



The Local Safeguarding
Children Board
Working to Keep West Cheshire's
Children and Young People Safe



Pan-Cheshire CHILD DEATH OVERVIEW PANEL PROTOCOL

Participating LSCBs:

Cheshire East
Cheshire West & Chester
Halton
Warrington

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PAN-CHESHIRE CHILD DEATH OVERVIEW PANEL

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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.

When a child's death is regarded as 'expected', Working Together (2013) suggests that the professionals who undertook the care of the child may wish to organise a discussion of the case, as it may identify learning points which may improve the care of other children. The guidance suggests the recommendations of such a meeting could be captured on the C Form Analysis. Information from discussions would then provide the Pan-Cheshire CDOP with evidence of good local practice and allow a wider engagement of professionals with the Pan-Cheshire CDOP process.

2 TERMS OF REFERENCE

2.1 Purpose

Through a comprehensive and multidisciplinary review of child deaths, the Pan-Cheshire CDOP aims to better understand how and why children in Cheshire die and use findings to take action to prevent other deaths and improve the health and safety of children.

In carrying out activities to pursue this purpose, the Pan-Cheshire CDOP will meet the functions set out in Regulation 6 of the LSCBs Regulations 2006, made under section 14(2) of the Children Act 2004, in relation to the deaths of any children normally resident in their area:

a) collecting and analysing information about each death with a view to identifying –

- (i) Any case giving rise to the need for a review mentioned in Regulation 5(1)(e);
- (ii) Any matters of concern affecting the safety and welfare of children in the area of the authority;
- (iii) Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

b) putting in place procedures for ensuring that there is a co-ordinated response by the authority, their Board partners and other relevant persons to an unexpected death. (Working Together to Safeguard Children (2013), p73).

2.2 Objectives

In line with the guidance in Working Together to Safeguard Children (2013), the functions of the CDOP include:

- Reviewing the available information on all child deaths up to the age of 18, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
- Implementing, in consultation with the 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;
- Collecting and collating an agreed minimum data set on each child who has died and seeking relevant information from professionals and, where appropriate, family members;
- Meeting quarterly for a full day to review and evaluate the routinely collected data on all deaths of all children, and thereby identify lessons to be learned 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, at subsequent meetings. This may involve revisiting child deaths after the outcome of other types of investigations is known (examples being, outcomes from SCRs or criminal proceedings);
- Monitoring the appropriateness of the response of professionals to an unexpected death of a child and reviewing reports produced by the Strategy Meetings following the implementation of the Pan Cheshire SUDIC guidelines (2013) and the Pan-Cheshire CDOP Protocol (2013). The CDOP must consider other investigations, e.g. Health & Safety or other legal proceedings;

- 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).

3 PAN-CHESHIRE`S ARRANGEMENTS FOR UNEXPECTED AND EXPECTED CHILD DEATHS

3.1 Definition of an Unexpected Child Death

As highlighted in Working Together to Safeguard Children (2013) an unexpected death is defined as the death of a 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.

The Designated Consultant Paediatrician responsible for unexpected deaths in childhood should be consulted where professionals are uncertain about whether the child's death is unexpected. If in doubt, the process for unexpected child deaths should be followed until the available evidence enables a different decision to be made.

3.2 Definition of preventable Child Deaths

Working Together to Safeguard Children (2013) defines preventable child deaths as those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

When reviewing the death of each child, the Pan-Cheshire CDOP should consider such modifiable factors, examples being any factors in the child, the family and environment, parenting capacity or service provision. The Pan-Cheshire CDOP should then consider what action could be taken locally and what action could be taken at a regional or national level.

3.3 Notification of an Unexpected Child Death

As highlighted earlier, local rapid response arrangements are provided within the already established Pan Cheshire Protocol for SUDIC. These guidelines will be used in the event of an unexpected death of a child or young person in Cheshire.

3.4 Notification of an Expected Child Death

If a Cheshire child dies in Cheshire the Child Death Notification Form A is completed and returned to the Pan-Cheshire CDOP Coordinator. When a child who is normally resident in any of the participating LSCB areas dies in an acute hospital outside that area the child death notification form is completed by the Children's Liaison Service of the relevant acute hospital and forwarded to the Pan-Cheshire CDOP Coordinator within 72 hours following the child's death.

When a child who is normally resident in another area dies in an area covered by the Pan-Cheshire CDOP it is the responsibility of the locally agreed professional to notify his/her equivalent in the child's area of residence. Similarly, when a child normally resident in Pan-Cheshire dies outside the area, the Pan-Cheshire CDOP Coordinator should be notified by their equivalent in the area where the child died.

3.5. Notification of a Child Death Abroad

Where a child dies abroad, the UK Coroner only becomes involved if the child's body is brought back to this country, in which case the procedure is the same as for any other child death. Any such deaths will usually involve an inquest except when the death is from natural causes. Deaths that occur abroad are not registered in the UK. This means that, in a very small number of cases (that is, those that do not involve an inquest), the Pan-Cheshire CDOP may not become aware of a death in the area unless it is reported by the local media or brought to the Panel's attention by another means.

The GP and UK Coroner's Office may be informed in some cases of deaths due to natural causes.

Hence the GP and Coroner office should inform Pan Cheshire CDOP co-ordinator of any such deaths.

4 PANEL PROCESSES

4.1 Pan-Cheshire CDOP Membership

The Pan-Cheshire CDOP will have permanent representatives drawn from the key professional areas represented on participating LSCBs. Members of the CDOP attend the meetings as representatives of their profession/designation rather than representing their employing organisation. Members have a responsibility to disseminate recommendations and learning to Agency representatives on the Boards in the other Cheshire LSCB areas. Other members may be co-opted to contribute to the discussion of certain types of death when they occur. This will be agreed with the Chair of the Panel and their roles and responsibilities will be clearly identified by requiring them to sign and adhere to the Pan-Cheshire CDOP Confidentiality Statement.

Representatives will consist of:

- Chair (who is approved by the LSCBs)(Public Health)
- CDOP Coordinator
- Designated Nurse for Safeguarding Children/CDOP Nurse x2
- Designated Doctor for CDOP x2
- Police Inspector from PPU and SPPU
- Local Authority Service Manager, Safeguarding Unit
- Local Authority Service Manager, Children's Social Care
- Education Representative (where needed)
- Maternity Services Representative x2
- Lay Member x1
- LSCB Business Manager x1
- Co-opted Advisory Member (Paediatrician/Deputy Coroner)
- North West Ambulance Service (where needed)

CDOP Members will nominate a suitable deputy who will attend meetings in their absence to ensure that business can continue effectively. Details of designated deputies will be maintained by the Pan-Cheshire CDOP Coordinator. CDOP Members will ensure that their deputy is suitably briefed prior to attendance and has access to the necessary paperwork required for the meeting.

Regular attendance is essential to the effective running of the CDOP meeting, therefore if any Member fails to attend or send a suitable deputy on two occasions in a twelve month period, then the Chair will discuss with the Member whether an alternative Member should be nominated.

4.2 Child Death Review Process

The overall process of what happens following a child death involves a number of stages. This assumes that immediate management of the death, including issuing a death certificate; implementation of the

Pan-Cheshire Joint Agency SUDIC Protocol; bereavement care etc. will take place within the relevant agencies.

4.3 Referral of Cases to Pan-Cheshire CDOP

The process relates to children resident in the Pan-Cheshire area. There are 3 strands to the child death review processes, depending on the nature of the death:

- Expected deaths; the family receives standard bereavement care, including where appropriate planned palliative care. The doctor issues a medical certificate of the cause of death and the death is registered with the Registrar. Information is collected from all agencies and submitted to the Pan-Cheshire CDOP who will then review the case in depth.
- Where the death is unexpected; the Pan-Cheshire Joint Agency SUDIC Guidelines and Pan-Cheshire CDOP Protocol process is followed to gather information and support the family. This process helps inform the Coroner for the Inquest; information is collated through the SUDIC strategy meetings and a report from this case discussion is submitted to the Pan-Cheshire CDOP.
- Where, at any stage, a child may have been or likely to be harmed, there will need to be an interagency child protection and / or criminal investigation led by the Police. The nature of the rapid response therefore changes. The subsequent investigation informs the Coroner's inquest.

4.4 Confidentiality and Information Sharing

Information discussed at the CDOP meetings will be anonymised prior to the meeting. However due to the nature of the cases, the potential involvement of the media and involvement of some Members of the CDOP panel in prior case discussions and meetings, individuals details may be known to those at the meeting.

All Members must adhere to strict guidelines on confidentiality and information sharing. Information is being shared in the public interest for the purposes set out in Working Together and is bound by legislation on data protection.

CDOP Members will all be required to sign a Confidentiality Agreement before participating in the CDOP. Any ad-hoc or invited or Co-Opted Members and Observers will also be required to sign the Confidentiality Agreement. At each meeting of the CDOP all participants will be required to sign an Attendance Sheet, confirming that they have understood and signed the Confidentiality Agreement.

Any reports, minutes and recommendations arising from the CDOP will be fully anonymised and steps taken to ensure that no personal information can be identified. This information must not be shared with anyone without the agreement of the Pan-Cheshire CDOP Chair.

4.5 Accountability and Reporting Arrangements of Pan-Cheshire CDOP

Pan-Cheshire CDOP is accountable to the Chairs of the participating LSCBs. The Pan-Cheshire CDOP will be responsible for working to a Work Plan approved by the four Cheshire LSCBs. It will prepare a

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

parents at the time of their child's death and if not to establish the reasons for this. The CDOP will make recommendations as to how appropriate bereavement services should be offered.

5 PRACTICE GUIDANCE

5.1 Pan-Cheshire CDOP Assessment and Review

The Pan-Cheshire CDOP benefits from being able to review each individual child death in the context of other deaths of children within the four boroughs in Cheshire (Cheshire East, Cheshire West & Chester, Halton and Warrington) and thereby, identify any potentially contributory or recurrent themes and circumstances, or possible limitations in service provision by one or more agencies.

At case level and population level the Pan-Cheshire CDOP will seek to:

1. Consider any relevant factors identified from the Pan-Cheshire CDOP Agency Report Form B and the Analysis Proforma Form C and consider the degree to which the factors may have contributed to the death of the child or young person. This includes factors intrinsic to the child; factors in parenting capacity; factors in the family and environment; factors in relation to service provision.
2. Determine if there were modifiable factors identified in the death of a child. It is important to recognise that this categorisation is to inform any efforts to reduce childhood deaths. It does not in itself carry implication of blame in respect of any individual party, but acknowledges where factors are identified which, had they been different, may have resulted in the death being prevented.
3. Request additional information where necessary in order to make a decision about the category of death and whether there were modifiable factors.
4. Decide whether to refer the case back for further child protection enquiries or other investigations under Section 47 of the Children Act 1989, or Serious Case Review.
5. Evaluate data on the deaths of all children normally resident in Pan-Cheshire, 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. The focus of these actions and recommendations are on lessons learned at population level as it is anticipated that, in most cases, any individual action in relation to specific case management will have been identified and addressed through local case discussion or other related processes.

5.2 Categories of Child Death

There are two types of child death cases for the members of the Pan-Cheshire CDOP to consider:

1. Where the child's death is anticipated or expected 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.
2. Where the child's death is unexpected, such as a Sudden Unexpected Death in Children (SUDIC), an accident, homicide or suicide where a child subsequently dies, there will be additional factors in relation to the child's death which will be required for the Pan-Cheshire CDOP to review the death. Thus, the Pan-Cheshire CDOP will require extra information which will be in addition to the core

papers, for example a copy of the minutes from a SUDIC Strategy Meeting / Rapid Response Meeting.

As highlighted in Working Together 2013, where a suspicion arises that neglect or abuse may have been a factor in the child's death the case should be highlighted to the Chair of the relevant LSCB and the SCR procedures set out in Chapter 4 – Learning and Improvement Framework, Page 68 Serious Case Reviews of Working Together 2013 should be followed. If an SCR is initiated, the Pan-Cheshire CDOP will not be able to conclude the child death reviewing process until after the SCR has been published. Similarly, Pan-Cheshire CDOP will be unable to complete the child death reviewing process if the outcomes of criminal proceedings and/or an inquest are outstanding. This should **not**, prevent lessons from being learned and from being acted upon in a timely way.

5.3 Service Improvement

The Pan-Cheshire CDOP will seek to improve services locally by the following:-

- To improve the health and safety of children and to prevent other children from dying;
- To maintain a focus on prevention;
- To improve agency responses to all child deaths through monitoring the appropriateness of the response of professionals to each unexpected death of a child, reviewing relevant reports produced by the Pan-Cheshire CDOP who will be able to provide the professionals concerned with feedback on their work;
- To review the support and assessment services offered to families of children who have died;
- To ensure there is an independent review of all child deaths to give confidence to the public of Cheshire.

5.4 Training and Support for Staff

The Pan-Cheshire CDOP recognises that child deaths have an impact upon the staff that have been involved with the child and family prior to the death, or become involved with them as a result of the death.

If agency support for staff who require additional help in dealing with the death of a child is not accessible or available to them, the Pan-Cheshire CDOP is committed to identifying this concern. Thus, ensuring staff know who they may approach for help and support in dealing with the death of a child that affects them personally.

The Pan-Cheshire CDOP is also committed to ensuring that all staff understand their role in the Pan-Cheshire CDOP process by offering specific multi-agency training on the role of the Child Death Overview Panel.

6 OPERATIONAL PROCEDURES

6.1 Notification of Child Deaths

- Professionals, confirming the death of a child or young person, will notify the Pan-Cheshire CDOP Coordinator within 24 hours providing as much information as possible, such as name, age, address and circumstances of death of the child or young person. Notification is generally done by a direct telephone call or email and is followed by completion of Form A. The professional must complete a Form A and send to the Pan-Cheshire CDOP Coordinator within 48 hours.
- Any person notifying the Pan-Cheshire CDOP Coordinator of the death of a child should provide as much detail as is known to them in relation to the child and family and the circumstances of the death. They should also inform them of any professionals who are known to be involved with the deceased child or family.
- The Pan-Cheshire CDOP Coordinator will receive all notifications for children with a residential address within the Cheshire LSCB areas. The deceased child or young person will be allocated a unique identification number and all information will be collated onto a Pan-Cheshire CDOP Database.
- An Agency Report Form B and relevant form B supplements will be sent out to the lead professional in each agency and any professionals known to be involved.
- Professionals receiving an Agency Report Form B should retrieve any relevant case records for the child or other family members to complete the form and submit it to the Pan-Cheshire CDOP Coordinator within three weeks (Working Together to Safeguard Children 2013, Chapter 5, Page 83, Flowchart 6: Process to be followed for all child deaths), by secure means of transfer. Though in reality this may be longer due to on-going medical or police investigations.
- Confidentiality is crucial and information should be shared on a need to know basis only. Each Pan-Cheshire CDOP Member is responsible for sharing information with their own agency in line with the Pan-Cheshire CDOP Confidentiality Agreement.
- Once all Agency Report Form Bs have been returned to the Pan-Cheshire CDOP Coordinator they will collate the information onto a single Report Form B, anonymise and enter onto the Pan-Cheshire CDOP Database.
- Pan-Cheshire CDOP Combined Agency Report Form B should clearly identify the source of the information which may have come from health, police, social care and education. Pan-Cheshire CDOP Members may also wish for supplementary material such as SUDIC Strategy Meeting Minutes, Rapid Response Minutes and / or post mortem results.
- Prior to each Pan-Cheshire CDOP meeting, anonymised, collated Combined Agency Report Form Bs should be available on the Pan-Cheshire CDOP Sharepoint secure website to all Pan-Cheshire CDOP Members within 10 working days prior to the Pan-Cheshire CDOP meeting to allow them to read all the material in preparation for the meeting. This will avoid delay in scheduled meeting time. Any questions or omissions should be communicated to the Pan-Cheshire CDOP Chair or Pan-Cheshire CDOP Coordinator in advance of the meeting. If they cannot be dealt with before the

meeting, the case may be withdrawn and deferred to the next Pan-Cheshire CDOP when the required information/documents can be provided. This process requires secure communication systems to share information in a timely way.

- As reflected in Working Together to Safeguard Children (2013) the Pan-Cheshire CDOP should review each case brought before it to consider any modifiable factors contributing to the death, its classification of the death, and any lessons to be learnt from the death. CDOP Reporting Form C – the Analysis Proforma will be used to facilitate this discussion and provides a template for local and national data collection.
- The Pan-Cheshire CDOP Coordinator will ensure these forms remain anonymous with a unique identifier but no patient identifiable information. For each death Pan-Cheshire CDOP Members should classify the cause of death, identify any modifiable factors, and consider any recommendations that may be made about actions which could be taken to prevent such deaths in the future and to whom these recommendations should be addressed.
- If the Pan-Cheshire CDOP is unable to classify the death, or the information available is insufficient to adequately review the death, the Panel will make a decision as to whether and what further information could be obtained to assist them. Where appropriate, the case should be rescheduled for the next Pan-Cheshire CDOP Meeting. Where it is recognised that further learning is unlikely, even with further information, the final review of the case should be undertaken.
- The Pan-Cheshire CDOP will ensure that information is also received and evaluated by them regarding the services and immediate support offered to families of children who have died in Cheshire
- The Pan-Cheshire CDOP will ensure that information is also received and evaluated by them regarding the services and immediate support offered to families of children who have died in Cheshire, but who would usually reside in other CDOP areas. This will be undertaken via liaison between the Pan-Cheshire CDOP Coordinator and their equivalent in the relevant CDOP area.

6.2 Safeguarding Children Concerns

Where there is an on-going criminal investigation, the Pan-Cheshire CDOP must take advice from the Crown Prosecution Service as to what information is appropriate for the Pan-Cheshire CDOP to consider and what actions it must take in order not to prejudice any criminal proceedings.

If, during the enquiries, or following the implementation of the Pan-Cheshire Joint Agency SUDIC Protocol concerns are expressed in relation to the welfare of surviving children in the family, discussions should take place with the relevant Children's Social Care service. It may be decided that it is appropriate to initiate a single assessment.

If concerns are raised at any stage about the possibility of surviving children in the household having suffered or being at risk of suffering significant harm then the Pan-Cheshire Multi-Agency Safeguarding Children Procedures should be followed. The Police and Coroner must be informed immediately that there is a suspicion of a crime or evidence has come to light that the death may be of a suspicious

nature. The Chair of the relevant LSCB should be informed of the case to ensure that appropriate procedures are followed and to consider the need for a Serious Case Review.

6.3 Taking Action to Prevent Child Deaths

Individual deaths and overall patterns of childhood deaths across Pan Cheshire will be evaluated to determine if the deaths were preventable. This is undertaken by the Pan-Cheshire CDOP by the identification of modifiable risk factors specifically related to the child, parenting capacity, wider family, environment and society. It will also review services which were provided or required by the family. This information will enable the Pan-Cheshire CDOP to determine the best strategies for prevention.

Strategies to prevent child deaths may be considered at different levels:

- Strengthening Individual Knowledge and Skills. This will assist individuals to increase their knowledge and capacity to act leading to behaviour change, through education, counselling and individual support;
- Promoting Community Education;
- Training providers to improve knowledge, skills, capacity and motivation to effectively promote prevention;
- Changing organisational practices where system failures are identified or models of good practice highlighted;
- Mobilising neighbourhoods and communities in the process of identifying, prioritising, planning and making changes;
- Influencing policy and legislation where appropriate through local and national advocacy;

Recommendations made by the Pan-Cheshire CDOP will be based on the lessons learnt locally and nationally from the review of child deaths. The Pan-Cheshire CDOP will report to each LSCB on a six monthly basis, detailing recommendations. Local LSCBs will be responsible for acting on these recommendations. They should focus on specific measurable actions, including plans for monitoring the implementation of the recommendations by the relevant local agencies.

6.4 Pan-Cheshire CDOP Disagreement

The Pan-Cheshire CDOP Chair should encourage panel members to form a consensus opinion in their assessment of child deaths, for example whether a case should have been handled differently or whether the criteria for a Serious Case Review, as set out in Working Together to Safeguard Children (2013) are met in the opinion of the Pan-Cheshire CDOP. Where a consensus is not agreed, the decision of the Chair of Pan-Cheshire CDOP is final. The panel will record when there is no consensus.

7 COMMUNICATIONS AND THE MEDIA

All LSCBs will work together where there is media interest in the work of the Pan-Cheshire CDOP. Media interest in individual cases will be dealt with by the appropriate LSCB following their local arrangements.

Media interest in individual cases, where there is police involvement will be dealt with by the appropriate police communications team.

Appendix 1

ROLES AND RESPONSIBILITIES OF MEMBERS OF THE PAN-CHESTER CDOP PROCESS

The Pan-Cheshire CDOP will meet quarterly beginning in July 2013. The panel will be chaired by a Public Health Consultant who will Chair the first 6 meetings to give consistency to the panel during the initial 16 months.

The Named/Designated Person will be provided by Cheshire East and this person will also be responsible for the Business Support to the Pan-Cheshire CDOP.

The Designated Doctors will attend 8 meetings before being rotated.

For all other Pan-Cheshire CDOP member roles, a nominated member will be selected to represent that agency – Children & Families (Safeguarding and Social Care), police (SPPU and PPU), education (when required), nursing and midwifery. These representatives will attend all the meetings. CDOP members are accountable to all of the Cheshire LSCBs. Irrespective of which area they are employed to work in.

The process will be reviewed at the end of 1 year with full participation of all the Pan-Cheshire CDOP Members and Business Managers from the 4 LSCBs.

Pan-Cheshire CDOP Chair

The Chair of the Pan-Cheshire CDOP is responsible for ensuring that the Panel operates effectively and will:

- Co-ordinate Panel meeting dates with the Pan-Cheshire Business Support;
- Meet with the Pan-Cheshire CDOP Business Support prior to each Panel Meeting to discuss the agenda and any problems with information gathering;
- Ensure that new Panel Members, Members invited by the Panel 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 effectively; ensuring that all statutory requirements are met; and maintaining a focus on preventive work;
- Facilitate resolution of any agency disputes;
- Advise the Pan-Cheshire CDOP Business Support in the development of the annual report;
- Monitor and evaluate the effectiveness of recommendations and prevention initiatives and activities.

Local Pan-Cheshire CDOP Business Support – Named/Designated Person Role

- Ensure and monitor the effective running of the notification, data collection and storage systems;
- Be the named/designated person to whom the child death notification and other data on each child death should be sent;
- Allocate a unique identifier number to a deceased child following completion of the Pan-Cheshire CDOP Agency Report Form A ;

- Seek to establish which agencies have been involved with the child or family either prior to or at the time of death;
- Contact the lead professional from agencies who have been involved with the family and forward the Pan-Cheshire CDOP Agency Report Form B for them to complete;
- Place collated Form B and other relevant information on the secure website 10 working days before the Panel Meeting;
- Alert the relevant LSCB Business Manager to any difficulties encountered in obtaining information relating to a child's death;
- Provide business support to facilitate the efficient implementation of the Pan-Cheshire CDOP;
- Prepare the agenda alongside the Chair;
- Manage all correspondence, databases and all relevant paperwork associated with the Pan-Cheshire CDOP;
- Attend and minute the Panel Meetings.

Designated Nurse/CDOP Nurse

The Designated/Specialist CDOP Nurses will:

- 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 preventative strategies;
- Liaise with other nursing and allied health professionals;
- Assist the Panel in its evaluation of perinatal deaths;
- Review and evaluate the practice and learning from all involved health professionals and providers commissioned by CCGs across Cheshire;
- In preparation for the Panel Meeting read all relevant papers which will be available approximately 10 working days prior to the meeting on the secure website.

Pan-Cheshire CDOP Midwife

The maternity services representative will:

- 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 preventative strategies involving antenatal care or support;
- Liaise with other midwifery and obstetric colleagues;
- Provide feedback and support to health professionals involved in individual case management;
- In preparation for the Panel Meeting read all the relevant papers which will be available approximately 10 working days prior to the meeting on the secure website.

Public Health

The Public Health representative will:

- Chair the Panel Meetings;
- Take responsibility for all the Chairs functions above;
- 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;
- In preparation for the Panel Meeting read all the relevant papers which will be available approximately 10 working days prior to the meeting on the secure website.

Designated Doctor

The Designated Paediatricians will:

- Assist the Panel in interpretation of 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 post mortem 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;
- In preparation for the Panel Meeting read all the relevant papers which will be available approximately 10 working days prior to the meeting on the secure website.

Police

The Police representatives will:

- Upon receipt of the Pan-Cheshire CDOP Agency Report form B, the Police Pan-Cheshire CDOP Representative will retrieve any relevant police involvement with the child and family, including any Child Protection concerns in respect to the deceased child and other family members, which will enable them to complete the form to provide the Panel with information;
- The completed form should be submitted to the local Pan-Cheshire CDOP Business Support within a requested time frame which is generally three weeks, using a secure means of transfer;
- 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;
- Feedback to police officers and staff involved in individual case management;
- In preparation for the Panel Meeting read all the relevant papers which will be available approximately 10 working days prior to the meeting on the secure website.

Children's Social Care and Safeguarding

The Children's Social Care and Safeguarding representatives will:

- 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;
- Liaise with other local authority services;
- Provide feedback to Social Workers and other local authority staff involved in individual case management;
- In preparation for the Panel Meeting read all the relevant papers which will be available approximately 10 working days prior to the meeting on the secure website.

Education Representative:

The Education representative will:

- Assist the Panel in interpretation and evaluation of information about the education needs and the education service provided for the deceased child and other children within the household;
- Assist the Panel in providing appropriate preventative strategies;
- Provide feedback to education staff involved with the deceased child and other family members;
- In preparation for the Panel Meeting read all the relevant papers which will be available approximately 10 working days prior to the meeting on the secure website.

Lay Representative:

The Lay representative will:

- Assist the Panel in interpretation and evaluation of information;
- Assist the Panel by providing an independent view;
- In preparation for the Panel Meeting read all the relevant papers which will be available approximately 10 working days prior to the meeting on the secure website.

Advisory Paediatrician:

The Advisory Paediatrician will:

- Assist the Panel in the identification of geographically defined modifiable factors;
- Assist the Panel in the development and implementation of appropriate preventative strategies;
- Provide regular review and update of the SUDIC Guidelines and related documents;
- In preparation for the Panel Meeting read all the relevant papers which will be available approximately 10 working days prior to the meeting on the secure website.

LSCB Business Manager:

The LSCB Business Manager will:

- Assist the Panel to operate in a way that will achieve its functions as set out in Working Together guidance.
- Ensure that business items from all Cheshire LSCBs are included on the CDOP agenda as appropriate.
- Liaise with other LSCB Business Managers.

Appendix 2

LEGAL FRAMEWORK TO INFORMATION SHARING FOR THE PAN-CHESTER CDOP

The sharing of information within the Pan-Cheshire CDOP is a function set out in regulation 6 under s13 Children Act 2004. The sharing of information within the Child Death Overview Processes are designated a proportionate response in relation to the pressing social need for the protection of health and morals or the protection of rights and freedom of others. The functions of the Pan-Cheshire CDOP are, therefore, considered to be in the public interest.

The following legal frameworks are relevant to information sharing:

- **Children Act 2004 (Section 10):** statutory guidance for section 10 states that good information sharing is the key to successful collaborative working and that arrangements under s10 Children Act 2004 should ensure that information is shared for strategic planning purposes and to support effective service delivery.
- **Children Act 2004 (Section 11):** places a duty on bodies within the NHS to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children
- **Working Together to Safeguard Children 2013 (Chapter 5):** (HM Government 2013) sets out the functions of the CDOP. This includes collection and collating an agreed minimum data set and where relevant seeking information from professionals and family members.

- **Human Rights Act 1998 (Article 8.2):** the right to respect for private and family life can be legitimately interfered with where it ‘is in accordance with the law and is necessary ... in the interests of ... the protection of health and morals or the protection of rights and freedoms of others’.
- **Common Law Duty of Confidentiality:** The common law provides that where there is a confidential relationship, the person receiving the confidential information is under a duty not to pass on the information to a third party. The duty is not absolute and can be shared without breaching the common law duty if there is an overriding public interest in disclosure.
- **Data Protection Act 1998:** Information sharing within the CDOP is a statutory function and the Data Protection Act, therefore, permits the sharing of information without the express consent of the subjects.

Appendix 3

INFORMATION SHARING

The following sets out an agreement for the agencies that constitute the Pan-Cheshire CDOP for sharing and maintaining the confidentiality of information necessary for the Pan-Cheshire CDOP to perform its function. It identifies the data management systems established to record, analyse and monitor child deaths and to meet intended purposes and outcomes. Information for panel discussion will be sent to panel members 1 week before the panel meeting.

Data Collection: Initial Notification

- Any professional (or member of the public) hearing of a local child’s death in circumstances that may mean it is not yet known about (for example, the death of a child abroad) can notify the Named/Designated Person.
- Where the child dies in another area, the local Named/Designated Person should notify the Pan-Cheshire Named/Designated Person within 24 hours and provide contact details of their equivalent in the identified area. The Chairs of the respective Panels should agree which Panel will review the child’s death and how they will report and share the outcomes and lessons to be learned.
- Where a child dies abroad, the UK Coroner only becomes involved if the child’s body is brought back to this country, in which case the procedure is the same as for any other child death. Any such deaths will usually involve an inquest except when the death is from natural causes. Deaths that occur abroad are not registered in the UK. This means that, in a very small number of cases (that is, those that do not involve an inquest), the Pan-Cheshire CDOP may not become aware of a death in the area unless it is reported by the local media or brought to the Panel’s attention by another means.

Data Collection

- Local data collection and analysis – All the agreed child and family specific data in relation to the death, preventability scoring and summary outcomes and recommendations must be recorded and this information should be inputted into a simple local electronic database (Access or Excel) which is consistent across the participating panels and allows the collation of all Pan-Cheshire child death data by the participating LSCBs for annual strategic analysis and recommendations.
- Reporting – Local data, lessons and recommendations to be reported to the LSCB at least annually or as agreed.
- The Pan-Cheshire CDOP Business Support will inform this process by completing the Pan-Cheshire CDOP Reporting Form B. This collects and collates information from key agency representatives and discussions with individual practitioners. The collated information will enable the Pan-Cheshire CDOP Business Support to prepare a case summary of relevant information for Panel members 10 working days before the Panel meets.

Data management / storage and processing

- Cheshire East has provided a secure website – Sharepoint, which enables Panel Members across the NHS, Cheshire Police and Local Government to have access to panel papers prior to the meetings.
- **IMPORTANT: when sharing information by email only emails sent between nhs.net, gesx.gov.uk and pnn.police.uk are secure and other steps to protect the data must be taken when sending to or from other addresses.**

Appendix 4

WHERE A CHILD DIES ABROAD

Where a child dies abroad, the UK Coroner only becomes involved if the child's body is brought back to this country, in which case the procedure is the same as for any other child death.