



London Child Death Overview Panel Procedure

**London Safeguarding Children Board
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www.londonscb.gov.uk

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1. Introduction

- 1.1 This Procedure sets a minimum standard for a Child Death Overview Panel (CDOP) as outlined in chapter 7 of the Government guidance [Working Together to Safeguard Children \(DCSF, 2006\)](#) (*Working Together*).
- 1.2 As described in *Working Together* and the [Local Safeguarding Children Board Guidance \(DCSF, 2006\)](#), there are two inter-related processes for reviewing child deaths. Either process can trigger a serious case review.
- 1.3 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, this is detailed in the [London Rapid Response Procedure \(LSCB, 2008\)](#).
 - An overview of all child deaths (birth up to 18th birthday, excluding babies stillborn) in the LSCB area/s, undertaken by a panel drawn from key organisations represented on the LSCB, this Procedure applies.
- 1.4 Each Local Safeguarding Children Board (LSCB) has a responsibility for convening and maintaining a CDOP.
- 1.5 This is a baseline Procedure, for local areas to expand on in relation to local needs.

2. Context

- 2.1 When a child/ren dies within the area in which s/he normally resides, the LSCB must collect and analyse information about each death with a view to identifying:
- any case giving rise to the need for a review mentioned in *Regulation 5(1)(e) of the Local Safeguarding Children Board Regulations 2006*;
 - any matters of concern affecting the safety and welfare of children in the area of the authority; and
 - any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area;
- 2.2 When a child dies outside of the area in which s/he normally resides, the two LSCBs may, in some cases, decide to conduct individual reviews.

3. Core purpose

- 3.1 The CDOP will undertake an overview of all child deaths within the locality. This process uses a standard set of data (see www.everychildmatters.gov.uk/socialcare/safeguarding/childdeathreview/ and the [Child death information and evaluation booklet in appendix 4 of the London Rapid Response Procedure \(LSCB, 2008\)](#)), based on information available from those who were involved in the care of the child, both before and immediately after the death, and other sources such as:
- Case summaries from health records;
 - Case information from police, LA children's social care and education; and
 - Post mortem reports.
- 3.2 The CDOP has responsibility for reviewing the deaths of all children, with priority given to those deaths that are both unexpected and unexplained.

- 3.3 If there is to be a serious case review, it will be undertaken by the LSCB where the child normally resides, with the decision taken by the LSCB Chair.

4. Membership

- 4.1 There will be a fixed core membership on the CDOP, which is drawn from the key organisations represented on the LSCB. The minimum should be senior management representation from:

- Designated paediatrician for unexpected deaths in childhood;
- Public health;
- Child health;
- LA children's social care;
- Police;
- Plus designated doctor for unexpected deaths.

- 4.2 Other members will be co-opted as and when appropriate. This may be so that the membership of the CDOP better reflects the characteristics of the local population, to provide a perspective from the independent or voluntary sector or to contribute to the discussion of certain types of death e.g. London Fire Brigade, adult mental health services, education / early years, bereavement services etc.

- 4.3 The CDOP Chair should be a member of the LSCB, but should not be involved in providing direct services to children and families in the LSCB area.

5. Frequency of CDOP meetings

- 5.1 The CDOP should hold meetings on a regular basis to enable the circumstances of each child death to be discussed in a timely manner. The frequency of the meetings should reflect the number of cases in the LSCB area.

6. Notification of child deaths

- 6.1 Each CDOP must nominate a single point of contact (SPOC) to be informed of all child deaths in the LSCB area, regardless of whether the child is resident in the area. The police public protection desk has a key role in informing the SPOC of child deaths.

For notification of unexpected child deaths see the [London Rapid Response Procedure \(LSCB, 2008\)](#).

- 6.2 The details of each borough's SPOC must be reported to the London Safeguarding Children Board to enable a list to be kept up to date on www.londonscb.gov.uk.

7. Deaths of children out of area

- 7.1 When a child dies in the area s/he is not permanently resident in, the SPOC for the area in which the child died will inform the SPOC in the area the child normally lived.

- 7.2 The CDOP in the area where the death occurred will normally review the death and liaise with the area of permanent residency where appropriate. The two CDOPs may, in some cases, decide to conduct individual reviews. In these cases, the Chairs of both CDOPs must negotiate management of the two reviews to ensure that there is a uniform response.

- 7.3 Information sharing between two CDOPs when a child dies out of his / her normal residency area, is in addition to informing the coroner within 1 working day, and immediate notification of the designated paediatrician for unexpected deaths in childhood if the death was unexpected (see the [London Rapid Response Procedure \(LSCB, 2008\)](#)).
- 7.4 The CDOP Chair is responsible for ensuring that this process operates effectively.
- 7.5 Children who die in hospital should normally be reviewed by the CDOP for the area in which they lived.
- 7.6 The CDOP must review the circumstances of children who are normally resident in the area but who die abroad.

8. Key functions

- 8.1 The key functions of the CDOP are to:
- a) Receive notification on all child deaths occurring in the local area.
 - b) Collect and collate an agreed national minimum data set.
 - c) Seek information from professionals who had involvement with the child before and immediately following the death and, where relevant, the child's family members.
 - d) 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.
 - e) Assess the cases with regard to the threshold criteria to enable specific cases to be reviewed in depth (see [Threshold criteria in appendix 2](#))
 - f) Ensure that individual case discussions have taken place regarding unexpected child deaths.
 - g) 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.
 - h) Scrutinise the recommendations from the reports compiled by the designated doctor for unexpected deaths.
 - i) Identify any common themes from individual cases and consider these in more depth.
 - j) Consider whether the death was avoidable, if so how such deaths might be prevented in the future.
 - k) Identify any patterns or trends in the local data and reports these back to the LSCB.
 - l) Consider the [Framework for the Assessment of Children in Need and their Families \(Department of Health et al. 2000\)](#) to assess any child, parent, social or environmental factors which could contribute to developing an understanding of the individual child's death (*Sidebotham and Fleming, 2007; p20-24*).

- m) Alert the Chair of the LSCB 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.
- n) Inform the Chair of the LSCB where specific new information should be passed to the coroner or other appropriate authorities.
- o) 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.
- p) Monitor the support and assessment services offered to families of children who have died.
- q) Monitor and advise the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths.
- r) Identify any public health issues and consider, with the Director/s of Public Health, how best to address these and their implications for both the provision of services and for training;
- s) Co-operate with regional and national initiatives to identify lessons on the prevention of unexpected child deaths e.g. the *London learning from information about child deaths initiative* and the Confidential Enquiry into Maternal and Child Health (CEMACH)¹.
- t) 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.

9. Consent and confidentiality

9.1 Information in CDOP meetings will not be anonymised.

9.2 Parental consent is not required for this information to be passed to the designated paediatrician for unexpected deaths in childhood / the LSCB 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*.

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 to 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 and followed up with a letter. There is a LSCB leaflet available to assist parents and others with parental responsibility in understanding the review process and how they can contribute (see [template for letter and leaflet for parents in appendix 5](#)).

9.3 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.

9.4 Members of the CDOP must sign a confidentiality agreement, including sharing and securely storing information (see [model confidentiality statement in appendix 3](#)) when they join the CDOP. This agreement will be reviewed at each meeting.

9.5 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. Public statements about the

¹ See www.cemach.org.uk/

general purpose of the child death review process may be made, as long as they are not identified with any specific case.

10. Professional and family support

- 10.1 Before the CDOP meets, the Chair should consider what explanatory information is sent to the child's family (see [template for letter and leaflet for parents in appendix 5](#)).
- 10.2 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.
- 10.3 The CDOP Chair should ensure that information is also received and evaluated by the CDOP regarding the services and immediate support offered to families of children who have died (see section 6.3 Care of the bereaved family in the [London Rapid Response Procedure \(LSCB, 2008\)](#)).

11. Learning from child deaths

- 11.1 The CDOP should monitor and advise the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths.
- 11.2 The CDOP should identify any public health issues and consider, with the Director(s) of Public Health, how best to address these and their implications for both the provision of services and for training.
- 11.3 The CDOP should contribute to regional and national initiatives to identify lessons on the prevention of unexpected child deaths e.g. the *London learning from information about child deaths initiative* and CEMACH.

12. Reporting mechanisms

- 12.1 Each CDOP must submit an annual report to its respective LSCB.
- 12.2 The LSCB is responsible for:
 - Disseminating the lessons to be learnt to all relevant organisations;
 - Ensuring that relevant findings inform the *Children and Young People's Plan*;
 - Acting on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children; and
 - 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: Model terms of reference

..... *[name of borough]* **Safeguarding Children Board**
Child Death Overview Panel

Terms of reference

1. Purpose

- 1.1 Through a comprehensive and multidisciplinary review of child deaths, the Child Death Overview Panel (CDOP) aims to improve the understanding of how and why children in *[name of borough/s]* (the area) die and use the findings to take action to prevent future child deaths and more generally to improve the health and safety of the children in the area.
- 1.2 In carrying out activities to pursue this purpose, the CDOP will meet the Local Safeguarding Children Board (LSCB) functions, as set out in paragraph 7.4 of *Working Together to Safeguard Children (2006) (Working Together)*, in relation to the deaths of any children normally resident in the area:
- (a) Collecting and analysing information about each death with a view to identifying –
 - (i) any case giving rise to the need for a serious case review
 - (ii) any matters of concern affecting the safety and welfare of children in the area
 - (iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area
 - (b) Establishing procedures for ensuring a coordinated response to an unexpected child death.

2. Objectives

Notification and data collection

- 2.1 The CDOP will seek to:
- a) Ensure, in consultation with the *[name of borough]* coroner's office, that local procedures and protocols are developed, implemented and monitored, in line with the guidance in Chapter 7 of *Working Together* on enquiring into unexpected deaths;
 - b) Ensure the accurate identification of every child death in the area;
 - c) Ensure uniform, consistent reporting of the manner and cause of every child death in the area;
 - d) Collect and collate the agreed national minimum data set of information on all child deaths in the area and, where relevant, to seek additional information from professionals and family members;
 - e) Ensure that these information gathering processes minimise distress to families; and
 - f) Co-operate with regional and national initiatives to identify lessons on the prevention of unexpected child deaths e.g. the *London learning from*

information about child deaths initiative and the Confidential Enquiry into Maternal and Child Health (CEMACH)².

Case assessment and review

Case level

2.2 The CDOP will seek to:

- g) Evaluate specific cases in depth, and identify any issues of concern or lessons to be learnt; and
- h) Where concerns of a criminal or child protection nature are identified, ensure that the police and coroner are aware and inform them of any specific new information that may influence their inquiries; notify the Chair of the relevant LSCB of those concerns and advise them on the need for further enquiries under section 47 of the *Children Act 1989*, or to recommend a serious case review.

Population level

2.3 The CDOP will seek to:

- i) Evaluate data on the deaths of all children normally resident in the area, thereby identifying 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.

Service improvement

2.4 The CDOP will seek to:

- j) Improve agency responses to child deaths through monitoring the appropriateness of the response of professionals to each unexpected death of a child, reviewing the reports produced by the Child Death Rapid Response Team and providing the professionals concerned with feedback on their work (for a description of a rapid response service see the [London Rapid Response Procedure \(LSCB, 2008\)](#));
- k) 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; and
- l) Monitor the support and assessment services offered to families of children who have died.

Prevention and advocacy

2.5 The CDOP will seek to:

- m) Identify significant risk factors and trends in individual child deaths and in the overall patterns of deaths in the area, including relevant environmental, social, health and cultural aspects of each death, and any systemic or structural factors affecting children's well-being to ensure a thorough consideration of how such deaths might be prevented in the future;

² See www.cemach.org.uk/

- n) Identify any public health issues and consider, with the Directors of Public Health and other provider services, how best to address these and their implications for both the provision of services and for training;
- o) Identify and advocate for needed changes in legislation, policy and practices to promote child health and safety and to prevent child deaths.
- p) Increase public awareness and advocacy for the issues that affect the health and safety of children; and
- q) Monitor and advise the Local Safeguarding Children Boards on the resources and training required locally to ensure an effective inter-agency response to child deaths.

3. Scope

- 3.1 The CDOP will gather and assess data on the deaths of all children from birth (excluding those babies who are stillborn) up to their 18th birthday who are normally resident in the area. This will include neonatal deaths, expected and unexpected deaths in infants and in older children. Where a child normally resident in another area dies within the area, that death shall be notified to the CDOP in the child's area of residence. Similarly, when a child normally resident in the area dies outside the area, the CDOP should be notified. In both cases, an agreement should be made as to which CDOP (normally that of the child's area of residence) will review the child's death and how they will report to the other.

4. Panel membership

- 4.1 The Child Death Overview Panel will have a permanent core membership. Other members may be co-opted to contribute to the discussion of certain types of death when they occur. Core membership will consist:
- Chair (who must be appointed by the LSCB Chair);
 - CDOP manager;
 - Public health representative;
 - Consultant paediatrician;
 - Other PCT representation, as appropriate;
 - DI from Central Police CAIT;
 - Local authority children's social care;
 - A representative from a bereavement counselling agency.

5. The role of core CDOP members

Public health

- 5.1 The public health representative can:
- Provide the panel with information on epidemiological and health surveillance data;
 - Assist the panel in strategies for data collection and analysis;
 - Assist the panel in evaluating patterns and trends in relation to child deaths and in learning lessons for preventive work;

- Inform the panel of public health initiatives to support child health; and
- Advise the panel on the development and implementation of public health prevention activities and programmes.

Paediatrician

5.2 The paediatrician can:

- Provide the panel 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 panel 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 panel 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; and
- Liaise with other health professionals and agencies.

Police

5.3 The police representative can:

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

Children's social care

5.4 The children's social care representative can:

- Provide the panel with information on any social care involvement with the child and family, including any child protection concerns;
- Help the panel to evaluate issues relating to the family and social environment and circumstances surrounding the death;

- Advise the panel 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; and
- Provide feedback to social workers and other local authority staff involved in individual case management.

Bereavement agency representative:

5.5 The bereavement representative can:

- Advise the panel on ongoing bereavement support needs for the family or others involved;
- Be an advocate for the family;
- Assist the panel in monitoring and evaluating the appropriateness of professional responses to child deaths;
- Provide support to other panel members, ensuring appropriate member care; and
- Facilitate the provision of support to other professionals involved in individual case management.

6. Duties of the CDOP Chair and manager

6.1 The Chair of the CDOP is responsible for:

- Chairing the CDOP meetings, encouraging all team members to participate appropriately;
- Ensuring that all statutory requirements are met;
- Maintaining a focus on preventive work;
- Facilitating resolution of agency disputes; and
- Ensuring that this process operates effectively.

6.2 The CDOP manager will be responsible for the smooth running of all child death review processes. S/he will:

- Be the designated person to whom the death notification and other data on each child death in the area should be sent;
- Ensure and monitor the effective running of the notification, data collection and storage systems;
- Determine meeting dates and send meeting notices to team members;
- Obtain names and compile the summary sheet of child deaths to be reviewed and distribute to team members two to three weeks prior to each meeting;
- Select, in consultation with the CDOP Chair, cases for in-depth review by the CDOP, following the principles set out in core functions;
- Ensure that notifications of child deaths are available for team review;

- Ensure that new members receive an orientation to the panel prior to their first meeting;
- Ensure that all new CDOP members, ad hoc members and observers sign a confidentiality agreement;
- Encourage the sharing of information for effective case reviews;
- Compile and disseminate notes from each CDOP meeting;
- Maintain the rota for the Child Death Rapid Response Team;
- Complete and submit an annual report to the LSCB; and
- Monitor the outcome of recommendations and prevention initiatives and activities.

7. Confidentiality and information sharing

- 7.1 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.
- 7.2 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.
- 7.3 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.

8. Accountability and reporting arrangements

- 8.1 The CDOP will be accountable to the chair of the LSCB.
- 8.2 The Child Death Overview Panel is responsible for developing its work plan, which should be approved by the LSCBs. It will prepare an annual report for the LSCB, which is responsible for publishing relevant, anonymised information.
- 8.3 The LSCB takes responsibility for disseminating the lessons to be learnt to all relevant organisations, ensuring that relevant findings inform the *Children and Young People's Plans* and acting on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.
- 8.4 The LSCB will supply data regularly on every child death as required, e.g. by:
- The London learning from information about child deaths initiative to collate and analyse information about child deaths across London, in order to identify lessons on the prevention of child deaths; and
 - The Department for Children, Schools and Families to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of child deaths.

9. Conflict resolution

- 9.1 The CDOP Chair should encourage panel members to form a consensus in their assessment of child deaths (e.g. whether a case should have been handled differently or whether the criteria for a serious case review, as set out in *Working Together* Chapter 8, are met in the opinion of the CDOP). However, where a consensus is not agreed, the Chair's decision is final.
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Appendix 2: Threshold criteria

There are three levels or types of child death cases for the members of the Child Death Overview Panel (the CDOP) to consider.

Level 1 – Scope: where the child's death is 'anticipated / not unexpected' and likely to be more 'straightforward', with no additional complicating factors.

Cause of death may be reviewed briefly to learn key lessons. These are likely to be the substantial number of the deaths for review, and the majority are likely to be neonates. It is suggested that occasionally there should be a more detailed review of a random selection of some of these more 'straightforward' cases to look at them in more depth. The selection could be theme based on the cause of death (e.g. SUDI, cancer, congenital, other, etc).

Level 2 – Scope: where there are additional factors in relation to the child's death. The CDOP will require papers additional to the core papers. The range of types of deaths meeting level 2 are listed below (this is not exhaustive).

Level 3 (serious case review) – Scope: whilst it is not the business of a CDOP to re-discuss the information contained in a serious case review, lessons and recommendations from any serious case review need to be incorporated into the overall planning and strategy (including policy and staff development) arising from all child deaths. The serious case reviews should also be included in the annual report of the CDOP.

The decision to undertake a serious case review is made by the Chair of the Local Safeguarding Children Board.

Process – All CDOP members contract to read the CDOP case papers in advance of the meeting to avoid delay in scheduled meeting time. Any glaring questions or omissions should be communicated to the CDOP Chair in advance of the meeting and if they cannot be dealt with before the meeting, the case is withdrawn and deferred to a subsequent panel with the required information / documents provided.

This process requires secure communication systems to share information in a timely way.

Local data collection and analysis / London learning – All the agreed child and family specific data in relation to the death, preventability scoring and summary outcomes and recommendations must be recorded as per the *Child death information and evaluation booklet* (Appendix 3 of the [London Rapid Response Procedure \(LSCB, 2008\)](#)).

This information should input into a simple local electronic database (Access or Excel) which is consistent across London and allows the collation of all London child death data by the London Safeguarding Children Board for annual strategic analysis and recommendations.

Reporting – Local data, lessons and recommendations to be reported to the Local Safeguarding Children Board at least annually or more frequently, as agreed.

Type of case	Core papers	Additional papers?	Process and planned outcome
Level 1			
Straightforward deaths Natural Expected SUDI SIDS	<p><i>Child death information and evaluation booklet</i></p> <p>Notes from the rapid response meeting, if a meeting was held</p> <p>Brief (A4) summary descriptions of agency contact with the family prior to the death, and any lessons learned or questions unanswered from agency contact – suggest 3 or 4 headings for this summary</p> <p><i>(If possible case summary prepared by CDOP co-ordinator providing overview note and key points for the CDOP review sent out in advance of meeting – resource and skills issue.)</i></p>	<p>Only those which exist already and will be deemed – by Chair and CDOP Co-ordinator – to assist the CDOP. To be kept to a minimum and should have been summarised in the <i>Child death information and evaluation booklet</i> or the agency summary.</p>	<p>All CDOP members under contract to read the CDOP papers in advance of the meeting to avoid CDOP meeting being delayed by reading time.</p> <p>Any significant questions or omissions to be communicated to CDOP Chair in advance of the meeting and if these cannot be answered, case withdrawn from the CDOP discussion for outstanding issue to be resolved / answered.</p> <p>Brief summary discussion – 10 – 15 minutes</p> <p>Panel summary under agreed headings – or as agreed at London level - to be attached to the data to be sent to London Safeguarding Children Board</p> <p>e.g.</p> <ul style="list-style-type: none"> clinical issues, preventability lessons social / cultural lessons recommendations

Level 2			
All alleged murders or violent deaths	Core papers	Any reports on outcomes of the criminal proceedings / coroner's inquest	Full discussion 30 – 45 minutes
Any death where criminal, coroner or civil proceedings or H&S Executive process are being considered as a result of the death Such cases cannot come to the panel for full discussion until after these proceedings have ended.	Core papers	Any reports on outcomes of the coroner / criminal proceedings / H&S Executive enquiry, NPSA or similar investigations or reviews <i>Issues disclosability and PII may arise if the panel seeks to discuss the case before the closure of other legal or quasi-legal processes.</i>	CDOP summary under agreed headings to be attached to the data to be sent to London-wide data collector / body e.g. <ul style="list-style-type: none"> – clinical issues, – preventability – clinical lessons – social / cultural lessons – systems lessons – practice lessons (pre and post death) – recommendations
Any death for which there has been an agency critical incident/ Serious Untoward Incident review	Core	Outcome of the SUI, Serious Untoward Incident Report and Review	
Any death which remains unexplained	Core papers		
Any death where the 'parenting' or lifestyle or pre-death care, behaviour of the parent, carer or key family member is a possible contributing factor in the child's death	Core papers	May require additional reports from adult services, mental health services or substance misuse services <i>There will be issues of consent and proportionality from the parents or other family members in such information being shared – it may not meet an automatic information sharing threshold.</i>	As above, it will be helpful to have a London wide approach to the outcome summary from the CDOP discussion, to be developed over time under some agreed headings to aid review and data collection

Level 2 continued			
All traffic deaths	Core papers	Input to CDOP from traffic specialist – possible information about ‘school travel plan’ for child’s school, if appropriate, etc	Full discussion 30 – 45 minutes
All deaths resulting from suicides and self harming behaviours	Core papers	Psychiatric review of the papers?	CDOP summary under agreed headings to be attached to the data to be sent up London-wide
Drowning, death by fire, death by animal	Core papers	Other relevant reports – police / HSE? LFB etc	e.g.
Accidents / unintentional	Core papers		<ul style="list-style-type: none"> – clinical issues, – preventability – clinical lessons – social/cultural lessons – systems lessons – practice lessons (pre and post death) – recommendations
Any death where the death although ‘later’ may be directly earlier attributed to an act of violence, assault, lapse of care or self-harming behaviour some time before but which may not have been the immediate cause of death at the time of the death	Core papers	Relevant incident based reports from police and possibly health	
Any death which has attracted public or media interest, subject to the governance panel of LSCB	Core papers	Possibly summary of public / media coverage	It would be helpful to have a London wide approach to the outcome summary from the CDOP discussion, where possible over time to be developed under some agreed headings
All deaths notified to DCSF / Ofsted under the notification system	Core papers		

Deaths arising from major incidents e.g. terrorism, major accidents	Core papers	Any relevant reports from HSE, other enquiries, investigations etc	
Level 3 (serious case reviews)			
Any SCR into the death of a child after the SCR is complete	Core data set only But no additional agency summaries as this will have been covered in the IMRs for the SCR	SCR overview report Any actions of Management Sub Group or QA sub group if relevant Any outcome from any criminal proceedings if relevant	Note the lessons and outcomes only for aggregation into the CDOP overall work

Appendix 3: Model confidentiality statement³

The purpose of the Child Death Overview Panel is to conduct a thorough review of all preventable child deaths in [enter LSCB area here] 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 London Procedures for *Rapid Response* and for *Child Death Overview Panels* and the [enter local safeguarding children board name] 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

³ This Child Death Overview Panel Confidentiality Statement, was designed by University of Warwick

Appendix 4: Notification to the designated paediatrician for unexpected deaths in childhood and the LSCB of a child's death

[Working Together to Safeguard Children \(DfES, 2006 - WT\)](#) chapter 7 sets out a statutory requirement for the Local Safeguarding Children Board to review the deaths of all children under the age of 18 years.

Section 7.51 (WT) states that the Local Safeguarding Children Board (LSCB) should be informed of all deaths of children normally resident in the LSCB's geographical area. The designated paediatrician for unexpected child deaths in childhood (designated paediatrician) or delegate will usually do this and should be notified of all child deaths in the area or of children usually resident in the LSCB area but who die in another area.

Local agencies responding to a child's death as well as informing the coroner, if needed, should inform the designated paediatrician (or delegate) for the LSCB area using the attached Notification proforma. Information can be conveyed in a confidential telephone conversation but there should be agreement during this call as to who will take responsibility for completing the attached written Notification proforma. Where the information is passed by telephone it will be helpful for both parties to have a copy of the proforma in front of them while talking to aid the sharing of information.

The information should be treated in strictest confidence.

Designated doctors:

[insert name of Local] Safeguarding Children Board Fax: Tel:

[insert name of Local] Safeguarding Children Board Fax: Tel:

Etc.

The written notification proforma should be completed as fully as possible and sent the same day. For deaths which occur after 5pm, at weekends or on bank holidays, the written notification proforma should be sent by 10am the next working day.

Parental consent is not required for this information to be passed to the designated paediatrician / LSCB 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 2006*. 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 to prevent future deaths of children. This must be handled sensitively. There is a LSCB leaflet available to assist parents and others with parental responsibility in understanding the review process and how they can contribute (see www.londonscb.gov.uk/child_death/). This would normally be done by the doctor confirming the child's death to the parents.

A death that is unexpected⁴ may require a Rapid Response service or a specific review of circumstances or an unexpected child death meeting as set out in the [London Child Protection Procedures section 12](#)⁵. It will be the responsibility of the designated paediatrician (or delegate) and senior police officer in the case to agree the process that such a response will take. This may involve LA children's social care or other agencies as needed.

⁴ '... defined as a death of a child (birth to 18 years, excluding babies stillborn) which was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death'. London Child protection Procedures 2007 Section 12.1.1

⁵ **London Child Protection Procedures** – every agency must ensure that staff have access to a copy – they can also be accessed at www.londonscb.gov.uk/procedures

Initial notification of the death of a child – to be completed as fully as possible within the hour. DO NOT DELAY.

1	Initial notification Unique Reference Number (e.g. NI/08/0001)		
2	Date / time of notification		
3	Name and title / role of caller		
4	Caller contact number		
5	First and other names of child		
6	Family name of child		
7	Date of birth of child		
8	Sex of child		
9	Ethnicity of the child		
10	Home address of child		
11	Postcode of child's home address		
12	Carer of child at time of death		
13	Name/s of persons with parental responsibility i.e. mother, father or other (state relationship)		
14	Other children in household or affected by the death (including children potentially at risk of harm)	Names (PRINT)	Ages / date of birth if known
15	Date and time of death		
16	Place / locality of death		
17	Contact number of place of death		
18	Summary description of the circumstances of the death		
19	Is this an unexpected death? i.e. not expected in the previous 24 hours	YES / NO	
20	GPs name		
21	Signature / name of the caller Sign and PRINT		
22	Date		

Please fax the form to the relevant LSCB Single Point of Contact. The fax should be marked **STRICTLY CONFIDENTIAL**

See www.londonscb.gov.uk for contact details of the Single Point of Contact for each London LSCB.

Appendix 5: Template for letter and leaflet for parents

a) Template for letter to parents CDOPs can adapt for all child deaths

Dear (parents name/s)

I have been told of the death of your (son/daughter), (child's name). I would like to express my condolences to you and your family at this sad time.

I am the chair of the Child Death Overview Panel for (borough name/s) and I am writing to you because the law requires that every child death must be reviewed to see if there is anything that we or anyone else can do to improve services for children and their families in the future.

I need to let you know that we will now gather information about (child's name) from the school, health services, children's services and other services who were involved before his/her death.

The leaflet enclosed explains about the review. If you would like to know more about this, please contact me at the address above.

I shall write to you again to invite you, if you find it is possible, to write to me with any information or views you think would help us understand..... (child's name) death better; and about services provided to him/her and your family before and after his/her death.

Yours sincerely

Chair of the Child Death Overview Panel

b) Template for leaflet CDOPs can adapt for all child deaths

Back page

[for a joint panel: (borough) and (borough) have agreed with our local hospitals, health trusts, children’s services, police and the coroner to have a joint Review Panel.]

The *[Joint (borough) and] (borough)* Child Death Overview Panel can be contacted at Tel 020 xxxx xxx. Address:

Please ask for the Child Death Overview Panel Administrator xxxxxxxx or the Chair of the Child Death Overview Panel.]

Further information about the role of Child Death Overview Panels can be found on the (borough) website (www.xxxxxxxx.gov.uk/safeguardingchildren) or from the Government Guidance *Working Together to Safeguard Children from Harm 2006*; or from the Administrator at the above address.

April 2008

Front page: Council/s logos

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Safeguarding Children Board/s

The Review

we have to do when

a child dies

Information

for

Parents, Families

and Carers

Page 1

The death of a child is always tragic. Talking and thinking about a child's death is a sensitive and painful subject which is be particularly upsetting for parents, families and carers.

What is a Review and why is it needed?

Government legislation now requires every LSCB to Review the death of every child (up to the age of 18 years), in their area. This is because the government believes that it may help other children and families in the future.

How does a Review happen?

Information about each child and the circumstances of their death must be collected and summarised into a short report from records held by hospitals, local health services, schools, police, children's services or other agencies whose staff knew the child.

A small Child Death Overview Panel of doctors, other health specialists and child care professionals must consider the report to be clear what caused the child's death and what support and treatment was offered to the child and their family up to the death; and also what support was offered to the family after that time.

The Child Death Overview Panel must consider whether they can make any recommendations to improve how things are done for children and their families. These recommendations must be shared with the local health trusts, children's services and the police, as well as specialist agencies such as the fire service or traffic authorities, as appropriate.

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So that planning of services for children and families in the future can be helped.

What does this mean for you?

As part of this process Local Safeguarding Children Board has been informed of your child's death. Our first concern is that you and your family are offered any support we are able to give you. We also want to ensure that you know that we are required to do a Review and to plan for the circumstances of your child's death to be included at a future meeting of a Child Death Overview Panel.

It may take several months as we cannot do this until all other enquiries are completed, such as the work of the pathologist and coroner, or any legal processes.

You may feel able to contribute

We will let you know when your child's circumstances are to be considered by the Child Death Overview Panel and will invite you to write to us to share any information or questions that you may have. Alternatively you can meet a Panel member and talk things through if you would prefer.

Unfortunately it is not possible for parents or family representatives to attend the Panel meetings.

All the information we gather will be treated with the deepest respect and in strictest confidence. We promise that none of our findings, recommendations or reports will name your child or family.