



**Protocol and terms of reference for the  
Child Death Overview Panel  
For Cambridgeshire and Peterborough LSCB**

**Revised September 2015**

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## 1.0 Introduction

- 1.1 The Child Death Overview Panel is a sub group shared between the Cambridgeshire LSCB and Peterborough LSCB to comply with the statutory guidance *Working Together to Safeguard Children 2015*. This protocol is based on Chapter 5 of *Working Together* and should be read in conjunction with this.

The panel undertakes two inter-related processes to understand and review all child deaths, these are;

Firstly to collect and analyse information about the death of every child under 18 years in Cambridgeshire and Peterborough, with a view to achieve:

- (a) Reduction in numbers of child deaths
- (b) Prevention of accidents to children
- (c) Identification of and understanding of patterns of childhood death
- (d) Improvement in interagency practice in this very sensitive area
- (e) Education of public and of professionals working with children
- (f) Highlighting any matters of concern
- (g) Identifying the need for a Serious Case Review (SCR)

Secondly, to oversee the process of conducting a rapid response by a group of key professionals to enquire into and evaluate the unexpected death of any child.

Either of these processes may identify information indicating abuse or neglect was a factor in the death and if so this is reported to the LSCB chair for consideration of a Serious Case Review.

## 2.0 CDOP tasks

- 2.1 For any child who dies who is normally a resident of Cambridgeshire or Peterborough, CDOP will collect and analyse information about the death. This is in order to identify;
- Matters of concern affecting the safety and welfare of other children in the area of the authority
  - Wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area.
  - Whether information is collected which indicates neglect or abuse may have contributed to the death and interagency working was an issue. If so, the family will be referred to the chair of the LSCB to consider if a SCR is appropriate. After a SCR has been completed the case reverts back to CDOP to complete the overview process.
- 2.2 In order to review all child deaths in the area, information is gathered using the DFE (Department for Education) forms:
- ◆ Form A, notification to the CDOP coordinator.

- ◆ Forms B Agency Report Form and Forms B1 – B13, information gathering specific to each agency/death, these will be requested when required from the CDOP Co-ordinator
- ◆ Form C – analysis proforma for the panel discussion or 3<sup>rd</sup> case review of the rapid response team

2.3 The panel will have information available from;

- ◆ Case summaries from health records and health investigations;
- ◆ Notification by Registrars within 7 days
- ◆ Case information from police, LA children's social care and education;
- ◆ Post mortem reports and Coroners enquiries.
- ◆ Police
- ◆ Information from the rapid response team
- ◆ Feedback from Serious Case Reviews and Individual Management Reports

### **3.0 Children who die in this area but are not normally resident**

3.1 Sometimes children die in this area and Cambridgeshire or Peterborough is **not** their normal place of residence, CDOP will:

- ◆ Inform the CDOP coordinator in the home area.
- ◆ For all deaths, agree between the areas how the process will be undertaken, in particular how we can support other areas to gather information and review
- ◆ For unexpected deaths the local rapid response team should strongly consider a scene of death visit.
- ◆ To request that the completed form C is shared from the home area to ensure any learning, which is locally applicable, is available, e.g. learning about road traffic accident spots.

### **4.0 Death of a local child outside of area**

4.1 When a child, normally resident in the area, dies elsewhere, the CDOP coordinator will liaise with their counterpart, and as for 3.1 negotiate respective roles. The death will be included in the national returns of the home county, and unless there was a reason to do otherwise, the child will be reviewed in their home county. It is helpful to note, that the Coroner will be identified by the place of death not the home address.

4.2 If a child dies outside of the jurisdiction of the UK, the CDOP coordinator will seek information about the death and a review will take place to ensure that any possible advice or interventions might be recommended.

4.3 Children who die in hospital outside of area will reviewed by the CDOP for the home area, this applies for children being treated in this area from outside and for local children who may be being treated out of area.

- 4.4 Children where parental responsibility is shared with the Local Authority (e.g. looked after children) but may be placed in another county will be reviewed by the panel in their normal area of residence in conjunction with social care providers and local children's services.
- 4.5 The Coroners (Investigations) Regulations 2013 place a duty on Coroners to inform the LSCB, for the area in which the child died or the child's body was found, where the Coroner decides to conduct an investigation or directs that a post mortem should take place. The Coroner must provide to the LSCB all information held by the Coroner relating to the child's death. Where the Coroner makes a report to prevent other deaths, a copy must be sent to the LSCB. On receipt of an initial report of a death of a child, the LSCB with an interest in this information should inform the coroner of the address(es) (including email address(es)) to which future information should be supplied. If any information comes to the attention of an LSCB which it believes should be drawn to the attention of the relevant coroner, then the LSCB should consider supplying it to the coroner as a matter of urgency.

## **5.0 Membership of Panel**

- 5.1 CDOP membership consists of representatives from:
- Cambridge University Hospital NHS Foundation Trust
  - Peterborough and Stamford Hospitals NHS Foundation Trust
  - Hinchingsbrooke Healthcare NHS Trust
  - Public Health for both Cambridgeshire and Peterborough
  - Cambridgeshire County Council (Children and Young People's Services)
  - East Anglia Children's Hospices
  - Peterborough City Council Children's Services
  - Cambridgeshire Constabulary
  - Designated Paediatricians for Safeguarding
  - Designated / Named Safeguarding Children Nurses
  - Coroner's Office
  - NHS Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
  - Cambridgeshire Community Services NHS trust
  - East of England Ambulance Service NHS Trust
  - Safeguarding Children Board Business Managers
- 5.2 Other members to be co-opted as and when appropriate to ensure membership reflects the characteristics of a local population, provide a perspective from the independent sector, or contribute to the discussion of certain types of death.
- 5.3. The Chair and Vice Chair are accountable to the LSCB Chair.
- 5.4. The criteria for visitors to observe a panel meeting. They must be:
- Employed by one of the agencies represented on the panel or directly involved in child death or looking to be promoted into a role in this field and should be sponsored by a representative on the panel.

## 6.0 Key functions of the Child Death Overview Panel

- 6.1 To ensure, in conjunction with the relevant Coroners, procedures and protocols comply with Chapter 5 of *Working Together to Safeguard Children: 2015* to enquire into and review all children's deaths in the area.
- 6.2 To collect a minimum data set as required by the DFE and submit this annually for national data collection.
- 6.3 Where relevant and appropriate, to seek further information from professionals and family members should they wish to contribute.
- 6.4 To meet regularly to review and evaluate anonymous data on all child deaths. To focus on effective interagency working and undertake some reviews in more depth.
- 6.5 Deaths of neonates who do not leave hospital during their lifetime are considered separately by a Neonatal Panel with members including representatives of Midwifery, Obstetrics and Neonatology. This panel is chaired by the Designated Paediatrician for Death in Childhood (Vice Chair of the CDOP) who will escalate any concerns to the CDOP Chair and will be responsible for an annual report of issues to the panel.
- 6.6 In order to identify possible modifiable factors, which may or will prevent future deaths, cases can be evaluated in depth, if necessary by deferring to subsequent meetings. The review/evaluation will aim to;
  - ◆ Review an unexplained death to identify lessons to be learnt
  - ◆ To consider an individual cases in more depth following referral from LSCB Chair and/or SCR Panel.
  - ◆ To consider clusters of cases with similar issues.
- 6.7 The panel will oversee professionals' responses to an unexpected death by reviewing the reports of the rapid response team, recording this discussion and enabling feedback to be given on professionals' roles.
- 6.8 Generally cases involving a criminal investigation are not reviewed before the conclusion of proceedings, if ongoing; the panel will be advised by the Crown Prosecution Service regarding what information the Panel can consider which will not prejudice criminal proceedings.
- 6.9 Refer to the Chair of the LSCB any deaths where from the available information, the Panel considers there may be grounds to undertake further enquiries, investigations or a Serious Case Review.
- 6.9 Informing the Chair of the LSCB where specific new information should be passed to the Coroner or other appropriate authorities.
- 6.10 Where relevant, to provide information to a professional working with the family so they can convey this information in a sensitive and timely manner to them.
- 6.11 Monitoring that support and appropriate assessment services are offered to families of children who have died.

- 6.12 To formulate and support training plans, advising the LSCB on the resources and training required locally ensuring an effective inter-agency response to child deaths.
- 6.13 Organising and monitoring the collection of data for the nationally agreed minimum data set, and making recommendations (to be approved by LSCBs) for any additional data to be collected locally.
- 6.14 Co-operating with regional and national initiatives – e.g. MBRRACE-UK Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
- 6.15 Preparing a Business Plan for the Panel with timescales, to be approved by the LSCB, this is coterminous with the LSCB work plan.
- 6.16 Identifying any public health issues and considering, with the Director(s) of Public Health, how best to address these and their implications for both the provision of services and for training
- 6.17 To report annually to both LSCB's, with relevant, anonymous information and SMART recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children by reducing child death, reducing hospital admissions caused by unintentional and deliberate injuries to children.
- 6.18 To provide an interim report 6 monthly to each LSCB updating the action plan.

## **7.0 Consent and confidentiality**

- 7.1 All LSCB member agencies must be aware of the need to share information about all child deaths with the panel in order that CDOP can fulfill its statutory duty.
- 7.2 All members of the panel must respect and maintain confidentiality of the children who are being reviewed.
- 7.3 Information brought to the panel will be anonymous. However some cases may have elements of identifiable information that has to be shared in order to properly understand the death.
- 7.4 Parental consent is not required for information to be passed to the designated paediatrician for unexpected deaths in childhood and CDOP co-ordinator. Parental responsibility is deemed as defined in the Children Act 1989 and they should be advised that their child is to be reviewed by the panel. This must be handled sensitively and usually the doctor confirming the child's death does this, followed up with a letter (see appendix 2). There is also a leaflet available at [http://www.lullabytrust.org.uk/file/----internal-documents/Lullaby-CDR\\_Booklet.pdf](http://www.lullabytrust.org.uk/file/----internal-documents/Lullaby-CDR_Booklet.pdf)

- 7.5 Members of the panel are required when they join the panel to sign a confidentiality agreement that includes requirements about sharing and securely storing information. (see appendix 1)
- 7.6 No panel member may disclose any information from the discussions which take place within the meeting, other than in the course of the 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.

## **8.0 Professional and family support**

- 8.1 Before the panel meets, the Chair will consider for each case what information should be sent to the child's family about the process. This should reach the parents with enough time for them to respond before the panel meets should they so wish.
- 8.2 The panel will consider what feedback is necessary to be given to 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.
- 8.3 The Chair will ensure that the panel considers what bereavement services and immediate support is offered to families of children who have died.

## **9.0 Learning from child deaths**

- 9.1 The Chair will monitor and advise the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths.
- 9.2 The panel may identify public health or welfare issues and report these to the Children's Trusts to consider how best to address these and the implications for both the commissioning of services and training.
- 9.3 The local CDOP process will contribute to regional and national initiatives to identify lessons on the prevention of unexpected child deaths, to monitor advice and research nationally and internationally with knowledge about effective interventions.
- 9.4 From advice and recommendations from CDOP the LSCB will:
  - Disseminate the findings and lessons to all relevant organisations;
  - Ensure that relevant findings inform single agency plans.
  - Act on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.
  - Ensure that data relating to child deaths is submitted to relevant local, regional and national initiatives including the Joint Strategic Needs Assessment to identify lessons on the prevention of avoidable factors in child deaths, hospital admissions, accidents and morbidity.



## Appendix 1



### Confidentiality Statement

The purpose of the Child Death Overview Panel is to conduct a thorough review of all preventable child deaths in Cambridgeshire and Peterborough 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 Cambridgeshire and Peterborough Protocols for *Rapid Response* and for *Child Death Overview Panels* and the Cambridgeshire LSCB and the PSCB protocols 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

## Appendix 2

Letter to parents



Name  
Address  
Date

Dear (Name of parents)

As Chair of Peterborough and Cambridgeshire Child Death Overview Panel, I am writing to advise you that in the next few weeks, the panel will meet to review the records and information held about your **baby' s/ child's** death.

Every council area in England has to have a Child Death Overview Panel. The panel consists of representatives from agencies who work with children and its role is to look at the circumstances of each baby, child or young person under the age of 18 who dies in their area. The panel is a sub group of the Local Safeguarding Children Board and its purpose is to see if there are changes that agencies, such as Health and Social Care, can make to improve services for children and families. We also review the help and support you received immediately after **NAME** died.

The information we look at may include records held by the Local Authority Children's Services, Health or the Police. All the information considered by the panel is anonymous and will remain confidential. I have enclosed a leaflet which explains the process in more detail.

If you would like to receive a summary of our findings, either now or in the future, I am happy to provide this.

If you would like to let the Panel have your views about what would have helped you both before and after **NAME's** death, or you have any questions or concerns, please do not hesitate to contact me on the address below.

Yours sincerely

Felicity Schofield  
Independent Chair of the Child Death Overview Panel

Copy to: **GP**

**Appendix 3**

**Interface between SCR and CDOP**

