

- Ensure, in consultation with the two Buckinghamshire Coroners' offices, local Registrars and Medical Examiners, that local procedures and protocols are developed, implemented and monitored, in line with the guidance in Chapter 7 of Working Together on enquiring into unexpected deaths;
- Ensure the accurate identification of every child death in the area;
- Ensure uniform, consistent reporting of the manner and cause of every child death in the area;
- Collect and collate the agreed national minimum data set of information on all child deaths in the area
- Establish mechanisms for appropriately involving parents and other family members in the child death overview and rapid response processes
- Ensure that these information gathering processes minimise distress to families; and
- Co-operate with regional and national initiatives to identify lessons on the prevention of unexpected child deaths e.g. the Confidential Enquiry into Maternal and Child Health (CEMACH.org.uk).

Case assessment and review

Case level

2.2 The CDOP will seek to:

- Review each case of child brought before it where it will:
 - Classify the cause of death;
 - Make a decision as to the preventability of the death;
 - Identify any modifiable factors; and
 - consider any recommendations that may be made about actions which could be taken to prevent such deaths in the future and to whom those recommendations should be made;
- Evaluate specific cases in depth, and identify any issues of concern or lessons to be learnt;
- Contact the LSCB Chair if it is thought that the criteria for a Serious Case Review might apply
- Where concerns of a criminal or child protection nature are identified, ensure that the police and Coroner are aware and inform them of any specific new information that may influence their inquiries; notify the Chair of the LSCB of those concerns and advise them on the need for further enquiries under section 47 of the Children Act 1989, or to recommend a serious case review.
- Decide what information will be shared with the family and how this can be done sensitively and appropriately

Population level

2.3 The CDOP will seek to:

- Evaluate data on the deaths of all children normally resident in the area (excluding those deaths set out in paragraph 1.1 of the Buckinghamshire CDOP Procedures), thereby identifying lessons to be learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children.

Service improvement

2.4 The CDOP will seek to:

- Improve agency responses to child deaths through monitoring the appropriateness of the response of professionals to each unexpected death of a child, reviewing the reports produced by the Strategic and Serious Cases Review Group and providing the professionals concerned with feedback on their work
- Provide relevant information to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family; and
- Monitor the support and assessment services offered to families of children who have died.

Prevention and advocacy

2.5 The CDOP will seek to:

- Identify significant risk factors and trends in individual child deaths and in the overall patterns of deaths in the area, including relevant environmental, social, health and cultural aspects of each death, and any systemic or structural factors affecting children's well-being to ensure a thorough consideration of how such deaths might be prevented in the future;
- Identify any public health issues and consider, with the Directors of Public Health and other provider services, how best to address these and their implications for both the provision of services and for training;
- Identify and advocate for needed changes in legislation, policy and practices to promote child health and safety and to prevent child deaths.
- Increase public awareness and advocacy for the issues that affect the health and safety of children; and
- Monitor and advise the Local Safeguarding Children Boards on the resources and training required locally to ensure an effective inter-agency response to child deaths.

3. Scope

3.1 The CDOP will gather and assess data on the deaths of all children from birth (excluding those babies who are stillborn, planned terminations of pregnancy carried out within the law) up to their 18th birthday who are normally resident in the area. This will include neonatal deaths, expected and unexpected deaths in infants and in older children. Where a child normally resident in another area dies within the area, that death shall be notified to the CDOP in the child's area of residence. Similarly, when a child normally resident in the area dies outside the area, the CDOP should be notified. In both cases, an agreement should be made as to which CDOP (normally that of the child's area of residence) will review the child's death and how they will report to the other.

4. Panel membership

- The Child Death Overview Panel will have a permanent core membership drawn from key organisations represented on the Buckinghamshire Safeguarding Children Board. Other members may be co-opted to contribute to the discussion of certain types of death when they occur.
- The CDOP Manager will attend all meetings and present additional information relevant to the proceedings of the panel.
- The CDOP Administrator will attend all meetings, provide papers and take minutes

5. Confidentiality and information sharing

Information discussed at the CDOP meeting will not be anonymised prior to the meeting, it is therefore essential that all members adhere to strict guidelines on confidentiality and information sharing. Information is being shared in the public interest for the purposes set out in Working Together and is bound by legislation on data protection.

CDOP members will all be required to sign a confidentiality agreement before participating in the CDOP/ Any ad-hoc or co-opted members and observers will also be required to sign the confidentiality agreement. At each meeting of the CDOP all participants will be required to sign an attendance sheet, confirming that they have understood and sign the confidentiality agreement.

Any reports, minutes and recommendations arising from the CDOP will be fully anonymised and steps taken to ensure that no personal information can be identified.

6. Accountability and reporting arrangements

The CDOP will be accountable to the chair of the Buckinghamshire Safeguarding Children Board.

The Child Death Overview Panel is responsible for developing its work plan, which should be approved by the Buckinghamshire Safeguarding Children Board. It will prepare an annual report for the Buckinghamshire Safeguarding Children Board which is responsible for publishing relevant, anonymised information.

The Buckinghamshire Safeguarding Children Board takes responsibility for disseminating the lessons to be learnt to all relevant organisations, ensures that relevant findings inform the Children and Young People's Plan and acts on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.

The Buckinghamshire Safeguarding Children Board will supply data regularly on every child death as required by the Department for Education to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of these deaths.

7 The role of core CDOP members

Public health:

7.1 The public health representative can:

- Provide the panel with information on epidemiological and health surveillance data;
- Assist the panel in strategies for data collection and analysis;
- Assist the panel in evaluating patterns and trends in relation to child deaths and in learning lessons for preventive work;
- Inform the panel of public health initiatives to support child health; and
- Advise the panel on the development and implementation of public health prevention activities and programmes.

Paediatrician:

7.2 The paediatrician can:

- Provide the panel with information on the health of the child and other family members, including any general health issues, child development, and health services provided to the child or family;
- Help the panel interpret medical information relating to the child's death, including offering opinions on medical evidence; providing a medical explanation and interpretation of the circumstances surrounding a child's death;
- Assist with interpreting the autopsy findings and results of medical investigations;
- Advise the panel on medical issues including child injuries and causes of child deaths, medical terminology, concepts and practices;
- Provide feedback and support to medical practitioners involved in individual case management; and
- Liaise with other health professionals and agencies.

Police:

7.3 The police representative can:

- Provide the panel with information on the status of any criminal investigation;
- Provide the panel with information on the criminal histories of family members and suspects;
- Identify cases that may require a further police investigation;
- Provide the panel with expertise on law enforcement practices, including investigations, interviews and evidence collection;
- Help the panel evaluate any issues of public risk arising out of the review of individual deaths;
- Liaise with other police departments, and the Crown Prosecution Service; and
- Feedback to police officers involved in individual case management.

Children’s social care:

7.4 The children’s social care representative can:

- Provide the panel with information on any social care involvement with the child and family, including any child protection concerns;
- Help the panel to evaluate issues relating to the family and social environment and circumstances surrounding the death;
- Advise the panel on children’s rights and welfare, and on appropriate legislation and guidance relating to children;
- Identify cases that may require a further child protection investigation, or a serious case review;
- Liaise with other local authority services; and
- Provide feedback to social workers and other local authority staff involved in individual case management.

Bereavement agency representative:

7.5 The bereavement representative can:

- Advise the panel on ongoing bereavement support needs for the family or others involved;
- Be an advocate for the family;
- Assist the panel in monitoring and evaluating the appropriateness of professional responses to child deaths;
- Provide support to other panel members, ensuring appropriate member care; and
- Facilitate the provision of support to other professionals involved in individual case management.

Child Health Nurse representative:

7.6 The Child Health Nurse representative can:

- Provide the panel with information on any child health involvement with the child and family, including any child protection concerns;
- Help the panel to evaluate issues relating to the family and social environment and circumstances surrounding the death;
- Identify cases that may require a further child protection investigation, or a serious case review;

Midwifery representative

7.7 The Midwifery representative can:

- Provide the panel with information on any midwifery health involvement with the child and family, including any child protection concerns;
- Help the panel to evaluate issues relating to the family and social environment and circumstances surrounding the death;
- Identify cases that may require a further child protection investigation, or a serious case review;

Education representative

7.8 The Education representative can:

- Provide the panel with information on any education involvement with the child and family, including any child protection concerns;
- Help the panel to evaluate issues relating to the family and social environment and circumstances surrounding the death;
- Identify cases that may require a further child protection investigation, or a serious case review;

8. Duties of the CDOP Chair and manager

8.1 The Chair of the CDOP is responsible for:

- Chairing the CDOP meetings, encouraging all team members to participate appropriately;
- Ensuring that all statutory requirements are met;
- Maintaining a focus on preventive work;
- Selecting cases for in-depth review by the CDOP, as part of the in core functions
- Ensure that new members receive an orientation to the panel prior to their first meeting;
- Facilitating resolution of agency disputes; and
- Ensuring that this process operates effectively
- Communicating the outcomes of decisions
- Provide an annual report to the Buckinghamshire Safeguarding Children Board.

8.2 The CDOP manager will be responsible for the smooth running of all child death review processes. S/he will:

- Be the designated person to whom the death notification and other data on each child death in the area should be sent;
- Ensure and monitor the effective running of the notification, data collection and storage systems;
- Determine meeting dates and send meeting notices to team members;
- Obtain names and compile the summary sheet of child deaths to be reviewed and distribute to team members two to three weeks prior to each meeting;

- Select, in consultation with the CDOP Chair, cases for in-depth review by the CDOP, following the principles set out in core functions;
- Ensure that notifications of child deaths are available for team review;
- Ensure that new members receive an orientation to the panel prior to their first meeting;
- Ensure that all new CDOP members, ad hoc members and observers sign a confidentiality agreement;
- Encourage the sharing of information for effective case reviews;
- Compile and disseminate notes from each CDOP meeting;
- Maintain the rota for the Child Death Rapid Response Team;
- Researching, collating and writing CDOP reports, including submitting an annual report to the LSCB; and
- Monitor the outcome of recommendations and prevention initiatives and activities. Liaising with senior staff across a range of agencies and promoting engagement at a strategic and operational level;
- Liaising with senior staff across a range of agencies and promoting engagement at a strategic and operational level;

8.3 The CDOP Administrator is responsible for:

S/he will:

- Be the designated person to whom the death notification and other data on each child death in the area should be sent;
- Ensure the effective running of the notification, data collection and storage systems;
- Book venues for panel meetings and send invitations to panel members;
- Obtain names and compile the summary sheet of child deaths to be reviewed and distribute with the agenda to panel members at least two weeks prior to each meeting;
- Ensure that all new CDOP members, ad hoc members and observers sign a confidentiality agreement;
- Take and disseminate minutes from each CDOP meeting;

9. Conflict resolution

9.1 The CDOP Chair should encourage panel members to form a consensus in their assessment of child deaths (e.g. whether a case should have been handled differently or whether the criteria for a serious case review, as set out in *Working Together* Chapter 8, are met in the opinion of the CDOP). However, where a consensus is not agreed, the Chair's decision is final.

Appendix 2: Threshold criteria

There are two levels or types of child death cases for the members of the Child Death Overview Panel (the CDOP) to consider.

For all deaths, the panel will use information collated from Form Bs to:

- Classify the cause of death using the categorisation schema produced by DCFS
- Make a decision as to the preventability of the death
- Identify any modifiable factors
- Consider any recommendations that may be made and to whom these should be addressed. (These include recommendations to escalate to Serious Case Review or about actions which could be taken to prevent such deaths in the future.)

Form C will be used to facilitate this discussion.

Level 1 – Scope: where the child’s death is ‘anticipated / not unexpected’ and likely to be more ‘straightforward’, with no additional complicating factors.

These are likely to be the substantial number of the deaths for review, and the majority are likely to be neonates. The panel may consider whether groups of similar deaths should be discussed at designated panel meetings.

Level 2 – Scope: where there are additional factors in relation to the child’s death. The CDOP will require papers additional to the core papers. The range of types of deaths meeting level 2 are listed below (this is not exhaustive):

- Any death that remains unexplained
- All deaths subject to the Rapid Response process
- All deaths resulting from:
 - Deliberately inflicted injury, abuse or neglect
 - Suicide or deliberate self-inflicted harm
 - Trauma and other external factors.

- Any death that has attracted public or media interest, subject to the governance panel of Buckinghamshire Safeguarding Children Board.

Additional papers may include:

- The minutes from Rapid Response meetings
- Additional B forms or reports from services working with the child/family
- Any reports on outcomes of Serious Case Reviews/ criminal proceedings/ coroner’s inquest or other investigations or reviews
- Possible summary of public/media coverage

Process – All CDOP members contract to read the CDOP case papers in advance of the meeting to avoid delay in scheduled meeting time. Any glaring questions or omissions should be communicated to the CDOP Chair in advance of the meeting and if they cannot be dealt with before the meeting, the case is withdrawn and deferred to a

subsequent panel with the required information / documents provided. This process requires secure communication systems to share information in a timely way.

CDOP will not be able to complete a review if the outcome of a Coroner's inquest is still pending.

Local data collection and analysis – All the agreed child and family specific data in relation to the death, preventability scoring and summary outcomes and recommendations must be recorded

This information should input into a secure electronic database for Buckinghamshire and allows the collation of all Buckinghamshire child death data for annual strategic analysis and recommendations.

Reporting – Local data, lessons and recommendations to be reported to the Safeguarding Children Board at least annually or more frequently, as agreed.

Appendix 4: Notification to the designated paediatrician for unexpected deaths in childhood and the LSCB of a child's death

Working Together to Safeguard Children (DfES, 2006 - WT) chapter 7 sets out a statutory requirement for the Local Safeguarding Children Board to review the deaths of all children up to their 18th birthday.

Section 7.51 (WT) states that the LSCB should be informed of all deaths of children normally resident in the LSCB's geographical area. The designated paediatrician for unexpected deaths in childhood (or delegate) will usually do this and should be notified of all child deaths in the area or of children usually resident in the LSCB area but who die in another area.

Local agencies responding to a child's death as well as informing the coroner, if needed, should inform the designated paediatrician for unexpected deaths in childhood (or delegate) for the LSCB area using the attached proforma. Information can be conveyed in a confidential telephone conversation but there should be agreement during this call as to who will take responsibility for completing the attached written notification proforma. Where the information is passed by telephone it will be helpful for both parties to have a copy of the proforma in front of them while talking to assist the sharing of information.

The information should be treated in strictest confidence.

Designated paediatricians:

Buckinghamshire Safeguarding Children Board Fax: **01296 382383**

Tel: **383485/382537**

The written Notification proforma should be completed as fully as possible and sent the same day. For deaths which occur after 5pm, at weekends or on bank holidays, the written Notification proforma should be sent by 10am the next working day. Parental consent is not required for this information to be passed to the designated paediatrician / Local Safeguarding Children Board. It should only be shared with those who need to know as governed by the Caldicott Principles, the *Data Protection Act* and *Working Together 2006*. Persons with parental responsibility (*Children Act 1989*) should be advised that the child's death will be subject to a review in order to learn any lessons that may help to prevent future deaths of children. This must be handled sensitively. There is a LSCB leaflet available to assist parents and others with parental responsibility in understanding the review process and how they can contribute. This would normally be done by the paediatrician confirming the child's death to the parents.

A death that is unexpected³ may require a Rapid Response service or a specific review of circumstances or an unexpected child death meeting as set out in the *LSCB Child Protection Procedures*⁴.

It will be the responsibility of the designated paediatrician (or delegate) and senior police officer in the case to agree the process that such a response will take. This may involve LA children's social care or other agencies as needed.

³ '... defined as a death of a child (birth to 18 years, excluding babies stillborn) which 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 led to the death'.

⁴ *LSCB Child Protection Procedures* – every agency must ensure that staff have access to a copy

Notification of Child Death

Form A - Notification of Child Death

Notification to be reported to CDOP Manager at: Email: cdop@buckscc.gov.uk

Tel: 01296 383485

Fax: 01296 382383

The information on these forms and the security for transferring it to the CDOP Co-ordinator should be clarified and agreed with your local Caldicott guardian.

If there are a number of agencies involved, liaison should take place to agree which agency will submit the Notification.

Child's Details

Full Name of Child		
Any aliases		
DOB / Age	/ / days/months/years	NHS No.
Address		
Postcode		
School/nursery etc		
Date & time of death	/ /	Time
Other significant family members		

Referral details

Date of referral	/ /
Name of referrer	
Agency	
Address	
Tel Number	
Email	

N.B. Page 1 can be removed for the purposes of anonymising the case. Page 2 should be made available with Form B to the child death overview panel.

Page 2 Details of the death:

Location of death or fatal event (Give address if different from above)			
Death expected?	<input type="checkbox"/>	Expected	<input type="checkbox"/> Unexpected [†]
Reported to Coroner		Y / N / NK / NA	Date: / /
			Name:
Reported to Registrar		Y / N / NK / NA	Date: / /
			Name:
Has a medical certificate of cause of death been issued?		Y / N / NK NA	Date: / /
Post mortem examination:		Y / N / NK / NA	Date: / /
			Venue:

† An unexpected death is defined as the death of an infant or child (aged under 18 years) where there is no prior condition that might be expected to cause the death at that time, and the child dies either immediately or subsequently from the consequences of the precipitating event or collapse.

Notification Details:

Please outline circumstances leading to notification. Also include if any other review is being undertaken e.g. internal agency review; any action being taken as a result of this death.

Details of Agency Contacts

Agency	Name, Address & Tel No.	Agency Report	
		Requested (date)	Received (date)
GP		/ /	/ /
Midwife/ Health Visitor/ School Nurse		/ /	/ /
Paediatrician		/ /	/ /
Police		/ /	/ /
Children's Social Care		/ /	/ /
School/ nursery etc		/ /	/ /
Others (list all agencies known to be involved)		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

Please fax the form to the relevant LSCB Single Point of Contact.

The fax should be marked **STRICTLY CONFIDENTIAL**

Appendix 5: Template for letter and leaflet for parents

XXX DATE XXX

Dear (PARENTS NAME)

I have been informed of the very sad death of your child (CHILDS NAME). I would like to express my sincere condolences to you and your family at this most difficult time.

My name is XXXXXXXXXXXX and I write to you as the Chair of the Child Death Overview Panel for Buckinghamshire. I am writing to you at this time because the law requires that every child death must be reviewed to see if there is anything that we, or anyone else, can do to improve services for children and their families in the future.

I need to let you know that we will now gather information about (CHILDS NAME) from health services/school/children's services and any other services that may have been involved with your family prior to (CHILDS NAME)'s death.

The leaflet enclosed explains the review process. I would be very pleased to hear from you if you have any information or views that you feel would help us to understand how (CHILDS NAME) died or any comments on the support offered to you.

If I can help with any questions you might have about the review process please feel free to contact me.

I do apologise for sending you this letter at this distressing and difficult time. We are confident that our work will bring about improvements in services for children and better support for bereaved families.

Yours Sincerely

XXXXXXXXXXXXXXXXXX

CHAIR - CHILD DEATH OVERVIEW PANEL