

# **Joint Guidance Between Staffordshire & Stoke on Trent Local Safeguarding Children Boards**

## **PART 10-E**

### **WHEN A CHILD DIES**

#### **E - CHILD DEATH OVERVIEW PANEL**

##### **CHILD DEATH OVERVIEW PANEL OPERATIONAL PROCEDURES**

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# **CHILD DEATH OVERVIEW PANEL OPERATIONAL PROCEDURES**

## **CORE FUNCTIONS OF THE CHILD DEATH OVERVIEW PANEL**

### **Statutory Responsibilities**

1. Collecting and analysing 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);
  - any matters of concern affecting the safety and welfare of children in the area of the authority; and
  - any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area.
2. Putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.
3. See the LSCB Regulations 2006, Statutory Instrument no. 2006/90).

### **Overview**

4. Staffordshire and Stoke on Trent Safeguarding Children Boards have agreed joint process to fulfil the statutory requirement to review the deaths of all children within Staffordshire and Stoke on Trent. This function will be undertaken by the Child Death Overview Panel.

### **Age Scope**

5. All deaths of children (excluding stillbirths) age 0 days - 17 years and 364 days.

### **Membership**

6. Refer to Appendix 2.
7. Any difficulties in achieving or maintaining required membership of the Panel will be communicated via the Child Death Review Panel Administrator to the Chair of the Panel and ultimately, if resolution cannot be reached, to the appropriate LSCB who will take supportive actions to address the issue.

### **Geographic Scope**

8. All deaths of children within the areas of Staffordshire County Council Local Authority and Stoke on Trent City Council Unitary Authority.

## **Definition of Preventable and Avoidable Factors**

9. Events, actions or omissions contributing to the death of a child or to substandard care of a child who died, and which, by means of national or locally achievable interventions can be modified (adapted from Krug, Pattison and Power, 2004). These factors would be amenable to primary, secondary or tertiary prevention.
10. The process for determining preventable and avoidable factors will be the analysis made within Form C data.
11. Frequency of the Child Death Overview Panel Meetings Quarterly for a fully day. To be reviewed after 6 months of this procedure becoming operational.

## **Chair**

12. The Chair of the Child Death Overview Panel should be agreed by and be a member of either Staffordshire or Stoke on Trent Safeguarding Children Boards. The Panel Chair should not be involved in providing direct services to children and families in their area. The current Chair has been agreed as Detective Superintendent Neil Hemmings.
13. The Chair of the panel is responsible for ensuring that the processes for the CDRP Administrator receiving death notifications and other data operates effectively.
14. They will chair all meetings encouraging all team members to participate appropriately, ensure that all statutory requirements are met, and maintain a focus on preventative work.
15. The Chair will make arrangements to facilitate the resolution of agency disputes.
16. The Chair will encourage the sharing of information for effective case reviews.
17. The Chair will report any difficulties which they cannot satisfactorily resolve regarding the operation of local procedures in relation to child deaths to the chairs of both LSCBs via written report.

## **Child Death Overview Panel Administrator**

18. The CDOP Administrator will be responsible for the smooth running of all child death review processes. He/she will:
  - Ensure and monitor the effective running of the notification, data collection and storage systems.
  - Determine meeting dates and send meeting notices to CDOP team members.

- Obtain names and compile the summary sheet of child deaths to be reviewed and distribute to team members two or three weeks prior to each meeting.
- 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.
- Support the Chair to compile and disseminate notes from each CDOP meeting.
- Complete and submit an annual report to the LSCB.
- Provide data to enable the panel to monitor the outcome of recommendations and prevention initiatives and activities.
- Complete quarterly reports detailing compliance with local procedures for responding to sudden and unexpected death in childhood, via collation of data from Form D - Audit Tool for Rapid Response.
- Collate all paperwork in advance required for the panel to function effectively.
- In advance of each CDOP, the CDOP Administrator should interrogate local data in order to populate Form E, Audit Tool for Child Death Overview Panels. This document should be presented to each planned CDOP meeting.

### **Core Functions of the Child Death Overview Panel**

Notification (See Part 10-B for detailed notification procedures).

19. In order to ensure complete data, these notifications will come from a number of sources including the Primary Care Trust(s); the Registrar of Births, Deaths and Marriages; the Coroner(s); Emergency Departments; Paediatricians; and the Police Force(s). Individual professionals will notify the CDOP co-ordinator at the same time as they notify the Coroner (in the case of an unexpected death) or Registrar/PCT. Each death should be notified to the CDOP of the area in which the child (or mother in the case of a neonatal death) was normally resident. If a different team (for example the CDOP for the area in which the child died) is notified, the [CDOP administrator] should notify their counterpart in the area of residence. For deaths occurring in an area different to that of the child's normal residence, an agreement must be reached between the two [CDOP administrators/chairs] as to which team will review the death (normally

the CDOP for the area of residence) and how the other team will be notified of the outcome.

### Data Collection

20. To collect a core data set of information relating to each child's death. (Collated Form B). A data collection tool (Form B) will be sent to the notifier and other key professionals. Data returned will be entered on a secure database. In addition to the core data set, for deaths requiring more in-depth review, further information will be sought from all involved agencies. This may include: case summaries from health records; case information from police, social care and education; autopsy reports and results of further investigations; relevant information on the family and social circumstances; scene reports from police child abuse investigation units or accident investigators.

### Panel Meetings

21. To meet on quarterly basis to review specified child deaths, drawing on comprehensive information from all agencies on the circumstances of each child's death. This information will be reviewed by the team in order to meet the objectives set out above. Whilst all deaths will be notified to the team and a core data set collected, not all deaths will be reviewed in detail. Particular consideration shall be given to the review of sudden unexpected deaths in infancy and childhood; accidental deaths; deaths related to maltreatment; suicides; and any deaths from natural causes where there are potential lessons to be learnt about prevention. The team will determine, and review on a regular basis, which deaths are to be reviewed in an in-depth manner.

### Additional Responsibilities of the CDO Panel

22. To receive reports from other reviews of child deaths, including individual case reviews for SUDI, and hospital reviews of perinatal deaths.
23. To review annually the numbers and patterns of deaths in the Local Authority areas of Staffordshire and Stoke on Trent.
24. To notify the Chair of the LSCB Children's Social Care, the Coroner and the Police of any cases identified where there are previously unrecognised concerns of a criminal or child protection nature.
25. To identify any lessons to be learnt from individual reviews or reviews of overall patterns and trends, including any system or process issues and any public health issues.
26. To monitor professional responses to child deaths, and identify good practice as well as any gaps or deficiencies in the process.
27. To make appropriate recommendations to the LSCB.
28. To provide the LSCB and constituent agencies with an annual report on the work of the team.

## **Confidentiality and Information Sharing**

29. Information discussed at the CDOP meetings 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.
30. 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 signed the confidentiality agreement.
31. 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.

## **Child Protection Concerns/Criminal Investigations**

32. 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.
33. If, during the enquiries, concerns are expressed in relation to the needs of surviving children in the family, discussions should take place with LA Children's Social Care. It may be decided that it is appropriate to initiate an initial assessment using the *Framework for the Assessment of Children in Need and their Families* (2000). If concerns are raised at any stage about the possibility of surviving children in the household being abused or neglected, the inter-agency procedures set out in Chapter 5 of *Working Together* should be followed. The Police and Coroner must be informed immediately that there is a suspicion of a crime or evidence comes to light that the death may be of a suspicious nature. The Chair of the LSCB should be informed of the case to ensure that appropriate procedures are followed and to consider the need for a Serious Case Review.

## **Taking Action to Prevent Child Deaths**

34. The most important reason for reviewing child deaths is to improve the health and safety of children and to prevent other children from dying. The CDOP will maintain a focus on prevention through all its work.
35. Individual deaths and overall patterns of childhood deaths will be evaluated to determine if the deaths were preventable; to identify modifiable risk factors (taking account of factors in the child, the parenting capacity, wider family, environmental and societal factors,

and services provided to or needed by the child or family); and to determine the best strategy(ies) for prevention.

36. Strategies may be considered at different levels:

- Strengthening individual knowledge and skills: Assisting individuals to increase their knowledge and capacity to act leading to behaviour change, through education, counselling and individual support.
- Promoting community education.
- Training opportunities to improve knowledge, skills, capacity and motivation to effectively promote prevention.
- Fostering coalitions and networks of individuals and organisations to work for advocacy and health promotion.
- Changing organisational practices where system failures are identified, or models of good practice highlighted.
- Mobilizing neighbourhoods and communities in the process of identifying, prioritizing, planning and making changes.
- Influencing policy and legislation where appropriate through local and national advocacy.

37. Recommendations made by the CDOP will be based on the lessons learnt from the review of child deaths, will be focused on specific, measurable actions, and will include plans for monitoring implementation.

### **Working with the Media**

38. Media interest in the work of the CDOP or in individual cases will be dealt with by the press officer for Staffordshire Police, in consultation with relevant agency communication leads. The annual report of the CDOP will be a public document and as such will have no identifiable information contained within it. Details of individual case discussions are to be kept confidential and in no circumstances will such details be passed to the press. The LSCB Managers will work proactively with the media to promote the work of the CDOP alongside that of the LSCB in safeguarding and promoting the welfare of children in Staffordshire and Stoke on Trent.

### **Designated Person to be Notified of all Child Deaths**

39. The Child Death Overview Panel Administrator is located in the Child Abuse Investigation Unit at Staffordshire Police HQ. They are the nominated person to be notified of all deaths.

### **Frequency of Child Death Overview Panel**

40. Quarterly for a full day.

### **Process for Notifications**

41. See Part 10-B paragraphs 3-17.

### **The Process for Data Collection**

42. See Appendix 6.

## **Child Death Overview Panel**

### **Terms of Reference**

#### **Purpose**

1. Through a comprehensive and multidisciplinary review of child deaths, the Staffordshire and Stoke on Trent Child Death Overview Panel (CDOP) aims to better understand how and why children in Staffordshire and Stoke-on-Trent die and use our findings to take action to prevent other deaths and improve the health and safety of our children.
2. In carrying out activities to pursue this purpose, the CDOP will meet the functions set out in paragraph 7.4 of *Working Together to Safeguard Children* in relation to the deaths of any children normally resident in Staffordshire and Stoke-on-Trent. 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 Staffordshire and Stoke-on-Trent
  - (iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in Staffordshire and Stoke-on-Trent

#### **Objectives**

3. To ensure, in consultation with the local Coroner, 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.
4. To ensure the accurate identification of and uniform, consistent reporting of the cause and manner of every child death.
5. To Collect and collate an agreed minimum data set of information on all child deaths in Staffordshire and Stoke-on-Trent and, where relevant, to seek additional information from professionals and family members. (Form B's will inform the data collection).
6. To evaluate data on the deaths of all children normally resident in Staffordshire and Stoke-on-Trent, 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.
7. To evaluate specific cases in depth, where necessary to learn lessons or identify issues of concern.
8. To identify significant risk factors and trends in individual child deaths and in the overall patterns of deaths in Staffordshire and Stoke-on-Trent, 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.

9. To identify any public health issues and consider, with the Director(s) of Public Health and other provider services how best to address these and their implications for both the provision of services and for training.
10. To identify and advocate for changes needed in legislation, policy and practices to promote child health and safety and to prevent child deaths.
11. To increase public awareness and advocacy for the issues that affect the health and safety of children.
12. Where concerns of a criminal and/or child protection nature are identified, to ensure that the Police and Coroner are aware and to inform them of any specific new information that may influence their inquiries; to notify the Chair of either Staffordshire or Stoke-on-Trent Local Safeguarding Child Board's of those concerns and advise the Chair of the possible need for a Serious Case Review; to inform Children's Social Care of the need for further enquiries under S47 of the Children Act 1989.
13. 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 rapid response team and providing the professionals concerned with feedback on their work.
14. To 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.
15. To monitor the support and assessment services offered to families of children who have died.
16. To monitor and advise the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths.
17. To co-operate with any regional and national initiatives – eg the Confidential Enquiry into Maternal and Child Health (CEMACH) – in order to identify lessons on the prevention of child deaths.

### **Scope**

18. The CDOP will gather and assess data on the deaths of all children and young people from birth (excluding those babies who are stillborn) up to the age of 18 years who are normally resident in Staffordshire and Stoke-on-Trent. 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 Staffordshire or Stoke-on-Trent, that death shall be notified to the CDOP in the child's area of residence. Similarly, when a child normally resident in Staffordshire or Stoke-on-Trent dies outside these areas the Staffordshire and Stoke-on-Trent 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.

### **Team Membership**

19. The Child Death Overview Panel will have a permanent core membership drawn from the key organisations represented on the LSCB. Other members may be co-opted to contribute to the discussion of certain types of death when they occur.

### **Confidentiality and Information Sharing**

20. Information discussed at the CDOP meetings 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.

21. 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 signed the confidentiality agreement.

22. 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.

### **Accountability and Reporting Arrangements**

23. The CDOP will be accountable to the Chairs of the Local Safeguarding Children Board.

24. The Child Death Overview Panel is responsible for developing its work plan, which should be approved by both Staffordshire and Stoke-on-Trent LSCBs. It will prepare an annual report for the LSCBs, which is responsible for publishing relevant, anonymised information.

25. The LSCBs take responsibility for disseminating the lessons to be learnt to all relevant organisations, ensuring that relevant findings inform the Children and Young People's Plans of both authorities and acting on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.

26. The LSCBs will supply data regularly on every child death as required by the Department for Children, Families and Schools to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of these deaths.

**Team Membership**  
**(As of June 2008)**

Det. Supt. Neil Hemmings	- Staffordshire Police - (Chair)
Det. Chief Insp Adrian Walker	- Staffordshire Police
Sally Rowe	- Assistant Director, C&LL, Staffordshire
Ian Young	- Head of Safeguarding, Children's Services, SOT
Vonni Gordon	- Staffordshire SCB Manager
Carole Preston	- SOT SCB Manager
Dr Gunjan Patel	- Designated Doctor for CP, South Staffs
Dr Ros Negrycz	- Designated Doctor for CP, North Staffs
Alison Pryce	- Public Health, South Staffs
Heather Widdowson	- Designated Nurse for CP, South Staffs
Angela Willdigg	- Designated Nurse for CP, North Staffs
Steve Edwards	- Clinical Governance Manager, Staffordshire Ambulance
Paula Carr	- Designated Nurse for CP, SOT

**Staffordshire & Stoke on Trent Local Safeguarding Children Boards**  
**Child Death Overview Panel**

**Confidentiality Statement**

The purpose of the Child Death Overview Panel is to conduct a thorough review of all preventable child deaths in Staffordshire and Stoke-on-Trent in order to better understand how and why children die and to take action to prevent other deaths.

In order to assure a co-ordinated response that fully addresses all systematic concerns surrounding child deaths, all relevant data should be shared and reviewed by the team, as permitted within the stipulations of the Data Protection Act, including historical information concerning the deceased child, his or her family, and the circumstances surrounding the death. Much of this information is protected from public disclosure.

The Staffordshire and Stoke-on-Trent LSCB shared procedures for child death reviews stipulate that in no case will any team member disclose any information regarding team discussion 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.

The undersigned agrees to abide by the terms of this confidentiality policy.

Name	Agency	Signature	Date
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**Standard Agenda**

Under consultation.

## **DATA COLLECTION**

1. The CDOP Administrator is responsible for co-ordinating the process of data collection in relation to all child deaths in the areas of Staffordshire and Stoke on Trent.
2. Data relating to all deaths of children both expected and unexpected will be collated on the standard DCSF templates - Form B - B11.
3. Analysis of the data relating to all deaths of children in Staffordshire and Stoke on Trent will be analysed via the DCSF standard template - Form C - Analysis Pro forma.
4. Data in relation to the operation of the rapid response process for sudden and unexpected deaths of children will be collated via the DCSF standard template Form D - Audit Tool for Rapid Response.
5. Data in relation to the overall functions of the CDOP will be collated in advance of each CDOP on the DCSF standard template, Form E - Audit Tool for Child Death Overview Panels.
6. A further local form has been produced, taken from the Warwick materials, for use by the Paediatrician/DDUD, at the first interview and home visit, for sudden and unexpected deaths in infancy (SUDI).

### **Process of Data Collection for Child Deaths which are Expected**

7. The CDOP Administrator receives Form A - Notification.
8. The CDOP Administrator identifies relevant local agencies who may have been involved. It is important to ensure that onward referrals are made should any criminal or child protection concerns become apparent. Efforts should also be made to ensure that relevant agencies are providing appropriate care and support to the family.
9. Having identified involved agencies, the CDOP Administrator will send a Form B - Agency Report Form to all involved, requesting completion of the form within 2 weeks of receipt. All agencies are not required to complete all sections of the form, only those parts on which they can justifiably report.
10. The CDOP Administrator will then collate all Form B's received onto one form. This collated Form B will form the Case Summary and input into the child overview panel.

11. Where a post mortem has been conducted, the CDOP Administrator will contact the lead doctor identified for the child who will be asked to complete Form B11 - Summary of Post Mortem findings. A full copy of the post mortem report/copy of the final discharge/death summary should also be provided. For each expected death the CDO Panel will use the collated Form B to inform the completion of Form C - Analysis Pro forma.

### **Process of Data Collection for Child Deaths which are Unexpected/Sudden**

12. The CDOP Administrator receives Form A - Notification.
13. The CDOP Administrator liaises with the Designated Doctor for Unexpected Deaths in childhood, to ensure they are aware of the death.
14. Having identified involved agencies, the CDOP Administrator will send a Form B - Agency Report Form, to all involved. Agencies will populate this form within 2 weeks of receipt, or immediately following the case 'Case Discussion 2' if this is later. Completed Form B's should be forwarded to the CDOP Administrator who will collate them into a form. The collated Form B should be retained for the purposes of the CDO Panel and also forwarded back to the DDUD, with a copy of Form C - Analysis Pro forma, for use at the Final Case Discussion.
15. At the Final Case Discussion the DDUD and involved professionals should complete FORM (Analysis Pro forma). This should then be forwarded to the CDOP Administrator. Where relevant Form D - Audit Tool for Rapid Response, should also be completed.
16. For each unexpected death the CDO Panel will review the findings of the Form C, as prepared for them by the DDUD and members of the 'Final Case Discussion' to ensure its contents are agreed by them.