CUMBRIA LSCB

CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD

Multi Agency Guidance - Response to Unexpected Death in Infants, Children and Young People

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Introduction

This procedure applies to all children less than 18 years old who are resident in Cumbria and die unexpectedly.

In this guidance an unexpected death is defined as the death of an infant or child (less than 18 years old) which:

- Was not anticipated as a significant possibility for example, 24 hours before the death; or
- Where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

Two processes are described in this guidance:

The Case Response

1. Immediate Response process — within 24 hours
2. Information Sharing and Planning Meeting / Discussion — within 24-48 hours
3. Final Case Discussion — usually within 3–6 months

Overview

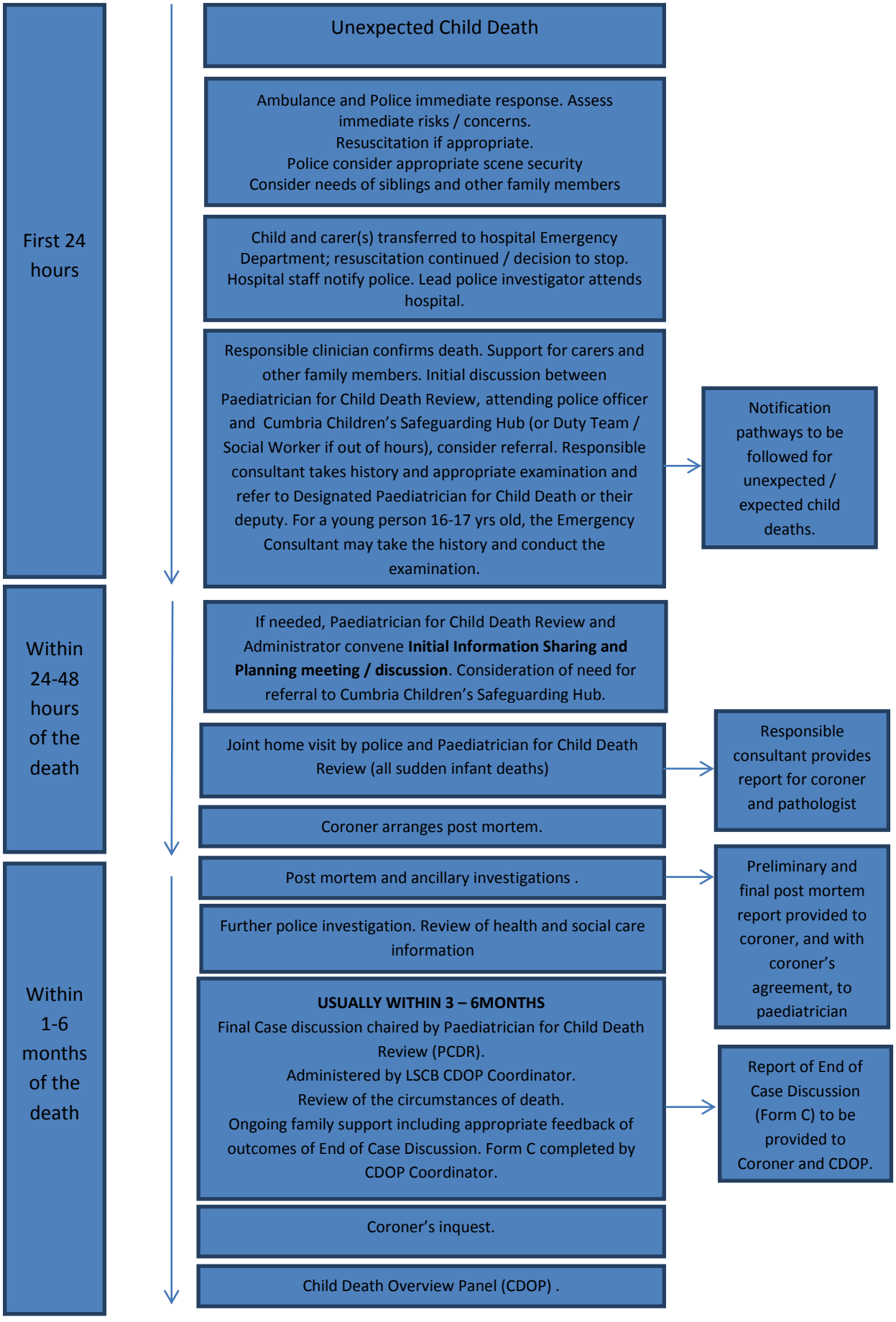
4. An overview of all child deaths (under 18 yrs) in the Local Safeguarding Children Board (LSCB) area undertaken by the Cumbria Child Death Overview Panel (CDOP). This will include reviewing information collected by the immediate response process for those deaths which were unexpected.

To note:

If a child dies unexpectedly in Cumbria who does not reside in Cumbria:

- It will be necessary for the immediate response to the case to be initiated in Cumbria
- It **may** be necessary for the child death review to be conducted in Cumbria

Flowchart for Response to the Unexpected Death of a Child



1. CASE RESPONSE - Immediate Response Process within 24 hours of the death being notified

1.1 Introduction

This section describes the immediate health response and the multi-agency processes which should be followed for all unexpected deaths of children and young people less than 18 years old. In this guidance an unexpected death is defined as the death of an infant or child (less than 18 years old) which:

- Was not anticipated as a significant possibility for example, 24 hours before the death; or
- Where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

This process should be followed for all sudden unexpected deaths whether they occur at home, in the community, in an Accident and Emergency Department (A&E) or on a hospital ward.

The guidance covers:

- The purpose of the response;
- Principles of practice;
- Roles and responsibilities;
- Detailed practical guidance describing the response;
- Information sharing;

1.2 Purpose of the Immediate Response Process

- To make immediate enquiries into and evaluate the reasons for and circumstances of the death in agreement with the Coroner;
- To address the possible needs of other children in the household;
- To provide support to the bereaved family and refer on as appropriate;
- To ensure that the family are informed and kept up to date with information about the child's death;

1.3 Principles of the Immediate Response Process

The death of a child is a tragedy for the family and the response to the family should be one of care and support. Any enquiries / investigations should keep an appropriate balance between forensic and medical requirements and the family's need for support. Collecting information about the child's death should be carried out in a sensitive manner, with families being aware that the process is necessary to help understand the cause of their child's death. Families should be treated with sensitivity, discretion and respect at all times and professionals should approach their enquiries with an open mind.

Parents should be informed of the process and that information about their child and their siblings will be shared between the statutory agencies. Contact should be maintained with the family at regular intervals throughout the process to ensure that they are informed and kept up to date with information about the child's death.

A very small number of cases may involve abuse or neglect. If at any time during the process concerns are raised about the possibility of surviving children in the household being abused or neglected, a referral must be made to Cumbria Children's Safeguarding Hub. In such cases consideration must be given to holding a multi-agency Strategy Meeting without informing the parents until the course of action has been agreed by the multi-agency group.

If it is thought, at any time, that the criteria for a Serious Case Review (SCR) might apply (see Appendix 4), Cumbria LSCB must be informed and a referral form completed.

1.4 Roles and Responsibilities

1.4.1 Child Death Review Administrators (NCUHT and UHMBT)

The Child Death Review Administrators (CDR Administrators) are the coordinators for initialising and supporting:

- The Immediate Response
- The information sharing and planning meeting / discussion

They provide all administrative support including the organisation of local meetings.

The CDR Administrators support the relevant Paediatricians for Child Death Review.

The CDR Administrators will liaise with the Safeguarding Business Manager at NHS Cumbria CCG particularly regarding notifications and the submission of information for the Child Death Overview Panel.

The NCUHT Administrator will provide support for cases of child deaths from the North of Cumbria.

The UHMBT Administrator will provide support for cases of child deaths from the South of Cumbria.

1.4.2 Paediatrician for Child Death Review (PCDR) and Deputy Arrangements

In the majority of cases the lead professional for the Immediate Response process will be the Paediatricians for Child Death Review (PCDR) in Cumbria who will manage the process.

However in cases in which the death is being investigated as a possible crime the lead agency may be the Police. In any case in which there is uncertainty there should be joint decision making and action planning between the Police and the relevant PCDR.

The Paediatricians for Child Death Review are required to have deputies available who are able to undertake the Paediatrician for Child Death Review role. The deputies for the Paediatricians for Child Death Review are the treating Paediatrician or Consultant Clinician who had contact with the child in relation to the death.

The NCUHT PCDR will lead for cases of child deaths from the North of Cumbria.

The UHMBT PCDR will lead for cases of child deaths from the South of Cumbria

1.5 – Immediate Response

High quality information sharing is essential. When a child dies unexpectedly, the Paediatrician for Child Death Review (PCDR) should initiate an immediate information sharing and planning discussion to decide what should happen next and who will do what. The lead agencies to be involved are: -

- Health agencies
- Police
- Local Authority Social Care

Some cases will also require an early information sharing meeting to be convened as soon as is practicable.

The decision as to whether such a meeting is required will be made by the PCDR in conjunction with colleagues from other agencies. In making that decision consideration should be given to: -

- the circumstances of the death,
- whether there is an apparent explanation for the death.

1.6 Decision to hold an Initial Information Sharing and Planning Meeting

In cases in which there is no explanation for the death, including all sudden and unexpected deaths of infants: -

An information sharing meeting should be held and attended by agency representatives who hold information and are able to make decisions about future actions.

In such cases there must also be information sharing following the post mortem, primarily between the PCDR, pathologist and senior investigating police officer. To note: If the initial post mortem findings or findings from the child's history suggest evidence of abuse or neglect as a possible cause of death, the Police and Cumbria Children's Safeguarding Hub should be informed immediately.

In some cases, even if an explanation has been provided, the circumstances of the death may be such that it is considered appropriate to hold a meeting e.g. death resulting from suicide.

If there are concerns about surviving children living in the household, an immediate referral must be made to the Cumbria Children's Safeguarding Hub.

1.7 Decision to share information and plan action by phone

In cases where there is an explanation for the death e.g. a road traffic collision, it may be sufficient to share information and plan action by phone or by convening an Information Sharing and Planning Meeting / Discussion.

1.8 Practical Guidance on Immediate Response Process for Unexpected Deaths

1.8.1 Transportation of the Child

Children who die unexpectedly at home or in the community must always be taken to a hospital Emergency Department by Ambulance.

In exceptional circumstances a child's body may remain at the scene, e.g. for forensic scene examination, and later transported by Ambulance.

1.8.2 – On arrival at the Hospital Emergency Department / Immediate actions in Hospital

Children and young people should always be examined.

For children under 16 the examination is carried out by the Consultant Paediatrician.

For young people aged 16 – 17 years, this assessment may be carried out by the Emergency Department Consultant.

The Paediatrician/Consultant should:

- Obtain a detailed history of events leading up to and following the child's death;
- Complete an examination of the child;
- Take investigative samples; except where the child has already been pronounced dead – where the decision regarding samples to be taken will be under the coroner's jurisdiction.
- Consider skeletal survey (recommended in unexpected deaths under 5 years);
- Advise parents of future involvement of the Police and Coroner and about the Child Death Review Process and provide parents with contact details for lead professionals;
- Inform the Coroner and the PCDR /CDR Admin.

1.8.3 - Out of hours – Urgent Information Sharing - Immediate Response

If the death occurred out of office hours, including weekends/bank holidays and the information needs to be shared urgently (before the 'in hours' information sharing process can be organised) the PCDR will liaise with Police and inform Local Authority Children's Services via Cumbria Children's Safeguarding Hub Emergency Duty Team/Social Worker.

If there is a clear cause of death e.g. death resulting from a road traffic collision, a detailed history may be taken by the locality Paediatrician within the days following the death, and they will continue to provide support for the family.

If there are immediate concerns about the welfare of other children in the household, an immediate referral must be made to Cumbria Children's Safeguarding Hub.

1.9 – Immediate Information Sharing

All information shared with the PCDR and Police SIO must be considered and:

A Risk Assessment undertaken with and any immediate actions carried out eg. Referral to Cumbria Children's Safeguarding Hub

and

Used in the decision making process regarding whether to hold an Information Sharing and Planning Meeting / Discussion.

1.9.1 Immediate Information Sharing – Agency Responsibilities

Child Death Review multi agency leads actions: Once members of the multiagency leads have been notified of a child death, they must:

- Establish whether any professionals from their agency have had contact with the child or their family;
- Inform relevant individuals within their agency of the death;
- Facilitate the timely sharing of relevant information and their agency's participation in the rapid response process if required.

1.10 - Specific responsibilities in the Immediate Response:

1.10.1 – Child Death Review Administrator (CDR Administrator)

- The CDR Administrator will lead the initial process with the PCDR.
- At the point of receipt of notification of an unexpected child Death, the CDR Administrator will: -
- Consult with and immediately share the information with the Paediatrician for Child Death Review / Deputy.
  and
- the PCDR / CDR Administrator will notify the Multi Agency Leads
- Collate internal health records as required;
- Organise the information sharing meeting if required;
- Informs Safeguarding Business Manager, NHS Cumbria CCG (who will inform CDOP and health organisations – see notification pathway p.11)
- Ensure that a Form A – Notification of Child Death (Child Death Overview Panel Form) is completed and forward this as soon as practicable to the Safeguarding Business Manager, NHS Cumbria CCG.

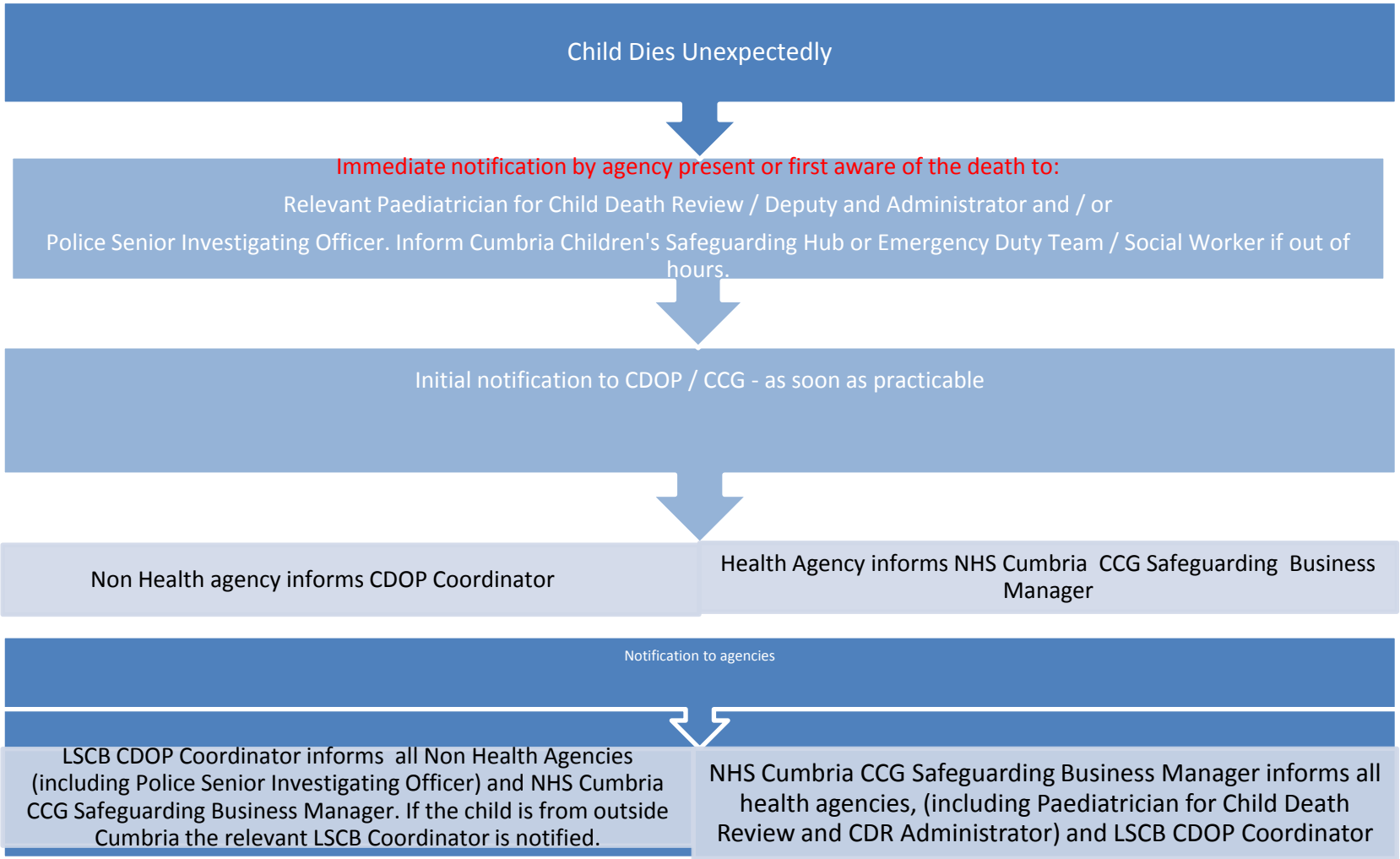
1.10.2 - Paediatrician for Child Death Review (PCDR)

- To lead information sharing and the planning process unless a criminal investigation has commenced, in which case the process may be led by the Police. In such cases, the PCDR should liaise with the Police SIO to ensure clarity of roles, and family contact;
- Contact the GP to share information and to discuss support the family may need;
- Contact the hospital Paediatrician involved. If the death is unexplained, establish:
    - What investigations have been carried out;
    - What the family have been told;
    - Whether a skeletal survey is being undertaken and if so, where and when;
    - How the hospital Paediatrician is going to share the information with the Pathologist prior to the post mortem. This may be by letter or via a telephone conversation.
- Liaise the multiagency Leads to collate single agency information and involvement;
- Discuss and risk assess with the Police Senior Investigating Officer (SIO) the information received about the case and carry out any agreed actions, eg. referral to Cumbria Children's Safeguarding Hub.
- Decide with the SIO whether any information sharing meeting / discussion is required and, if required, agree whether PCDR or SIO will chair and lead the process.
- Plan the information sharing meeting / discussion if required;
- If the death is unexplained, or there are concerns regarding the circumstances of the death, contact the Pathologist and inform them who the lead Paediatrician is for the case.

1.10.3 – Police Senior Investigating Officer (SIO)

- Gather background information;
- Establish details of any police information about or involvement with the child or family;
- Establish details of Family Liaison Officer.
- Discuss and risk assess with the PCDR the information received about the case and carry out any agreed actions, eg. referral to Cumbria Children's Safeguarding Hub.
- Decide with the PCDR whether an Information Sharing and Planning Meeting/Discussion is required and, if required, agree whether PCDR or SIO will chair and lead the process.
- Plan the Information Sharing and Planning Meeting/Discussion if required;

1.11.1 - Flowchart for Notification of Unexpected Child Deaths



1.11.2 Immediate Notification of the Unexpected Death of a Child

If death reported via informal process e.g. school, all administrators will check the accuracy of information prior to information being shared.

Immediate Notification

The relevant PCDR, CDR Administrator and Police SIO must be immediately informed by the professional with knowledge of the death, to initiate the Immediate Response. Cumbria Children's Safeguarding Hub must be informed or the Emergency Duty Team / Social Worker if out of hours.

See Appendix 7 for details regarding notification to relevant agencies.

1.11.3 For unexpected deaths which occur out of county.

The PCDR (Paediatrician for Child Death Review or their deputy) or Police SIO from Cumbria and out of county should discuss and agree the most appropriate lead for the Rapid Response and the subsequent Information Sharing and Planning meeting/s on a case by case basis. To support this, the following is a guide for expected practice:

- If a child from Cumbria dies out of county, usually the PCDR or SIO from Cumbria will lead the rapid response, convene and chair both the rapid response and Information Sharing and Planning meetings/discussions. The Paediatrician and relevant agency representatives from the area where the child died should be invited to join. Their involvement may be via a telephone / video conference.

2. CASE RESPONSE

Information Sharing and Planning Meeting / Discussion within 24-48 hours of the death being notified

If the death is unexplained or there are concerns regarding the circumstances of the death, an Information Sharing and Planning Meeting / Discussion should be organised as soon as practicable.

2.1 - Concerns re: other children

If there are concerns that other children may be at risk of abuse or neglect a referral must be made to the Cumbria Children's Safeguarding Hub immediately.

2.2 – Agency attendance

The meeting should involve the following representatives:

- Paediatrician for Child Death Review (PCDR) - Chair;
- Police Senior Investigating Officer (SIO)
- Team Manager from Social Care;
- Health Visitor/ School nurse;
- Hospital Paediatrician or Emergency Department Consultant involved in the case as appropriate;
- General Practitioner
- Consider inviting Ambulance representative or obtaining Ambulance information to share;
- Consider inviting safeguarding lead from school.

2.3 - Decisions to be made at the meeting:

- Who will provide relevant support and care to the family;
- Who will share information with the Pathologist;
- Whether any further information is required to help establish the cause of death or contributory factors;
- Whether a home visit is required and if so, when it will be done and who will accompany the paediatrician;
- Whether there are any concerns regarding the welfare of siblings or other children which require a referral to Cumbria Children's Safeguarding Hub.
- Consider media interest in the case and agree arrangements / contacts for media enquiries

- Discuss bereavement support for the family
- Discuss the requirements and responsibilities for informing others – e.g. other school pupils and peers and support to be put in place and the extent of information to be given (e.g. in order not to jeopardise criminal investigation)

2.4 - Other Actions:

- Police to provide accounts from parents/carers and make available to the PCDR prior to the home visit;
- The action plan from this meeting should specify how any new information will be shared. This should include:
    - Who will obtain results of the skeletal survey if not yet available and who these will be shared with;
    - Who will obtain results of post mortem and who these will be shared with;
    - Contact details of those involved including out of hours contact details for those representatives who need to know the results immediately, including the Paediatrician for Child Death Review, Police SIO and lead Social Worker.
- For babies, the sleeping arrangements and clothes are relevant for assessing the risk of Sudden Infant Death Syndrome (SIDS). The meeting should consider how the Paediatrician for Child Death Review can view these.

2.5 - Minutes

Minutes should be taken by the Child Death Review Administrator (NCUHT / UHMBT).

Copies of minutes should be distributed to all professionals invited and to the Coroner, the Pathologist, CDOP Coordinator, Police, and other relevant agencies.

If a meeting is not required, any information sharing and planning discussion should be led by the Paediatrician for Child Death Review. This should include liaison within Health services, Police and the Social worker as appropriate.

Representatives should record clearly the decision making process.

2.6 - Other actions post meeting

- The Paediatrician for Child Death Review should inform the Pathologist of the outcome of the meeting and provide relevant contact details for the Pathologist to share the results of the post mortem.
- Completion and submission of Form A (Child Death Overview Panel Notification Form). This is part of the formal notification process to the LSCB. See Appendix 8.

2.7 Post-Mortem Results

The post mortem results are particularly important if the death is unexplained or there are concerns about the circumstances of the death.

In such cases the Paediatrician for Child Death Review should request that the Pathologist contact the Paediatrician for Child Death review to provide the early post mortem results. (The Police and The Paediatrician for Child Death Review may attend the post mortem.)

The Paediatrician for Child Death Review should convene further multi-agency discussions, usually by phone, to review the post mortem information as it comes to light and agree relevant actions. This should take place as soon as possible and involve Police and Children's Services.

If the post mortem has been preceded by an initial Information Sharing and Planning Meeting/Discussion, this information should be shared as agreed at the initial meeting.

To note: The length of time from the date of death until receipt of the post mortem results may vary between cases.

Consideration should be given as to who will inform the parents of the result of the post mortem (Paediatrician or GP), with the Coroner's approval.

If the initial post mortem findings suggest evidence of abuse or neglect as a possible cause of death, the Police and the Cumbria Children's Safeguarding Hub must be informed immediately. The LSCB must also be informed.

If there are concerns about surviving children living in the household the Cumbria Children's Safeguarding Hub must be informed immediately.

2.8 Further Information Sharing and Planning Meetings

In complex cases it may be necessary to have further Information Sharing and Planning Meeting / Discussions as more information becomes available.

If complex findings are provided at the post mortem, an Information Sharing and Planning Meeting / Discussion should be held as soon as practicable, and should include the Pathologist. In cases in which there are complex pathology findings, it may be appropriate to have further information sharing meetings with Pathologists.

Minutes and action plans from previous Information Sharing and Planning Meeting / Discussions should be reviewed at each meeting.

Minutes should be taken by the Child Death Review Administrator. Copies of minutes should be forwarded to the LSCB Child Death Overview Panel (CDOP) Coordinator.

2.9 For unexpected deaths which occur out of county.

The PCDR (Paediatrician for Child Death Review or their deputy) or Police SIO from Cumbria and out of county should discuss and agree the most appropriate lead for the Rapid Response and the subsequent Information Sharing and Planning meeting/s on a case by case basis. To support this, the following is a guide for expected practice:

- If a child from Cumbria dies out of county, usually the PCDR or SIO from Cumbria will lead the rapid response, convene and chair both the rapid response and Information Sharing and Planning meetings. The Paediatrician and relevant agency representatives from the area where the child died should be invited to join. Their involvement may be via a telephone / video conference.

3. CASE RESPONSE

Final Case Discussion Meeting
usually held within 3-6 months of the death being notified

The Final Case Discussion meeting should be convened for all cases of unexpected death in children and young people. The meeting should be chaired by the relevant Paediatrician for Child Death Review (PCDR) with administrative support of the LSCB Child Death Overview Panel (CDOP) Coordinator.

If the PCDR recommends that a Final Case Discussion is not required for a case where death was unexpected, this must be discussed and agreed with the Chair of the LSCB Child Death Overview Panel.

3.**1 - Purpose of the Final Case Discussion meeting:**

- To share information about the life of the child and to identify cause of death and contributory factors;
- To plan future care for family;
- To complete Form C Analysis report form and case analysis
- To inform the Inquest;
- Potential lessons to be learned may also be identified by this process.

3.2 Agency participation in the Final Case Discussion

Invitations to be sent to agencies as relevant to the subject case.

- Ambulance Service;
- Police – Senior Investigating Officer (SIO);
- Family Liaison Officer as appropriate;
- Social Worker;
- Named Nurse from Acute Trust;
- Named Nurse from Community Services and Mental Health Services Trust;
- GP;
- Health Visitor, FNP Nurse or School Nurse;
- Pathologist;
- Consultant Paediatrician;
- School staff;

- Coroner's Officer;
- CAMHS team;
- Children Looked After team;
- Substance related deaths – relevant local services;
- Fire and Rescue;
- CDOP Coordinator (for administration purposes).

Participants will be informed that they need to prepare a verbal summary of their involvement prior to the meeting.

Copy minutes to all.

3.3 Process

After information has been shared by representatives and issues discussed, an analysis pro forma, 'Form C' will be completed by the LSCB Child Death Overview Panel (CDOP) Coordinator. The information included will be agreed by the Chair and all representatives present.

This form focuses on identifying contributory factors and lessons to be learned.

Completed forms B and C will then be anonymised by the LSCB Child Death Overview Panel (CDOP) Coordinator for discussion at the LSCB Child Death Overview Panel.

4. Child Death Overview Panel Process (CDOP)

4.1 Introduction

The Cumbria Child Death Overview Panel (CDOP) is a Sub Group of Cumbria LSCB.

The purpose of the overview process is to review information on all child deaths to inform local strategic planning on how best to safeguard and promote the welfare of children. For Cumbrian children the overview will be undertaken by the Cumbria Child Death Overview Panel. The Panel includes professionals from Health agencies, Police and Children's Services.

The overview is a paper exercise based on information available from those who were involved in the care of the child, both before and immediately after the death and in some cases the Coroner.

In order for Cumbria LSCB to fulfil its child death reviewing responsibilities, it will be informed of all deaths of children normally resident in its geographical area. The Cumbria LSCB Chair will decide who will be the designated person to whom the death notification and other data on each death should be sent. The Chair of the CDOP is responsible for ensuring that this process operates effectively.

Please note:

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.

4.2 Child Death Overview Panel Functions

- To review and evaluate the available information on all child deaths of children aged up to 18 years (including deaths of infants aged less than 28 days but excluding – deaths of babies who are stillborn and planned terminations of pregnancy carried out within the law to determine whether the death was preventable. This decision should always be approved by the Chair of the CDOP;
- To implement, in consultation with the local coroner, local procedures and protocols that are in line with this guidance on enquiring into unexpected deaths, and evaluating these as part of the information set held on all deaths in childhood;
- To collect and collate an agreed minimum data set on each child who has died and, seeking relevant information from professionals and family members;
- To 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;
- Having a mechanism to evaluate specific cases in depth, where necessary. This may involve revisiting child deaths after the outcome of other types of investigations is known (for example, outcomes from Serious Case Reviews or criminal proceedings);

- To monitor the appropriateness of the response of professionals to an unexpected death of a child, to review the reports produced by the immediate response on each unexpected death of a child, including the extent to which any recorded wishes and feelings of the child and family have been considered, making a full record of this discussion and providing the professionals with feedback on their work. Where a criminal investigation is being undertaken, the Crown Prosecution Service must be consulted as to what it is appropriate for the Panel to consider and what actions it might take in order not to prejudice any criminal proceedings;

- To refer to the Chair of the LSCB any deaths where, on evaluating the available information, the Panel considers there may be grounds to undertake further enquiries, investigations or a Serious Case Review and explore why this had not previously been recognised;

- To inform the Chair of the LSCB where specific new information should be passed to the coroner or other appropriate authorities;

- 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;

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

- To advise and monitor the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths;

- To organise and monitor 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;

- To identify 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; and

- To cooperate with regional and national initiatives - for example, by the Centre for Maternal and Child Enquiries (CMACE) - to identify lessons on the prevention of child deaths.

The outcomes of the CDOP process are:

- An understanding of patterns of childhood death;

- Improved procedures for responding to childhood death;

- Improved ascertainment of deaths due to abuse and neglect;

- Improved inter-agency working to prevent child deaths.

4.3 Child Death Overview Panel – Annual Report

In addition, the Child Death Overview Panel will prepare an annual report of relevant information for Cumbria LSCB.

This information will include: -

- The total numbers of deaths reviewed, recommendations made by the Panel about required future actions to prevent child deaths, and any further description of the deaths that the panel deems appropriate.
- A review of actions taken to implement the recommendations from the previous year's report, and set out any such recommendations which have not yet been fully implemented which are to be carried forward.

Appropriate care should be taken to ensure confidentiality of personal information and sensitivity to the bereaved families. Information which could lead to the identification of individual children or family members should not be included in the annual report.

Information regarding all Cumbria cases will be summarised in an annual report prepared for the Chair of Cumbria LSCB.

It is the responsibility of Cumbria LSCB to disseminate the lessons learned to all relevant organisations and act on any recommendations to improve policy, professional practice and inter agency working to safeguard and promote the welfare of children. This information will inform the Cumbria LSCB annual report.

The annual report will serve as a powerful resource for driving public health measures to prevent child deaths and promote child health, safety and well being.

4.4 CDOP Roles and Responsibilities

4.4.1 CDOP Chair

The Chair of the Panel is responsible for ensuring that the Panel operates effectively. He or she will:

- Ensure and monitor the effective running of the notification, data collection and storage systems
- Ensure that new members receive an orientation to the Panel prior to their first meeting
- Ensure that new Panel members, ad hoc members and observers sign a confidentiality agreement
- Promote and encourage the sharing of information for effective case reviews
- Chair Panel meetings effectively, encouraging all panel members to participate appropriately; ensuring that all statutory requirements are met; and maintaining a focus on preventive work
- Facilitate resolution of agency disputes
- Co-ordinate the development of the annual report
- Monitor and evaluate the effectiveness of recommendations and prevention initiatives and activities

4.4.2 - CDOP Panel Members Responsibilities (See Appendix 5 for responsibilities of individual panel members)

- Provide the panel with relevant information regarding cases eg. status of criminal investigation
- Assist the panel in evaluating patterns and trends in relation to child deaths and in learning lessons for preventive work
- In relation to their profession and organisation, each panel member will:

  - Provide relevant information regarding individual cases
  - Advise regarding relevant legislation

- Provide expert advice and professional opinion in the evaluation of issues relating to the circumstances of a child's death
- Identify areas of good practice
- Provide feedback to their own organisation
- Liaise with relevant professionals and professional bodies. Eg Coroner.
- Advise regarding the development and implementation of preventative initiatives.
- Help the panel evaluate any issues of public risk arising out of the review of individual deaths

4.5 Business Support for the Child Death Overview Panel

4.5.1 Documentation – Child Death Overview Panel Forms

There are three key documents (CDOP Forms) to support the child death review processes.

- **Form A**: Death Notification Form.
- **Form B**: Agency Report / Case Record (and supplementary forms relevant to the circumstances);
- **Form C**: Analysis Proforma

4.5.2 Form A – Notification Form

- The Form A should be completed by the agency which first became formally aware of the death.
- If the Form A is completed by a non-health agency the form should be sent to the CDOP Coordinator at Cumbria LSCB.
- If the Form A is completed by a health agency the form should be sent to the Safeguarding Business Manager at NHS Cumbria CCG

4.5.3 Form B: Agency Report / Case Record (and supplementary forms relevant to the circumstances);

- A form B should be completed by any services which had significant dealings with the child both at the time of death or during the period preceding the event.
- In cases of unexpected neonatal deaths Forms should be completed by all services which had contact with the mother of the child during the pregnancy and birth (eg midwifery, obstetrician, GP, paediatrician).
- In order to ensure completeness and accuracy of the information all representatives from each key agency should complete as much as they are able of Form B, drawing on a review of their agency records and discussions with individual practitioners.
- Some aspects of the form are specific to individual agencies (e.g. health), but all agencies should be able to prepare summaries of relevant information available to them.
- Nil returns are also required to be submitted and a **Form B should be submitted within 3 weeks of notification,** although there will be circumstances where, because of ongoing medical or police investigations, information may not be available for a longer period.
- The Paediatrician for Child Death Review will review Form Bs from health agencies for quality assurance and completeness of the information provided by each agency.

- Once all of the relevant investigations have been completed i.e. Police interviews, background checks, all Form Bs completed and returned, and any post mortem results are transcribed, the Child Death Overview Panel Coordinator can then initiate the next stage of the process – the Final Case Discussion.

4.5.4 Form C: Analysis Pro forma

The analysis pro forma is completed as the output from the Final Case Discussion.

4.5.5 Agencies returning completed CDOP Forms A and B

Forms from Cumbria non NHS agencies in Cumbria should be returned to the Cumbria Child Death Overview Panel Coordinator

Forms from Cumbria NHS agencies in Cumbria should be returned to the NHS Cumbria CCG Safeguarding Business Manager

4.6 CDOP Business Support – Roles and Responsibilities

4.6.1 Business Support – LSCB Child Death Overview Panel (CDOP) Coordinator

Provides all business and administrative support to the LSCB CDOP Panel. (See Appendix 6 for details of responsibilities).

Receives and records notifications of all child deaths of children

Notifies agencies within the county of the death of a child

Notifies out of county LSCBs of the death of a child from their area

Liaises with other LSCB CDOPs

Coordinates the collation of all information required by the panel to undertake the overview activity, including but not limited to:

- CDOP Form Bs
- CDOP Form C (output from End of Case Discussion)
- Post Mortem results
- Minutes of Information Sharing / Case Discussion meeting/s

Administers the Final Case Discussion and completes the Form C as output from the meeting

Liaises closely with Paediatricians for Child Death Review regarding information received for individual cases in preparation for consideration at the LSCB Child Death Overview Panel meeting.

Supports the LSCB CDOP Panel Chair in writing the CDOP annual report

4.6.2 NHS Cumbria CCG Safeguarding Business Manager

The NHS Cumbria CCG Safeguarding Business Manager: -

Provides notification support on behalf of health system within Cumbria and support regarding collation of documentation from the health system within Cumbria **(**See Appendix 6 for details of responsibilities).

Appendix 1: Cumbria Child Death Overview Panel Out of Hours Immediate Response Policy

Out of Hours immediate Response Meeting:

This meeting is required when:

A child/young person under the age of 18 dies and an Immediate Response is required (see guidance); and the death occurred out of office hours including weekends/bank holidays and the information needs to be shared urgently - before the 'in hours' information sharing meeting can be convened.

A discussion will take place between the Paediatrician for Child Death Review and Duty Crime Cadre (Police) about the arrangements, who will lead and minute the meeting on the circumstances of death, and a joint decision will be made.

The discussion may take place by phone but a record of the information shared and decision making must be made and documented (minuted).

Action: Why, Whom & When?

Procedures

Purpose of the meeting

1. **Briefing regarding the circumstances of death and information sharing by agencies**
2. **To share information regarding cause of death (if known)**
3. To identify any safeguarding concerns for other children in the family;
4. Consider whether there is any danger to others in relation to the cause of death eg. siblings
5. To identify whether there are any suspicious circumstances that may need further police investigation;
6. To identify any actions needed quickly by any agencies to help establish the cause of death and to then plan these actions;
7. To identify any contributing factors or causes which require immediate action to prevent recurrence/reduce risk
8. Agree immediate support for family and peer group
9. To consider media involvement.

The meeting should be attended by the following people:

1. Paediatrician who examined the child if the child is under 16 or;
2. Emergency Department Consultant
3. Social Worker for child's locality (Emergency Duty Team);

4. Police Senior Investigating Officer;
5. Ambulance staff if possible.
6. If the child is from out of county, appropriate representation from the out of county leads should be arranged if possible

Information required at the meeting

1. **From Paediatrician for Child Death Review /Emergency Department Consultant**:
    a. History related to the death;
    b. History of any relevant medical or social issues;
    c. Examination findings;
    d. Investigations undertaken i.e. retinal examination, CT/MRI, skeletal survey etc.
2. **From Police**:
    a. History given from the family;
    b. Information available from the examination of the scene or plan re-examination of scene;
    c. Background information regarding the family.
3. **From Children's Services**:
    a. Any previous involvement with family members.
4. **From Ambulance Staff**:
    a. Details of their involvement at the time of death including information about parent's presentation, history given and the scene.

Action Planning

The following actions should be agreed:

a. How this information will be passed onto the local multi agency leads for Child Death Review who will be organising the multi-agency information sharing meeting?
b. Who will liaise with the pathologist?
c. Who will inform family about the Child Death Review process?
d. If a skeletal survey is being organised - when this will be organised and who the results will be shared with?
e. A need to identify and respond to safeguarding concerns?
f. Possibility for media involvement and agreed immediate arrangements / contact details?

g. If the unexpected death is of a child from out of county, agreement with the out of county services regarding liaison and lead for the agreed actions.

Minutes

Any key discussion points and action points should be documented and agreed and later shared with:

- Those people who attended the meeting;
- Local paediatrician involved;
- Coroner;
- Pathologist;
- Child Death Review administrator;
- Child Death Overview Panel Coordinator.
- Out of county lead/s if the child is from out of county

Guidance - Child Deaths for which a Rapid Response is likely or certain to be appropriate

- Sudden Unexpected Deaths in Infancy (SUDI, up to 2 years old);
- Cardio-respiratory collapse of a previous healthy child;
- Where self-harm seems likely;
- The death from any lethal injury such as falls, drowning, fire, etc.
- Death that appears to be from a disease that is rarely lethal, such as diabetes or asthma;
- Deaths occurring in hospital (for instance, in intensive care) that follow any of the above.

Child Deaths for which a Rapid Response is very unlikely to be appropriate:

Deaths of babies occurring in hospital either shortly after delivery, or in infants so seriously unwell that they have never left hospital since birth.

Infants and children dying in hospital of a disease, even when the onset is very rapid.

Children dying while in receipt of an organised palliative care programme, either through a hospice, Macmillan nurses or some other clinical team.

Most deaths in children with degenerative, neurological, metabolic or other severely life-limiting illnesses, regardless of the place of death (*NB in making a decision not to undertake a rapid response, it must be borne in mind that occasionally children with such conditions are subjected to abuse or even killed*).

Appendix 2 – Child Death Overview Panel Forms

Form A Notification Form

To be completed by the agency which first became aware of the death.

Form B Agency Report Form

To be completed by all agencies involved with the child and family. All agencies should complete sections of the form with relevant information in order that the combined responses from all agencies will provide information about the child's family and life, care and support, any issues or concerns, and details regarding the circumstances of the death.

Section A - Identifying and Reporting Details

This section will normally be completed by the Child Death Overview Panel Coordinator from the notification form (Form A) prior to sending out to agency representatives. This identifying information can be separated from the rest of the form in order to anonymise the case prior to distribution to the Child Death Overview Panel members.

Section B- Summary of Case and Circumstances leading to the death

Information is included on the nature and circumstances of the death. As well as the core data items, narrative information on the circumstances leading to the death is included to inform the understanding of the case.

Other Sections:

C. The Child
D. Parenting Capacity
E. Family and Environment
F. Service Provision

Supplementary Forms (B2 – B12)

For some specific categories of death (e.g. road traffic accidents, apparent suicides, SUDI) further specific information will be gathered as part of the core data set. Additional forms will be distributed as appropriate.

To be completed in relevant circumstances by all agencies holding relevant information.

B2 – Neonatal Death
B3 – Death of a child with a known life limiting condition
B4 – Sudden Unexpected Death in Infancy
B5 – Road traffic accident
B6 – Drowning
B7 – Fire and Burns
B8 - Poisoning
B9 – Other non-accidental injury
B10 – Substance misuse
B11- Apparent homicide

B12 – Apparent suicide

Form C

Analysis pro forma to be completed by the Child Death Overview Panel Coordinator as an outcome of the Final Case Discussion.

Appendix 3 – Response to Expected Deaths

Following notification of the expected death of a child, the CDOP Coordinator and NHS Cumbria Safeguarding Business Manager should notify the relevant agencies in accordance with the distribution list for unexpected child deaths as a standard protocol.

The Paediatrician for Child Death Review and Child Death Review Administrator should seek to establish which agencies and professionals have been involved with the child or family either prior to or at the time of death. A lead professional should be nominated in each agency to assist with this.

A Form B should be sent out to the lead professional in each agency and to any professionals known to be involved. Professionals receiving an agency report form (Form B) should retrieve any relevant case records for the child or other family members to complete any information known to them or their organisation and return the form within the requested time frame using a secure means of transfer. Normally this should be within 3 weeks of notification.

In some cases it may be appropriate to organise a local case discussion. Such a discussion is captured on the Form C). In such cases it may not be necessary for all agencies to complete form B as this information will be collected at the discussion meeting.

Once the Form C has been completed, then all documentation about the child must be forwarded to the Child Death Overview Panel Coordinator who will anonymise the information ready to be submitted to the Child Death Overview Panel. Once the CDOP has reviewed and signed off the case review, feedback can be offered to the parents where applicable and other agencies involved.

Appendix 4 – Serious Case Review (SCR) Criteria

A Serious Case Review must be undertaken by the relevant LSCB for every case where abuse or neglect is known or suspected and either:

- a child dies; or
- a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child;

From:

Working Together to Safeguard Children and Young People (Department for Education, 2013)

Appendix 5

Roles and Responsibilities - CDOP Panel Members

Public Health representative

- 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
- Advise the panel on the development and implementation of public health prevention activities and programmes

Paediatrician

- 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
- Liaise with other health professionals and agencies

In respect of Neonatal Deaths the Paediatrician should:

- Provide the Panel with information relating to antenatal and perinatal care and support for the child and mother
- Advise the Panel on issues around antenatal and perinatal care
- Help the Panel to evaluate perinatal deaths
- Advise on any preventive strategies involving antenatal care or support
- Liaise with other midwifery and obstetric colleagues
- Provide feedback and support to midwifery and obstetric colleagues involved in individual case management

Children's Social Care

- Provide the panel with information on any social care involvement with the child and family, including any child protection procedures
- Provide the panel with information on other children in the home and any previous reports of neglect or abuse
- 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
- Provide feedback to social workers and other Local Authority staff involved in individual case management

Police

- Provide the panel with information on the status of any criminal investigation
- Provide the panel with relevant information relating to 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
- Feed back to police officers involved in individual case management

Designated/Named Nurse

- Provide the Panel with information on the health of the child and other family members, provided to the child and family
- Help the Panel to evaluate health issues relating to the circumstances of the child's death
- Advise the Panel on nursing practices that may have had a bearing on the child's health or well-being
- Assist the Panel 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

General Practice Representative

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

Appendix 6

Roles and Responsibilities - CDOP Business Support

CDOP Coordinator

- Provides all business and administrative support to the Panel.
- Receives and records notifications of all deaths of children under 18 years of age
- Notifies agencies within the county of the death of a child (see Appendix 7)
- Notifies out of county LSCBs of the death of a child from their area
- Co-ordinates meeting dates and ensures Panel members receive timely notification
- Coordinates the collation of all information required by the panel to undertake the overview activity, including but not limited to:
    - CDOP Forms
    - Post Mortem results
    - Minutes of Information Sharing / Case Discussion meeting/s
- Administers the Final Case Discussion and completes the Form C as output from the meeting
- Liaises closely with Paediatrician for Child Deaths regarding statues of individual cases and the review of the information received.
- Supports the CDOP Panel Chair in writing the CDOP annual report

Business Manager for Safeguarding, NHS Cumbria CCG

- Receives notifications from health agencies in Cumbria of the death of a child
- Notifies health agencies and the CDOP administrator of a child death (see Appendix 7)
- Coordinates the collation of CDOP Forms A and B from health organisations in Cumbria.

Appendix 7

Notification to relevant agencies – all child deaths:

When information is received about a child death, the information should be shared with relevant agencies as soon as practicable. This process should be followed for all child deaths: -

If the initial information is received by a non-health organisation the CDOP Coordinator must be informed. The CDOP Coordinator will notify the Safeguarding Business Manager at NHS Cumbria CCG, the relevant Child Death Review Administrator and relevant non health agencies. The Safeguarding Business Manager at NHS Cumbria CCG will inform all relevant health agencies

If the initial information is received by a health organisation the organisation will inform the Safeguarding Business Manager at NHS Cumbria CCG. The Safeguarding Business Manager will inform the CDOP Coordinator and all relevant health agencies including the relevant Child Death Review Coordinator and the relevant Paediatrician for Child Death Review.

If the Child Death Overview Panel (CDOP) Coordinator is notified about the death of a child or young person normally resident outside of Cumbria they should notify their counterpart in the area of their normal place 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 Child Death Overview Panels as to which panel will review the death and how the other panel will be notified of the outcome.

Appendix 8

Submission of completed CDOP Forms A and B

Form A – CDOP Notification Form

The Form A should be completed by the agency which first became aware of the death.

The Child Death Review Administrator should ensure that the Form A is completed by the relevant agency and forwarded to the Safeguarding Business Manager, NHS Cumbria CCG as soon as practicable.

Forms from Non NHS agencies in Cumbria

During the period in between the initial response meeting and the final case discussion (see Section 5.7) it is necessary for the Child Death Overview Panel Coordinator to collate as much information as is possible about the child's health and social background.

The CDOP Coordinator will forward a copy of the Form B to relevant non-health agencies for their completion eg:-

Children's Services Social Care

Police

NSPCC

Education / Schools

Unity Drug and Alcohol Service (commissioned by Public Health in Local Authority)

Hospice

Forms from non NHS agencies in Cumbria should be returned to the Cumbria Child Death Overview Panel Administrator

Forms from Out of County agencies

The CDOP Coordinator will forward a copy of the Form B to relevant out of county agencies (health and non-health) for their completion eg: -

Hospitals out of county providing tertiary / specialist care

Hospices out of county

Children's Homes out of county

Forms from Out of County agencies should be returned to the Cumbria Child Death Overview Panel Coordinator

Forms from commissioned NHS Health Organisations in Cumbria

The NHS Cumbria CCG Safeguarding Business Manager will forward a copy of the Form B to relevant commissioned NHS health organisations for their completion eg

Cumbria Partnership NHS Foundation Trust

General Practices

Cumbria Health On Call

North West Ambulance Service

University Hospitals Morecambe Bay NHS Foundation Trust

North Cumbria University Hospitals NHS Trust

Forms should be returned by health agencies to the Safeguarding Business Manager, NHS Cumbria CCG.