Pan-Cheshire
CHILD DEATH OVERVIEW PANEL PROTOCOL

Participating LSCBs:

Cheshire East
Cheshire West & Chester
Halton
Warrington

Version 2	Ratified:	CDOP 25.7.14 LSCBS:
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1 GENERAL

1.1 Background

From 1st April 2008, each Local Safeguarding Children Board (LSCB) has compulsory functions relating to child deaths as previously set out in Chapter 7 – Child Death Review processes of Working Together to Safeguard Children (2010) and revised in Chapter 5 – Child Death Review processes of Working Together to Safeguard Children (2013).

The Pan-Cheshire CDOP as a committee reporting to participating Cheshire LSCBs is responsible for reviewing the available information on all child deaths and is accountable to the Pan-Cheshire LSCB Chairs. The disclosure of information to the Pan-Cheshire CDOP about a deceased child is to enable the LSCB to carry out its statutory functions relating to child deaths under the 2004 C.A. The LSCBs functions in relation to child deaths are set out in Regulation 6 of the LSCBs Regulations 2006, made under section 14(2) of the Children Act 2004.

The Pan-Cheshire CDOP meets quarterly and is required to receive and analyse information about each child death within the Pan-Cheshire area and consider modifiable factors which may have contributed to the death. These factors can be defined as those which, by means of nationally or locally achievable interventions could be modified to reduce the risk of further child deaths. This will enable the Pan-Cheshire CDOP to make recommendations to prevent other deaths in the future. CDOP also has the responsibility for ensuring carers have effective information about bereavement including counselling and other services

1.2 Introduction

The death of a child is a traumatic time for everyone involved. The despair and pain the child's family experience is considered by many to exceed all other bereavement experiences. The family will experience extreme grief and shock and professionals will need to support the family sensitively to assist them in understanding what has happened and why. As highlighted in the guidance it is vitally important that LSCBs establish mechanisms for appropriately informing and involving parents and other family members in both the Child Death Overview and the Rapid Response processes. In Cheshire we will ensure that all agencies adhere to the rules for Rapid Response meetings including consistency of templates.

Sudden and unexpected childhood deaths need to be fully investigated to understand the circumstances of these deaths and to learn lessons about contributory factors in order to prevent future deaths. The management and investigation of sudden and unexpected deaths in childhood requires a sensitive balancing between medical management, the care and support of the family and any investigation into the cause of the death, including any forensic requirements.

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- Providing regular reports to the Chairs of the participating LSCBs on the progress and outcomes of Child Death Reviews.
- Referring to the Chair of the relevant LSCB any deaths where, on evaluating the available information, the Pan-Cheshire CDOP considers there may be grounds to undertake further enquiries, investigation or a SCR and explore why this had not previously been recognised;
- Informing the Chair of the relevant LSCB where specific new information should be passed to the Coroner or other appropriate agencies;
- Providing 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 family;
- Monitoring the support and assessment services offered to families of children who have died;
- Advising and monitoring the Cheshire LSCBs on the resources and training required locally to ensure effective inter-agency response to child deaths;
- Agree local procedures for responding to unexpected deaths of children.
- Organising and monitoring the collection of data for the nationally agreed minimum data set, and making recommendations for any additional data to be collected locally;
- Identifying any public health issues and considering, with the Directors of Public Health, how best to address these and their implications for both the provision of services for training; and
- Co-operating with regional and national initiatives to identify lessons on the prevention of child deaths.
- Where patterns and trends are identified CDOP will ensure LSCB's respond with appropriate campaigns and activities

The aggregated findings from all child deaths should inform local strategic planning, including the local Joint Strategic Needs Assessment, on how to best safeguard and promote the welfare of children in the area. The Pan-Cheshire CDOP should prepare an Annual Report of relevant information for the LSCBs.

2.3 Scope of Cases Considered by the Pan-Cheshire CDOP

The Pan-Cheshire CDOP will gather and assess data on the deaths of all children and young people from birth up to the age of 18 years who are normally resident in Cheshire. This will include neonatal deaths, expected and unexpected deaths in infants and in older children. This process excludes babies who have been stillborn and planned terminations of pregnancy which have been carried out under the law (Abortion Act 1967).

The Pan-Cheshire CDOP will gather and assess such data on the deaths of all babies over 22 weeks gestation if they were considered a 'live' birth (breathed or had a registered heart beat).

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Pan-Cheshire annual report, alongside annual reports for each individual LSCB. Copies of the Pan Cheshire and individual LSCB annual reports will be shared with the respective LSCB and relevant regional and national government bodies.

The Pan-Cheshire CDOP will provide quarterly reports to each LSCB which include information on the child death notifications received, reviews undertaken, analysis and learning in relation to the respective LSCB, as well as collated learning from Pan-Cheshire reviews. The quarterly reports will also provide an up-date on the impact of recommendations and learning from cases reviewed previously. The Pan Cheshire CDOP will provide six monthly reports to each LSCB which identifies learning and themes from the work undertaken over the last six months. The participating Cheshire LSCBs take responsibility for disseminating the lessons to be learnt to all relevant organisations, ensures that relevant findings inform local strategies, e.g. Children and Young People's Plan and acts on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.

The Pan-Cheshire CDOP will be responsible for supplying anonymised information on child deaths as required by the Department for Education to enable them to commission research and publish nationally comparable analyses of these deaths.

4.6 Involvement of Parents and Family Members

In line with Working Together guidance CDOP has recognised the importance of establishing mechanisms for appropriately informing and involving family members both in Rapid Response and the Pan-Cheshire CDOP process as follows:

Parents and family members are informed that their child's death will be reviewed and should be assured that the objective of the Child Death Review Process is to learn lessons in order to improve the health, safety and well-being of children and hopefully prevent further child deaths in the future. Parents should be advised that the Pan-Cheshire CDOP process is not about culpability or blame.

Parental consent is not required for the Pan-Cheshire CDOP process. The decision as to how and when a family will be informed of the role of the Pan-Cheshire CDOP is taken at the Rapid Response Meeting, for unexpected deaths. In the case of expected deaths the CDOP Coordinator will contact the respective CDOP Nurse/Safeguarding Nursing Team who will advise as to which practitioner will hand deliver the CDOP letter and leaflet to the family.

In Cheshire, it is agreed that good practice is to hand deliver a letter and leaflet that explains the CDOP process to the bereaved parents. This should be undertaken by a practitioner known to the family. The practitioner should be fully briefed on the CDOP process so that they can answer any immediate questions that the family might have.

4.7 Bereavement Support Services

The role of the Pan-Cheshire CDOP is to question whether bereavement services were offered to the

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