



TELFORD & WREKIN/SHROPSHIRE SAFEGUARDING CHILDREN BOARD

CHILD DEATH OVERVIEW PANEL (CDOP)

Operational Procedures

Core Functions of the Child Death Overview Panel

1. To receive notifications of the deaths of all children from birth to 18 years (excluding still births) in Telford & Wrekin and Shropshire. In order to ensure complete notification, these notifications will come from a number of sources including Telford & Wrekin Primary Care Trust and Shropshire County Primary Care Trust; the Registrar of Births Deaths and Marriages; the Coroner(s); Emergency Departments; Paediatricians; and Police. Individual professionals will notify the Designated Doctor (SUDIC Paediatrician), via the key administrator to the Panel e-mail address and phone number and notify the Coroner (in the case of an unexpected death). 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 Panel (for example the CDOP for the area in which the child died) is notified, the SUDIC Paediatrician 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 SUDIC Paediatricians as to which Panel will review the death (normally the CDOP for the area of residence) and how the other Panel will be notified of the outcome.
2. To collect a core data set of information relating to each child's death. A data collection tool 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.
3. To meet bi-monthly initially and then to revert to quarterly once established 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 Panel in order to meet the objectives set out above. 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 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 Panel will determine and review on a regular basis which deaths are to be reviewed in an in-depth manner.

4. To receive reports from other reviews of child deaths, including individual case reviews for SUDIC, and hospital reviews of perinatal deaths.
5. After notification and summary of a child death the Panel will decide if further intervention is required (responsibility of all panel members).
6. To review annually the numbers and patterns of deaths in Telford & Wrekin and Shropshire.
7. To notify the chair of the Telford & Wrekin or Shropshire Safeguarding Children Board, the coroner and the police of any cases identified where there are previously unrecognised concerns of a criminal or child protection nature.
8. To identify any lessons to be learning from individual reviews or reviews of overall patterns and trends, including any system or process issues and any public health issues.
9. To monitor professional responses to child deaths, and identify good practice as well as any gaps or deficiencies in the process.
10. To make appropriate recommendations to the Telford & Wrekin or Shropshire's Safeguarding Children Board.
11. To provide the Telford & Wrekin or Shropshire's Safeguarding Children Board and constituent agencies with an annual report on the work of the Panel.

Confidentiality and Information Sharing

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.

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.

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

Where there is an ongoing criminal investigation, the CDOP will hold any review in abeyance until the conclusion of the court case. If, during the enquiries, concerns are expressed in relation to the needs of surviving children in the family, discussions should take place with Borough of Telford & Wrekin Council or Shropshire County Council's Children's Social Care. It may be decided that it is appropriate to initiate any 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 local Safeguarding procedures (based on 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 Telford & Wrekin or Shropshire's Safeguarding Children Board 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

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.

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.

Strategies may be considered at different levels:

1. 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.
2. Promoting community education.
3. Training Providers to improve knowledge, skills, capacity and motivation to effectively promote prevention.
4. Fostering coalitions and networks of individuals and organisations to work for advocacy and health promotion.
5. Changing organisational practices where system failures are identified or model of good practice highlighted.
6. Mobilising neighbourhoods and communities in the process of identifying, prioritising, planning and making changes.
7. Influencing policy and legislation, where appropriate through local and national advocacy.

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 – we will adopt the protocol from the West Mercia Police and both Local Safeguarding Children Boards.

Media interest in the work of the CDOP or in individual cases will be dealt with by liaison between the CDOP Chair and the Business Managers of Telford & Wrekin and Shropshire Safeguarding Children Board and Police. The annual report of the CDOP will be a public document and, as such, will have no identifiable information contained within. Details of individual case discussions are to be kept confidential and in no circumstances will such details be passed to the press. The Telford & Wrekin or Shropshire PCT Communication Officers will work proactively with the media to promote the work of the CDOP alongside that of the Telford & Wrekin or Shropshire Safeguarding Children Board in safeguarding and promoting the welfare of children in Telford & Wrekin and Shropshire.

Duties of the CDOP Chair

The Chair of the Overview Panel is the Designated Nurse for Safeguarding Children and Young People who is responsible for ensuring that this process operates effectively.

The nominated Chair will be responsible for the smooth running of all child death review processes. With the administrative support available s/he will:

- Ensure and monitor the effective running of the notification, data collection and storage systems.
- Determine meeting dates and send meeting notices to Panel members.
- Obtain names and ensure the summary sheet of child deaths to be reviewed and distribute to Panel members two to three weeks prior to each meeting for the panel to decide if further intervention is required.
- Ensure that notifications of child deaths are available for Panel review.
- Ensure that new members receive an introduction to the Panel.
- Ensure that all new CDOP members, ad hoc members and observers sign a confidentiality agreement.
- Encourage the sharing of information for effective case reviews.
- Chair the CDOP meetings encouraging all Panel members to participate appropriately, ensure that all statutory requirements are met and maintain a focus on preventive work.
- Facilitate resolution of agency disputes.
- Compile and disseminate notes from each CDOP meeting.
- Complete and submit an annual report to the Telford & Wrekin and Shropshire Safeguarding Children Board.
- Monitor the outcome of recommendations and prevention initiatives and activities.