www.safeguardingchildren.stoke.gov.uk

The Child Death Overview Panel

STAFFORDSHIRE Safeguarding Children Board www.staffsscb.org.uk

A Quick Guide

What is the Child Death Overview Panel?

The Child Death Overview Panel (CDOP) is a panel of senior professionals from various agencies responsible for reviewing anonymised information on all child deaths up to the age of 18 years in Staffordshire and Stoke-on-Trent.

The majority of child deaths in England arise from medical causes. The CDOP aims to keep an appropriate balance between forensic and medical enquiries, while at the same time supporting the family at a difficult time.

What is the purpose of the CDOP and the review process?

The process of systematically reviewing the deaths of children is based on the rights of children and their families to understand why the death occurred and ensure lessons learned are acted on.

The purpose of a child death review is to identify any modifiable factors contributing to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken from the death and the way services cared for the family.

Whenever a child dies, practitioners should work together in responding to that death in a thorough, sensitive and supportive manner. Thus the aims of the Child Death Review process are to:

- establish, as far as is possible, the cause of the child's death
- identify any modifiable contributory factors
- provide ongoing support to the family
- learn lessons in order to reduce the risk of future child deaths and promote the health, safety and wellbeing of other children
- ensure that all statutory obligations are met.

Who is on the panel?

In Staffordshire, the panel is chaired by Detective Superintendent Jennie Mattinson and has representatives from:

- Public Health
- Local Authority Children's Services
- Child Health Services
- Police

On occasion the panel co-opt experts to assist their information gathering and analysis.

How do the reviews happen?

The panel meets five times a year. All the information presented is anonymised and is treated with sensitivity and respect.

How do we involve parents /carers with the process?

Parents/carers receive a leaflet from either the hospital, hospice, CDOP Nurse, Designated Doctor or police officer after their child's death advising them about the Child Death Review process.
This leaflet gives advice on how they can express their views and feed into the panels' review if they wish to, along with sources of local bereavement support.

How does the panel report its findings?

The panel provides an annual report that is publically available and can be found on both the Staffordshire and Stoke-on-Trent Safeguarding Children Boards websites.
All reports prepared by the panel are based on aggregated information and no personal case information is included in them.
The statutory framework that underpins this information is laid down in Working Together to Safeguard Children 2018.