

POLICY AND PROCEDURES FOR BURY, OLDHAM AND ROCHDALE CHILD DEATH OVERVIEW PANEL

1 POLICY

- 1.1 The purpose of the Bury, Oldham and Rochdale Child Death Overview Panel (CDOP) is to provide an overview of all deaths of children who are resident in the Bury, Oldham and Rochdale area; or where the root cause of death lies within the Bury, Oldham and Rochdale area.
- 1.2 The aim is for the information from the CDOP to contribute to the reduction of local childhood deaths, and serious and permanent impairment to the health and development of children and young people.
- 1.3 The CDOP will maintain a focus on prevention through all its work.
- 1.4 Working Together to Safeguard Children 2006 underpins the work of the CDOP.

2 Terms of reference

- 2.1 The terms of reference for the CDOP were agreed by the CDOP Steering Group, made up of representatives from Bury Safeguarding Children Board (BSCB), Oldham Local Safeguarding Children Board (OLSCB) and Rochdale Borough Safeguarding Children Board (RBSCB) on the 2nd November 2007. They are as follows:-
 - To consider the circumstances of all deaths of persons under eighteen,
 - To collate and analyse information about each death with a view to identifying any case that requires a serious case review; any matters of concern affecting the safety and welfare of children in the area and any wider public health or safety concerns arising from a particular death or pattern of deaths
- 2.2 This Policy and Procedure relates only to the operation of the Child Death Overview Panel which must be read in conjunction with the protocol of how Bury, Oldham and Rochdale will work together.
- 2.3 The protocol details the
 - Membership arrangements from the respective LSCBs and timescales for membership
 - Accountability
 - Designated Person's role
 - Agreed channels of communication to the individual LSCBs

2.4 Membership of the CDOP

2.4.1 The CDOP has a permanent core membership drawn from the key organisations represented on LSCBs. This will include

- Director of Public Health or representative
- Consultant Paediatrician
- Children's Social Care
- Police
- Education
- Mental Health Services
- Child Health

2.4.2 See protocol for role of core CDOP members

2.4.3 Other members may be co-opted as and when necessary to contribute to the discussion of certain types of death when they occur, e.g. fire fighters for house fires.

2.4.4 At any one time there should be

- Representation from each of the three LSCBs
- The Chair plus 50% of members present
- Representatives from Health and Children's Social Care

2.4.5 The Chair of CDOP must be a member of one of the Boards and should not be involved in providing direct services to children and families in the area.

2.4.6 Members should prioritise attendance at CDOP. Members are responsible for designating a named deputy, and if they are unable to attend, they must ensure that the deputy can attend and that they are fully briefed.

2.4.7 There is a clear relationship with the local Coronial Service through a protocol.

3 Functions of the CDOP

3.1 To receive notifications of the deaths of all children from birth to 18 years in the Bury, Oldham and Rochdale area. Each death should be notified to the CDOP of the area in which the child (or mother in the case of a neo-natal death) was normally resident. If a different panel (e.g. the CDOP for the area in which the child died) is notified, the Designated Person, should notify their counterpart in the area of the child's residence.

3.2 To collect a core data set of information relating to each child's death. By using the 'Agency Report Form' (Form B) and the 'Notification Form' (Form A) which will be completed professionals bodies involved in the child's life and stored on the 'secure website'. This may include information from: -

- Health records,
- Police,
- Children's Services (including social care and schools);
- Autopsy reports and results of further investigations;
- Relevant information in the family and social circumstances;
- Scene reports from police child abuse investigations units or accident investigators
- Etc...

3.3 To meet on a regular basis to review the data on each child's death. Whilst all deaths will be notified to the panel and a core data set collected, not all deaths will be reviewed in detail. Particular consideration will be given to the review of sudden unexpected deaths in infancy and childhood; accidental deaths; 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.

3.4 NB: - All deaths where abuse or neglect is known or suspected to be a factor in the child's death will be dealt with by the area LSCB.

3.5 To receive reports from other reviews of child deaths, including individual case reviews for SUDI and hospital reviews of perinatal deaths. This would be a part of the collation of information, and would require only relevant information.

3.6 To review annually the numbers and patterns of deaths in Bury, Oldham and Rochdale.

3.7 To notify the Chair of the relevant LSCB, the coroner and the police of any cases identified where there are previously unrecognised concerns of a criminal or child protection nature; and to explore why this had not previously been recognised. Also 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

3.8 To identify any lessons to be learnt from individual reviews or reviews of overall patterns and trends, including any system and process issues and any public health issues.

3.9 To monitor professional responses to child deaths and identify good practice as well as any gaps or deficiencies in the process

3.10 To make appropriate recommendations to the relevant LSCB(s)

3.11 To provide an annual report for distribution to each LSCB. This will identify any trends, and should comment on training/ resource issues to ensure an effective inter-agency response to child deaths.

3.12 To monitor the support and assessment services offered to families of children who have died

- 3.13 To co-operate with regional and national initiatives e.g. the Confidential Enquiry into Maternal and Child Health (CEMACH) to identify lessons on the prevention of unexpected child deaths

4 Process for Referral to the Child Death Overview Panel

4.1 Notification of Deaths

- 4.1.1 Each LSCB has a Designated Person to whom deaths should be notified: -

- Bury Designated Nurse PCT Tel 0161 762 2713
- Oldham Designated Nurse PCT Tel 0161 622 6500
- Rochdale Designated Nurse PCT Tel 01706 702077

- 4.1.2 Notifications may come from a number of sources-

- The PCT,
- The Registrar,
- The Coroner,
- Accident and Emergency Departments,
- Paediatricians
- The Police Service
- Etc...

- 4.1.3 The professional confirming a child's death should always notify the Designated Person for that area, by using the 'Child Death and Serious Cases Notification Form (Form A)'.

4.2 Preliminary Actions of the Designated Person:

- 4.2.1 Once the Designated Person has received notification / or a referral of a child death they will then start complete the 'Agency Report Form' (Form B) and the 'Notification Form (Form A)' on the secure website

- 4.2.2 The Designated Person will liaise with the: -

- CDOP Administrator to inform them that there is a new referral on the Secure Website
- her/his opposite number if the child is normally resident in another area.

4.3 Role of CDOP Administrator

- 4.3.1 The CDOP Administrator will inform the nominated person for Social Care, Police, Education within the appropriate Local Authority that a child death has occurred and that they are required to complete the appropriate part of 'Agency Report Form' (Form B) and 'Notification Form (Form A)' on the Secure Website.

- 4.3.2 The CDOP Administrator will inform the Fire Service and other relevant agencies when appropriate to complete information on the

'Agency Report Form' (Form B) and the 'Notification Form (Form A)' on the Secure Website.

4.3.3 The CDOP Administrator will ensure that the minutes and the agenda has sent out one week before the Panel meet.

4.3.4 The CDOP Administrator to make any papers child death anonymous prior to the CDOP.

4.3.5 The CDOP Administrator will complete all tasks discussed within the CDOP Administrators job description.

4.4 Role of the CDOP Chair:

4.4.1 The CDOP Chair will be responsible for informing the Local Safeguarding Children Board Chair in each authority if the Panel is not operating effectively.

4.4.2 To complete the tasks identified in the CDOP Chair job description. (link)

4.5 Flow Chart: Appendix 1 describes the work flow processes for the Child Death Overview Panel.

4.6 Arrangements for the meeting of the Child Death Overview Panel:

4.6.1 Meetings of the CDOP are held every 2 months. The agenda will be set by the Chair and meetings minuted, and distributed by the CDOP Administrator.

5 Practice Guidance

5.1 Conduct of the CDOP Meeting:

5.1.1 There will be a clear agenda, focussed on cases: it is expected that on average there will be three to six deaths will be discussed at each Panel meeting. The anticipated length of each meeting will be two to three hours.

5.1.2 Paperwork will be distributed one week in advance. All CDOP members will read the 'Agency Report Form' (Form B) information prior to the meeting in preparation for the Panel.

5.1.3 Individual deaths and overall patterns of childhood deaths will be evaluated using 'Agency Report Form' (Form B) 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 service provided to or needed by the child or family) and
- to determine the best strategies for prevention.

5.1.4 The CDOP will consider the information available and ascertain if they require more information to evaluate the child's death.

5.2 Options for the Outcome of the CDOP Meeting

5.2.1 The Panel has the following options: -

- to identify any case that requires a Serious Case Review
- to identify any cases where they believe an Agency Management Review would be appropriate
- to identify any matters of concern affecting the safety and welfare of children in the area and
- to identify any wider public health or safety concerns arising from a particular death or pattern of deaths

5.3 Serious Case Review (SCR)

5.3.1 It is likely that this will have already been identified by the specific LSCB, and be underway. However if the CDOP believes that there is information to suggest an SCR should take place and is/has not, then the Chair of the CDOP will inform the Chair of the relevant Board (and the relevant SCR Panel) of this matter. The SCR Panel will then follow their agreed LSCB procedures. The individual LSCB should be feedback to the Panel on what action, if any, they are intending to take. A copy of SCR Executive Summary will be sent to the CDOP Chair for information.

5.4 Management Reports

5.4.1 It is likely that this will have already been identified by the specific LSCB, and be underway. However the CDOP may decide that there are lessons to be learned, and Management Reports should be requested. This request will be sent, with reasons attached, to the Chair of the relevant Board and the Chair of the relevant SCR Panel. The SCR Panel will then follow their agreed LSCB procedures. The individual LSCB should feedback to the Panel on what action, if any, they are intending to take.

5.5 Matters of Concern for Children in an Area

5.5.1 It may decided there are no inter-agency issues which are required to be explored further, for example an accidental death or Sudden Infant Death may fall into this category. However, the information which is gained may influence future work and developments (see below).

5.6 Wider Public Health or Safety Concerns

5.6.1 There needs to be a regular review of patterns and trends of all child deaths. When any public health issues are identified, these need to be considered with the Director/s of Public Health as to how best to address these and their implications for both the provision of services and for training

5.6.2 Strategies may be considered at different levels:

- Strengthening individual knowledge and skills: assisting individuals to increase their individual knowledge and capacity to act leading to behavioural change, through education, counselling an individual support.

- Promoting community education
- Training providers 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 systems failures are identified, or models of good practice highlighted.
- Mobilising neighbourhoods and communities in the process of identifying, prioritising, planning and making changes.
- influencing policy and legislation where appropriate through local and national advocacy

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

5.7 Other Issues for Discussion at Panel Meeting

5.7.1 The Panel should

- 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 and providing them with feedback on their work; the audit tool for Rapid Response to be used.
- Monitor the support and assessment services offered to families of children who have died

5.8 Confidentiality and Information Sharing

5.8.1 Information discussed at CDOP meetings should be made anonymous prior to the meeting. All members must 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 2006 and is bound by legislation on data protection.

5.8.2 CDOP members will 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.

5.8.3 Any reports, minutes and recommendations arising from the CDOP will be made anonymous and steps taken to ensure no personal information can be identified.

5.8.4 The information given to parents must be carefully managed.

5.9 Accountability and Reporting arrangements

5.9.1 The CDOP is accountable all three Local Safeguarding Children Boards.

- 5.9.2 The CDOP is responsible for developing its work plan, which should be approved by each of the three LSCBs. It will prepare an Annual Report for the LSCBs. The individual LSCBs are responsible for publishing any relevant information from the report.
- 5.9.3 The individual Boards will take responsibility for disseminating the lessons to be learnt to all relevant organisations.
- 5.9.4 The individual Boards are responsible for ensuring that relevant findings inform the Children's and Young People's Plan.
- 5.9.5 The individual Boards are responsible to act on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.
- 5.9.6 The LSCBs will supply data regularly on every child death as required by the DCSF to bodies commissioned by the DCSF to undertake and publish nationally comparable, anonymised analyses of these deaths. Minutes of the discussion and outcome of cases discussed will be circulated to Panel Members and the Chairs of Local Safeguarding Children Boards.