Enfield Safeguarding Children Board
...because safeguarding children is everybody's business

Protocol and terms of reference for the Child Death Overview Panel

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1. Introduction

The Child Death Overview Panel is a subcommittee of the Enfield Safeguarding Children Board (ESCB) in accordance with the statutory guidance *Working Together to Safeguard Children 2015*. This protocol is based on Chapter 5 of Working Together and should be read in conjunction with this.

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

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

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

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

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

2. CDOP Tasks

2.1. For any child who dies who is normally a resident of Enfield, CDOP will collect and analyse information about the death. This is in order to identify;

- Matters of concern affecting the safety and welfare of other children in the area of the authority
- Wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area.
- Whether information is collected which indicates neglect or abuse may have contributed to the death and interagency working was an issue. If so, the family will be referred to the chair of the ESCB to consider if a SCR is appropriate. After a SCR has been completed the case reverts back to CDOP to complete the overview process.

2.2. In order to review all child deaths in the area, information is gathered using the DfE (Department for Education) forms:

- Form A - notification to the CDOP coordinator.
- Forms B - Agency Report Form and Forms B1 – B13, information gathering specific to each agency/death, these will be requested when required from the CDOP Co-ordinator
- Form C – analysis proforma for the panel discussion or third case review of the rapid response meeting.

2.3. The panel will have information available from;

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

3. Children who die in this area but are not normally resident

3.1. Sometimes children die in this area and Enfield is not their normal place of residence, CDOP will:

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

4. Death of a local child outside of area

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

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

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

4.4. Children where parental responsibility is shared with the Local Authority (e.g. looked after children) but may be placed in another county will be reviewed by the panel in their normal area of residence in conjunction with social care providers and local children's services.

4.5. The Coroners (Investigations) Regulations 2013 place a duty on Coroners to inform the LSCB for the area in which the child died or the child's body was found, where the Coroner decides to conduct an investigation or directs that a post mortem should take place. The Coroner must provide to the ESCB all relevant information held by the Coroner relating to the child's death.

Where the Coroner makes a report to prevent other deaths, a copy must be sent to the LSCB . On receipt of an initial report of a death of a child, the LSCB with an interest in this information should inform the coroner of the address(es) (including email address(es)) to which future information should be supplied. If any information comes to the attention of an LSCB which it believes should be drawn to the attention of the relevant coroner, then the LSCB should consider supplying it to the coroner as a matter of urgency.

5. Membership of Panel

5.1. CDOP membership consists of representatives from:

- North Middlesex University Hospital NHS Trust
- Royal Free London NHS Foundation Trust
- Barnet, Enfield & Haringey Mental Health NHS Trust
- Public Health for Enfield
- NHS Enfield Clinical Commissioning Group (CCG)
- London Ambulance Service NHS Trust
- London Borough of Enfield (Children and Young People's Services)
- Metropolitan Police Service (Enfield Borough)
- Metropolitan Police Service (Child Abuse Investigation Team)
- Designated Paediatricians for Safeguarding
- Designated / Named Safeguarding Children Nurses
- North London Coroner
- Enfield Safeguarding Children Board
- Designated GP

5.2. Other members to be co-opted as and when appropriate to ensure membership reflects the characteristics of a local population, provide a perspective from the independent sector, or contribute to the discussion of certain types of death.

5.3. The Chair and Vice Chair are accountable to the ESCB Chair.

5.4. The criteria for visitors to observe a panel meeting. They must be:

Employed by one of the agencies represented on the panel or directly involved in child death or looking to be promoted into a role in this field and should be sponsored by a representative on the panel.

5.5. Responsibility lies with individual Panel members who step down from their role on CDOP to formally advise the CDOP Chair and arrange a replacement from their Agency.

6. Key functions of the Child Death Overview Panel

6.1. To ensure, in conjunction with the relevant Coroners, procedures and protocols comply with Chapter 5 of Working Together to Safeguard Children 2015 to enquire into and review all children's deaths in the area.

6.2. To collect a minimum data set as required by the DFE and submit this annually for national data collection.

6.3. Where relevant and appropriate, to seek further information from professionals and family members should they wish to contribute.

6.4. To meet regularly to review and evaluate data on all child deaths. To focus on effective interagency working and undertake some reviews in more depth.

6.5. In order to identify possible modifiable factors, which may or will prevent future deaths, cases can be evaluated in depth, if necessary by deferring to subsequent meetings. The review/evaluation will aim to;

- Review an unexplained death to identify lessons to be learnt
- To consider individual cases in more depth following referral from ESCB Chair and/or SCR Panel.
- To consider clusters of cases with similar issues.

6.6. The panel will oversee professionals' responses to an unexpected death by reviewing the reports of the rapid response team, recording this discussion and enabling feedback to be given on professionals' roles.

6.7. Generally cases involving a criminal investigation are not reviewed before the conclusion of proceedings, if ongoing; the panel will be advised by the Crown Prosecution Service regarding what information the Panel can consider which will not prejudice criminal proceedings.

6.8. Refer to the Chair of the ESCB any deaths where from the available information, the Panel considers there may be grounds to undertake further enquiries, investigations or a Serious Case Review.

6.9. Informing the Chair of the ESCB where specific new information should be passed to the Coroner or other appropriate authorities.

6.10. Where relevant, to provide information to a professional working with the family so they can convey this information in a sensitive and timely manner to them.

6.11. Monitoring that support and appropriate assessment services are offered to families of children who have died.

6.12. To formulate and support training plans, advising the ESCB on the resources and training required locally ensuring an effective inter-agency response to child deaths.

6.13. Organising and monitoring the collection of data for the nationally agreed minimum data set, and making recommendations (to be approved by ESCBs) for any additional data to be collected locally.

6.14. Co-operating with regional and national initiatives – e.g. Reducing Risk through Audits and Confidential Enquiries across the UK

6.15. Identifying any public health issues and considering, with the Director(s) of Public Health, how best to address these and their implications for both the provision of services and for training

6.16. To report annually to the ESCB, with relevant, anonymous information and SMART recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children by reducing child death, reducing hospital admissions caused by unintentional and deliberate injuries to children.

6.17. To provide an interim report 6 monthly to each ESCB updating the action plan.

7. Consent and confidentiality

7.1. All ESCB member agencies must be aware of the need to share information about all child deaths with the panel in order that CDOP can fulfil its statutory duty.

7.2. All members of the panel must respect and maintain confidentiality of the children who are being reviewed.

7.3. Information bought to the panel will be anonymous. However some cases may have elements of identifiable information that has to be shared in order to properly understand the death.

7.4. Parental consent is not required for information to be passed to the designated paediatrician for unexpected deaths in childhood and CDOP co-ordinator. Parental responsibility is deemed as defined in the Children Act 1989 and they should be advised that their child is to be reviewed by the panel. This must be handled sensitively and usually the doctor confirming the child's death does this, followed up with a letter (see appendix B). There is also a leaflet entitled *When a Child Dies* (see Appendix C)

7.5. Members of the panel are required when they join the panel to sign a confidentiality agreement that includes requirements about sharing and securely storing information. (see appendix A)

7.6. No panel member may disclose any information from the discussions which take place within the meeting, other than in the course of the agency responsibilities of that individual. Public statements about the general purpose of the child death review process may be made, as long as they are not identified with any specific case.

8. Professional & Family Support

8.1. Before the panel meets, the Chair will consider for each case what information should be sent to the child's family about the process. This should reach the parents with enough time for them to respond before the panel meets should they so wish.

8.2. The panel will consider what feedback is necessary to be given to professionals involved with the child's family so that they can convey this information in a sensitive and timely manner to the family.

8.3. The Chair will ensure that the panel considers what bereavement services and immediate support is offered to families of children who have died.

9. Learning from child deaths

9.1. The Chair will monitor and advise the ESCB on the resources and training required locally to ensure an effective inter-agency response to child deaths.

9.2. The panel may identify public health or welfare issues and report these to the Health & Wellbeing Board to consider how best to address these and the implications for both the commissioning of services and training.

9.3. The local CDOP process will contribute to regional and national initiatives to identify lessons on the prevention of unexpected child deaths, to monitor advice and research nationally and internationally with knowledge about effective interventions

9.4. From advice and recommendations from CDOP the ESCB will:

- Disseminate the findings and lessons to all relevant organisations;
- Ensure that relevant findings inform single agency plans.
- Act on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.
- Ensure that data relating to child deaths is submitted to relevant local, regional and national initiatives including the Joint Strategic Needs Assessment to identify lessons on the prevention of avoidable factors in child deaths, hospital admissions, accidents and morbidity.

10. Appendices

10.1. **Appendix A – Confidentiality Statement**

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Confidentiality Statement

The purpose of the Child Death Overview Panel is to conduct a thorough review of all preventable child deaths in Enfield in order to better understand how and why children die and to take action to prevent other deaths.

In order to assure a co-ordinated response that fully addresses all systematic concerns surrounding child deaths, all relevant data should be shared and reviewed by the team, as permitted within the stipulations of the Data Protection Act, including historical information concerning the deceased child, his or her family, and the circumstances surrounding the death. Much of this information is protected from public disclosure.

The Enfield Protocols for *Rapid Response* and for *Child Death Overview Panels* and the Enfield Safeguarding Children Board protocols for child death reviews stipulate that in no case will any team member disclose any information regarding team discussion outside the meeting other than pursuant to the mandated agency responsibilities of that individual. Public statements about the general purpose of the child death review process may be made, as long as they are not identified with any specific case.

The undersigned agrees to abide by the terms of this confidentiality policy

Name Agency Signature

Date

10.2. **Appendix B - Letter to parents**

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Names(s) of parent(s) and address
Address
Address
Address
Address

Please reply to: Enfield Safeguarding Children Board
PO Box 59
Civic Centre
Silver Street
Enfield EN1 3BR

Tel Ext/Direct Dial: 020 8379 3012 / 2722

Fax Ext/Direct Dial: 020 8379 2888

E-mail: Local.safeguarding.children.board@enfield.gov.uk

Date:

Dear (insert parent or parent's name),

I have been told of the very sad death of your child, (child's name), and as the Chair of the Child Death Overview Panel for the London Borough of Enfield, I would like to express my condolences to you and your family at this sad time.

I am writing to you at this time because the law requires that every child death must be reviewed to see if there is anything that we or anyone else can do to improve services for children and their families in the future.

We will now gather information about (child's name) from health services / school / children's services and any other services that may have been involved with your family prior to (child's name)'s death.

The leaflet enclosed explains about the review. If you would like to share your experience or offer any information that you feel would help us to understand (child's name)'s death better; or anything about the services provided to her/him and your family before and after her/his death, please contact me on 020 8379 2722 or 3012.

Yours sincerely,

Glenn Stewart
Chair
Enfield Child Death Overview Panel
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10.3. **Appendix C When a Child Dies leaflet**

CDOP leaflet for bereaved parents Ma