Bexley Local Safeguarding Children Board Procedure for Multi-Agency Response to the Child Death Overview Process

Part 2 – Child Death Overview Panel

This procedure applies to all agencies and voluntary organisations who work with children and young people and their families in Bexley.

(Review date –April 2017**)**

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1. Introduction

1.1. The procedures are compliant with the requirements for the Child Death Overview Process (CDOP) as outlined in *Working Together to Safeguard Children* (DfE 2015).

1.2. There are two inter-related processes for reviewing child deaths. Either process can trigger a serious case review. 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 babies stillborn) in the LSCB area, undertaken by a panel drawn from key organisations represented on Bexley Safeguarding Children Board (BSCB).

1.3. Part 1 of the procedures applies to the Rapid Response required when a child dies unexpectedly. The procedure enables the capturing of immediate information about unexpected child deaths. In addition it will assist the support to the bereaved family.

1.4. Part 2 of the procedures applies to the Child Death Overview Panel (CDOP) and every LSCB has a responsibility for convening and maintaining a CDOP.

1.5. The CDOP will undertake a review of all child deaths in their area using a standard set of data.

1.6. The CDOP will collect and analyse information about each death with a view to identifying:

- Any case giving rise to the need for a Serious Case Review
- Any matter of concern affecting the safety and welfare of children in the area
- Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area

1.7. The CDOP has a responsibility for reviewing the deaths of all children with priority given to those that are unexpected.

2. Membership

The Core Membership of the CDOP in Bexley is:

- Head of Service, Ellenor Lions Hospice
- Designated Nurse Safeguarding Children, Bexley CCG (Chair)
- Consultant in Public Health,
- Oxleas NHS Trust (Community Services)
- Designated Doctor for child deaths
- Child Abuse Investigation Team, Metropolitan Police
- Head of Service, Professional Standards and Quality Assurance, Children's Social Care, LB Bexley
- Serious Incidents Manager, Lewisham and Greenwich NHS Trust (Queen Elizabeth Hospital)
- Consultant Paediatrician Dartford and Gravesham NHS Trust (Darent Valley Hospital)
- Single Point of Contact (SPOC), Administrator, BSCB

The roles and responsibilities of CDOP members can be found in *Appendix 1.*

3. Frequency of meetings

The CDOP meetings are held quarterly.

4. Notifications of Child Deaths

All child deaths should be notified to the Single Point of Contact (SPOC) who will collate all the information for the information templates for discussion at the CDOP meeting.

5. Deaths of children out of the area

5.1. When a child dies in an area that s/he does not reside in the SPOC for the area in which the child dies will inform the SPOC in the area where the child normally resided.

5.2. The CDOP in the area where the death occurred will normally review that death and liaise with the CDOP in the resident area.

5.3. On occasions CDOPs may decide to conduct individual reviews. In this case it is the responsibility of the Chairs of the CDOPs to negotiate the management of the reviews.

6. Process for gathering information on all child deaths

6.1. If a child dies unexpectedly the process in Part 1 of these procedures will be followed. It is the responsibility of Designated Paediatrician for Unexpected Deaths in Childhood to ensure all relevant information is appropriately reflected in the information gathering and reports to the CDOP.

6.2. For all other deaths the Notification (Form A) will be sent to the SPOC who will co-ordinate the gathering of information.

6.3. The Agency Report Forms (Form B) must be completed by each agency that has knowledge of the family or the circumstances of the death. These will be sent out by the SPOC with agreed timescales for return.

6.4. The Overview Report (Form C) will be collated by the Designated Paediatrician or person delegated by them. Consideration has to be given in this report as to whether the case meets the criteria for a full case discussion at the CDOP.

7. Key functions of the CDOP

The key functions of the CDOP are to:

- Receive notification on all child deaths occurring in the local area.
- Collect and collate an agreed national minimum data set.
- Seek information from professionals who had involvement with the child, before and immediately following the death and, where relevant, the child's family members.
- Evaluate the data available and 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.
- Ensure that Rapid Response discussions have taken place regarding unexpected child deaths.
- 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 CDOP to consider and what actions it might take in order not to prejudice any criminal proceedings.
- Scrutinise the recommendations from the reports compiled by the designated paediatrician for unexpected deaths.
- Identify any common themes from individual cases and consider these in more depth.
- Consider whether the death was avoidable, if so how such deaths might be prevented in the future.

- Identify any patterns or trends in the local data and report these back to BSCB.
- Consider any report from Children's Social Care that includes an assessment of parenting and environmental factors.
- Alert the Chair of BSCB 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.
- Inform the Chair of BSCB where specific new information should be passed to the Coroner or other appropriate authorities.
- 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.
- Monitor the support and assessment services offered to families of children who have died.
- Monitor and advise BSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths.
- 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.
- Co-operate with regional and national initiatives to identify lessons on the prevention of unexpected child deaths
- 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.

8. Consent and confidentiality

8.1. Information in CDOP meetings will not be anonymised.

8.2. Parental consent is not required for this information to be passed to the designated paediatrician for unexpected deaths in childhood or BSCB SPOC. It should only be shared with those who need to know as governed by the *Caldicott Principles* the *Data Protection Act* and *Working Together.*

8.3. 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 prevent future deaths of children. This must be handled sensitively. It should normally be done by the doctor confirming the child's death to the parents, or Coroner's officer. The CDOP leaflet, *The Review When a Child Dies*, will assist in explaining the role of CDOP

8.4. 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.

8.5. Members of the CDOP must sign a confidentiality agreement, including sharing and securely storing information. This agreement will be reviewed at each meeting.

8.6. 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.

8.7. 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.

9. Professional and family support

9.1. Before the CDOP meets, the Chair should consider what explanatory information is sent to the child's family based on a report from the Designated Paediatrician for Unexpected Deaths in Childhood, or LSCB Manager/SPOC. (For example, the CDOP leaflet, *The Review When a Child Dies*.)

9.2. 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.

9.3. The CDOP Chair should ensure that information is also received and evaluated by the CDOP regarding the services and immediate support offered to all families of children who have died.

10. Learning from child deaths and report to BSCB

10.1. The CDOP should monitor and advise BSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths.

10.2. 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.

10.3. The CDOP should contribute to regional and national initiatives to identify lessons on the prevention of unexpected child deaths

11. Reporting mechanisms

CDOP must submit an annual report to Bexley Safeguarding Children Board (BSCB). BSCB is responsible for:

- Disseminating the lessons to be learnt to all relevant organisations.

- Ensuring that relevant findings inform the Joint Service Needs Analysis (JSNA)
- Acting on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.
- 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

Child Death Overview Panel

The role of Child Death Panel members

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

1. Public Health:

The public health representative can:

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

2. Paediatrician:

The paediatrician can:

- Provide the team 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 team 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 team 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
- Liaise with other health professionals and agencies

3. Children's Social Care:

The children's social care representative can:

- Provide the team with information on any social care involvement with the child and family, including any child protection procedures
- Provide the team with information on other children in the home and any previous reports of neglect or abuse
- Help the team to evaluate issues relating to the family and social environment and circumstances surrounding the death
- Advise the team 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
- Provide feedback to social workers and other Local Authority staff involved in individual case management

4. Police:

The police representative can:

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

5. Designated Nurse:

The Designated nurse can:

- Provide the team with information on the health of the child and other family members, including primary care services provided to the child and family
- Help the team to evaluate health issues relating to the circumstances of the child's death
- Advise the team on nursing practices that may have had a bearing on the child's health or well-being
- Assist the team in developing appropriate preventive strategies
- Liaise with other nursing and allied health professionals
- Provide feedback and support to nursing colleagues involved in individual case management

6. Hospital representatives:

The hospital representatives can:

- Provide the team with information on the circumstances of death in the hospital
- Help the team to evaluate health issues relating to the circumstances of the child's death
- Obtain information from the hospital consultant in respect of a child's pre-existing condition
- Assist the team in developing policy and procedures in relation to links with the hospital