MERSEYSIDE CHILD DEATH OVERVIEW PANEL PROTOCOL
April 2014

Participating LSCBs:

Knowsley
Liverpool
Sefton
St Helens
Wirral

C O N T E N T S

SECTION 1: GENERAL

1.1 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. At this time 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.

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.

1.2 Context

From 1st April 2008, each Local Safeguarding Children Board (LSCB) was given compulsory functions relating to child deaths as set out in Chapter 5: Child Death Review Processes of Working Together to Safeguard Children (2015).

Merseyside CDOP (referred to as CDOP), as a sub-group reporting to participating Merseyside LSCBs, is responsible for reviewing the available information on all child deaths and is accountable to the Merseyside LSCB Chairs. The disclosure of information to the CDOP about a deceased child is to enable the LSCB to carry out its statutory functions relating to child deaths.

The CDOP meets monthly and is required to collect and analyse information about each child death within the Merseyside area. They should consider modifiable factors which may have contributed to the death. Modifiable factors are defined as factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.

Working Together to Safeguard Children (2015), Chapter 5, p81-91 describes the process for reviewing child deaths, and the circumstances which may trigger a Serious Case Review (SCR).

The first stage of the process is:

1. A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child. In Merseyside the LSCBs have worked closely to establish a system whereby deaths are reported and evaluated expeditiously. This rapid response is provided within the Merseyside Joint Agency Protocol for Sudden Unexpected Death in Infancy (SUDI) (Oct 2012) for children from birth up to 2 years and the Merseyside Joint Agency Protocol for Sudden Unexpected Death in Childhood (SUDiC) (January 2015) for children and young people aged 0 to 18 years**.** This protocol provides the rapid response arrangements to be progressed in the event of an unexpected child death.

2. An overview of all child deaths up to the age of 18 years by a multi-agency Child Death Overview Panel (CDOP). CDOP does not consider stillbirths and should not consider deaths that follow a planned termination under the law (Abortion Act 1967) even in instances where a death certificate has been issued. All other child deaths which have been registered as live should be reviewed by CDOP.

1.3 Types of Child Death

There are two types of child deaths for the members of CDOP to consider:

1. Where the child's death is anticipated or not unexpected and likely to be more straightforward, with no additional complicating factors. Cause of death may be reviewed briefly to learn key lessons. These are likely to be the substantial number of 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 Childhood (SUDiC), an accident, homicide or suicide where a child subsequently dies, there will be information regarding additional factors relative to the child's death that will be required for the CDOP to review the death. Thus, the CDOP will require additional information which will be in addition to the core papers, for example, a copy of the minutes from the SUDiC strategy meeting.

If in reviewing the child death CDOP consider that the criteria is met for a Serious Case Review (SCR), in that abuse or neglect are known or suspected, and there are concerns about how organisations or professionals have worked together to safeguard the child, the Chair of the relevant LSCB should be contacted and the Serious Case Review procedures set out in Chapter 4 of Working Together 2015 should be followed.

If a Serious Case Review is initiated, CDOP will not conclude the child death reviewing process until after the Serious Case Review has been published. Similarly, CDOP will be unable to complete the child death reviewing process if the outcomes of criminal proceedings, an inquest, or any other internal reviewing processes have not been concluded. This should **not** preclude action being taken where lessons are immediately identified and intervention is necessary to safeguard other children.

Following the conclusion of the SCR process CDOP should consider a summary of the report and the recommendations/action plan to accept them and progress categorisation of the death.

1.4 Involving Parents, Families and Carers

Merseyside CDOP has produced a leaflet entitled “What we have to do when a child dies” that contains information for parents, families and carers (Appendix 8). The leaflets are distributed by the Registrars at the point at which the child’s death is registered. In the event of an inquest the leaflet is contained within the inquest pack provided by Coroner’s Officers, as registration of the death will not occur until the inquest has concluded.

Contact details for the Merseyside CDOP Team are provided should anybody wish to seek further information.

1.5 Bereavement Services

A range of support services for those affected by the death of a child are available both locally and nationally; (for a resource list see appendix 6). The Alder Centre at Alder Hey Hospital in Liverpool is a specialist service set up to provide care and education to anyone affected by the death of a child of any age, by any cause, however recently or long ago – not just children who were patients at Alder Hey. Services at the centre are provided by a team of professional staff working alongside trained volunteers (who are themselves bereaved parents) and include counselling, support groups, training, befriending and a

telephone helpline. The Centre can also signpost and refer to other local and national agencies – to contact the Alder Centre call 0151 252 5391.

1.6 Definitions

1.6.1 Definition of a Preventable Child Death

Working Together 2015, page 85, defines a preventable child death as one 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.

In reviewing the death of each child, the CDOP should determine whether there were modifiable factors, for example relating to the child themselves, in the family and environment, parenting capacity or service provision, and consider what action could be taken locally or taken at a regional or national level and make recommendations to achieve.

1.6.2 Definition of an Unexpected Child Death

Working Together to Safeguard Children (2015) defines an unexpected death 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.

In accordance with the SUDiC protocol (January 2015) 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. The 'standing down' of the process, however, requires the permission of the relevant Coroner (see SUDiC protocol).

SECTION 2: TERMS OF REFERENCE

2.1 Purpose

Through a comprehensive and multidisciplinary review of child deaths, the CDOP aims to better understand how and why children in Merseyside 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 CDOP will meet one of the functions set out in Regulation 6 of the LSCBs Regulations 2006, in relation to the deaths of any children normally resident in their area:

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

  Any case giving rise to the need for a review mentioned in Regulation 5 (1) (e);

  Any matters of concern affecting the safety and welfare of children in the area of the authority; and

  Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
- 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 (2015), p81).

2.2 Objectives

In line with the guidance in Working Together to Safeguard Children (2015), the functions of the CDOP include:

- Reviewing all child deaths up to the age of 18 years, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
- Collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
- Discussing each child's case, and providing relevant information or any relevant actions, related to individual families, to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;
- Determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;

- Making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
- Identifying patterns and trends in local data and reporting these to the local LSCB;
- Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required;
- Agreeing local procedures for responding to unexpected deaths of children; **and**
- Cooperating with regional and national initiatives – for example, with the National Clinical Outcome Review Programme – to identify lessons on the prevention of child deaths.

2.3 Confidentiality and Information Sharing

Multi-agency reports submitted to CDOP are anonymised prior to the meeting. However, post mortem reports and any third party information that is in a format that cannot be anonymised will still be made available to the panel, therefore it is essential that all members adhere to strict guidelines on confidentiality and information sharing. Information is being shared in the public interest for the purposes set out in Chapter 5 of Working Together to Safeguard Children (2015) and is bound by legislation on data protection.

CDOP members are required to sign a confidentiality agreement before participating in the CDOP. Any co-opted members and observers will also be required to sign the confidentiality agreement. At each meeting of the CDOP, panel members sign the attendance sheet and are asked to sign the confidentiality agreement again.

Any reports, minutes and recommendations arising from CDOP will be anonymised thus preventing the identification of personal information. This should also apply to professionals as well as families. If identifiable information is to be conveyed outside of CDOP, this will require agreement from the CDOP Chair.

SECTION 3: PANEL PROCESSES

3.1 Child Death Review Process

The overall process of what happens following a child's death involves a number of stages. This assumes that immediate management of the death, including issuing a death certificate; implementation of the Merseyside Joint Agency SUDiC protocol; bereavement care etc. will take place within the relevant agencies.

3.1.1 Notification of a Child Death

Paediatric liaison staff within hospitals across Merseyside and staff in other agencies eg children's hospice, Walton Centre, input initial notifications (Form A: Appendix 7.1) directly on to the Sentinel database system. This informs the Merseyside CDOP team that a child death has occurred. Requests are then made to agencies via Sentinel for records to be checked. This involves an automatic e-mail from Sentinel being sent that states 'Child Death Number eg 777 requires your attention. If the child or any family member are known, or have been known in the past, an agency report form (Form B) should be completed on Sentinel and is available to the CDOP team once the report has been saved and Sentinel has been closed.

As there are a number of resources within Merseyside that offer services nationally the Sentinel system is used for all notifications but the relevant external CDOP/LSCB are notified by the Merseyside CDOP Team. This is achieved by converting the Sentinel notification into a word document and sending via secure e-mail to the named CDOP contact on the national list.

3.1.2 Child Deaths Within the Community

If a child dies in the community and is taken to a hospital it is the responsibility of the hospital paediatric liaison staff to inform the CDOP team. They should be informed by the department receiving the child eg A&E; mortuary

If a child death within the community is certified by a General Practitioner and the child is/ is not taken to the hospital, thereafter the GP should inform the Practice Manager, who in turn is required to alert the relevant hospital for the area, or the hospital that has been providing the ongoing care during the condition leading to the death.

3.1.3 Rapid Response Process

In all cases of unexpected child deaths the Merseyside SUDiC (Sudden Unexpected Death in Childhood 0 up to 18 years) multi-agency protocol (2015) should be followed.

However, the Coroner may indicate, in certain circumstances, that it is not necessary to continue with the protocol resulting in it being 'stood down'. In circumstances where the Coroner has not initiated the standing down, but agencies feel it is appropriate, before this occurs, a discussion between Merseyside Police and the relevant Coroner should take place to confirm it is acceptable to do so.

When the death has been expected, there is no requirement to implement the Merseyside Joint Agency SUDiC Protocol, however the CDOP needs to review the case.

3.1.4 Agency Reports (Form B)

Following any child death all LSCB partner agencies or any third sector agency having involvement are requested to check their agency records to establish if the child or any family member is, or has been, known to them in the past. This is achieved for most agencies using the Sentinel system, the exception being GPs and some third sector agencies, who are contacted directly.

Agencies will receive an e-mail indicating that a child death has occurred. It contains a number for the person responsible to use to access the initial notification details on the system. This provides sufficient information for agency checks to be undertaken. Having done this if there is any information available this should be recorded on the agency report form (Form B: Appendix 7.2) for the relevant agency on Sentinel.

3.1.5 Combined Multi-Agency Form B Report

On receipt of agency reports the CDOP team will combine all responses on to one multi-agency Form B word document, anonymise it and make it available to the CDOP members for consideration in advance of the meeting. The desired timescale for this is at least one week in advance of the meeting. Panel members access the documentation for panel meetings via a secure LSCB website.

3.1.6 Analysis by CDOP

Panel members consider the circumstances surrounding a child's death and analyse with regard to whether there are any modifiable factors evident that, if changed, may assist in reducing the number of similar deaths in the future. They have regard to four specific domains:

- Factors intrinsic to the child;
- Factors in the family and environment
- Factors in the parenting capacity
- Factors in relation to service provision

Panel members agree and attribute a number from 0-3 for each domain:
0: no information available;
1: no factors identified or factors identified that are unlikely to have contributed to the death;
2: factors identified that may have contributed to vulnerability, ill health or death;
3: factors identified that provide a complete and sufficient explanation for the death
This information should inform the learning of lessons at a local level.

It is important for agencies to provide as much information as they have available to them. Where chronologies of involvement exist they should be summarised.

3.1.7 Completion of Form C

The analysis is recorded on a Form C Analysis Proforma (Appendix 7.3) after the panel meeting. It is collated and inputted into a Department for Education Child Death Data Collection form that LSCBs complete annually.(Department for Education Form LSCB1)

The analysis assists with the identification of patterns and trends of child deaths and is made available to support the future considerations for service provision.

3.1.8 Confidentiality

Following the panel meetings all documentation provided to panel members is destroyed with the only copy of CDOP documentation being held by the CDOP Team. All documentation held by the CDOP team is stored securely in locked cabinets within a secure office. It has been agreed that this will be retained for a period of 25 years and then destroyed.

3.2 CDOP Membership

The CDOP has a permanent core membership drawn from the key organisations represented on participating LSCBs. 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 CDOP Confidentiality Statement.

Core membership consists of:

- Chair (who is approved by the LSCBs) – Merseyside has two Co-Chairs who alternate the chairing but participate in all meetings to represent Public Health;
- CDOP Manager;
- CDOP Administrator;
- Designated Nurse/s for Safeguarding Children;
- Designated Doctor for Safeguarding Children;*
- Public Health Representative (provided by the Co-Chairs);
- Named GP;
- CDOP Nurse/Safeguarding Specialist Nurse;
- Detective Inspector Merseyside Police;
- Safeguarding Service Manager;*
- Education Representative;*
- Legal Representative;*
- LSCB Business Manager;*
- Lay Member/s,

Rotas are devised to enable participation where there are several agency representatives, denoted with an asterisk*. When attending the nominated individual represents their profession rather than the LSCB area in which they work.

For neonatal panel the participation includes:

- Consultant Neonatologist;
- Consultant Obstetrician.

SECTION 4: GOVERNANCE

4.1 Accountability and Reporting Arrangements of CDOP

Merseyside CDOP is accountable to the Chairs of the participating LSCBs.

The CDOP is responsible for developing its work plan, which should be approved by the Merseyside LSCBs. It prepares quarterly reports and an annual report. Copies of the annual report will be shared with LSCBs and relevant regional and national government bodies and are uploaded to LSCB websites.

The participating Merseyside LSCBs take responsibility for disseminating the lessons to be learnt to all relevant organisations, ensuring 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.

Each LSCB will be responsible for supplying data regularly on every child death as required by the Department for Education to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of these deaths.

4.2 Involvement of Parents and Family Members

In line with Working Together to Safeguard Children (2015) CDOP has recognised the importance of establishing mechanisms for appropriately informing and involving family members during the rapid response stage. Details of who has provided information to the family regarding the rapid response process and who should keep them updated is an agenda item for the strategy meeting and should be documented.

Parents and family members are informed that their child's death will be reviewed as this is a statutory process. A leaflet, 'What we have to do when a child dies,' has been compiled to provide parents, families and carers with relevant information about the child death review process. This is conveyed to them by Merseyside Registrars at the point at which the family register their child's death, or the Coroner's Officer if there is an inquest.

Parents should be advised that the objective of the CDOP process is to learn lessons in order to improve the health, safety and well being of children in Merseyside. This is with the aim of preventing further child deaths in the future, and is not about culpability or blame. Contact details are provided if families wish to seek further information or

participate in some form. The opportunity to meet with a panel member is an option should families wish. Parental consent is not required for the CDOP process.

Following the CDOP meeting the CDOP Chair, if requested by parents/carers, will agree what information is to be shared with parents and family members and ensure this feedback is conveyed to the family in a sensitive and timely manner.

4.3 Learning and Improvement

4.3.1 Practice guidance for professionals

Agencies who are, or have been, involved with the child or family should input a summary of information known to them into Agency Report Form B on the Sentinel system. In addition to information relating to the child's death they should have regard for the four specific domains:

- Factors in the child
- Factors in the family and environment
- Factors in the parenting capacity
- Factors in the service provision

Agencies should provide as much information as they have known to them. All agency reports will be combined to form a multi-agency report that is anonymised for panel member's consideration.

4.3.2 Practice guidance for panel members

1. Consider the multi-agency report form and identify any relevant issues pertinent to the domains to be discussed at the panel meeting; 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 the 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 consideration for a Serious Case Review.

5. Evaluate data on the deaths of all children normally resident in Merseyside, 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.

4.4 Service Improvement

The CDOP will seek to improve services locally through 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 child deaths through monitoring the appropriateness of the response of professionals to each unexpected death of a child, reviewing relevant reports produced by the CDOP who will be able to provide the professionals concerned with feedback on their work;
- To provide relevant information to those professionals involved with the child's family;
- To review the support and assessment services offered to families of children who have died;

4.5 Training and Support for Staff

The 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.

Arrangements are in place for all panel members and professionals involved in the process to access support, if necessary, through the Alder Centre. The Alder Centre is a dedicated resource offering bereavement support to anyone affected by the death of a child.

In addition, respective agency staff should have access to Occupational Health resources via their line manager should they feel this would be more or equally beneficial.

LSCBs are committed to making sure that staff members understand their role in the CDOP process by ensuring awareness of CDOP, its function, purpose and the outcomes identified within the annual report are disseminated through single and multi-agency channels.

4.5. CDOP Briefing Sessions

With effect from June 2014 there will be monthly briefing sessions to highlight the work of CDOP and the lessons learned. The sessions will be provided to multi-agency partners and available to all staff. They will continue until April 2015 then be evaluated at the end of this series with a view to arranging further and developing them, if necessary, to aid learning.

Individual presentations to agencies can occur and have done so in the past to, for example, social work teams; children's centre staff; education staff; local medical councils; to promote participation and disseminate learning. All agencies can request this via the Merseyside CDOP Team.

SECTION 5: PREVENTION

5.1 Taking Action to Prevent Future Child Deaths

Individual deaths and overall patterns of childhood deaths across Merseyside will be evaluated to determine if the deaths were preventable. This is undertaken by CDOP through the identification of modifiable risk factors, which considers 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 provided by CDOP will enable LSCBs 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 CDOP will be based on the lessons learnt locally and nationally from the reviews of child deaths. 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.

5.2 CDOP Disagreement

The 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 (2015) are met in the opinion of CDOP. Where a consensus is not agreed, the decision of the Chair of CDOP is final. The panel will record when there is no consensus.

SECTION 6: MISCELLANEOUS

6.1 Communications and the Media

Media interest in the work of CDOP or in individual cases will be dealt with by the appropriate local LSCB communications team.

The website details for each LSCB involved in Merseyside CDOP are as follows:
Knowsley: www. knowsleyscb.org.uk
Liverpool: www.liverpoolscb.org.uk
Sefton: www.seftonlscb.co.uk
St Helens: www.sthelenslscb.org.uk
Wirral:www.wirral.gov.uk/my-services/childrens-services/local-safeguarding-childrens-board

6.2 Sentinel Database

The database used for all CDOP data collection is a web based system hosted by Vantage Technologies. All agencies involved in data inputting have been required to sign an information sharing agreement and comply with data sharing protocols.

SECTION 7: APPENDICES

Appendix 1

ROLES AND RESPONSIBILITIES OF MEMBERS OF CDOP

CDOP Chair

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

- Agree meeting dates with the CDOP Manager;
- Meet/liaise with the CDOP Manager prior to each CDOP meeting to discuss the CDOP agenda and any problems with information gathering;
- Promote and encourage the sharing of information for effective case reviews;
- Chair panel meetings, encouraging all panel members to participate effectively; ensuring that all statutory requirements are met; and maintaining a focus on preventative work;
- Facilitate resolution of any agency disputes;
- Advise the CDOP Manager in the development of the annual report;
- Monitor and evaluate the effectiveness of recommendations and prevention initiatives and activities;

Merseyside CDOP Manager and Merseyside CDOP Administrator

The Merseyside CDOP Manager and Merseyside Administrator are responsible for the smooth running of all child death review processes.

The Merseyside CDOP manager will:

- Prior to each CDOP meeting, ensure anonymised, collated CDOP Multi-Agency Report Form B`s are sent to all CDOP members in sufficient time to enable them to read all the material and prepare for the meeting;
- Ensure that new members to CDOP receive an orientation to the panel prior to their first meeting;
- With support from the CDOP Chair compile the annual report for the LSCBs;
- Compile a quarterly report of CDOP activity for the LSCBs;
- Manage, in conjunction with the Merseyside CDOP Administrator (the administrator), all correspondence, databases and all relevant paperwork associated with the CDOP process;
- Meet/liaise with the CDOP Chair prior to each CDOP for a pre-agenda meeting/discussion;
- Progress identified actions/preventative work in conjunction with relevant agencies as appropriate;

- Provide, in conjunction with the administrator, ongoing Sentinel database training as required;
- Receive all initial notifications of child deaths that occur in Merseyside:
- Request GP reports in relation to child deaths

The Merseyside CDOP Administrator will:

- Receive all initial notifications of child deaths that occur in Merseyside:
    - Send requests to relevant agencies for agency checks and completion of reports;
    - Convert Sentinel notification to a word document for child deaths occurring in Merseyside whose usual residence is external to Merseyside, and forward to the CDOP lead for that area;

- Prepare all relevant paperwork for the CDOP meeting and disseminate 5-7 working days before meeting dates;
- Ensure and monitor the effectiveness of the data collection and combine reports relevant to each child into a single multi-agency report that is anonymised for dedicated areas;
- Provide secretarial and administrative support to facilitate the efficient implementation of the CDOP meetings and the SUDiC Implementation Group meetings;
- Ensure that new panel members, ad hoc members and observers sign a confidentiality agreement;
- Pursue outstanding agency reports when the timescales for completion are exceeded;
- Manage the operation of the Sentinel database system, making changes to the system as necessary.

Local CDOP Administrator

- Ensure and monitor the effectiveness of the data collection and combine reports relevant to each child into a single multi-agency report that is anonymised;
- Progress the completion of agency reports where they have not been returned within the 15 working day timescale;
- Ensure all necessary documentation eg multi-agency anonymised reports, post mortem reports, SUDiC strategy meeting notes, is forwarded to the Merseyside

CDOP team in sufficient time for it to be disseminated to panel members, ideally two weeks prior to the meeting.

Designated/Deputy Designated Nurse

The Designated Nurse will:

- Help the CDOP to evaluate health issues relating to the circumstances of the child's death;
- Advise the CDOP on nursing practices that may have had a bearing on the child's health or well-being;
- Assist the CDOP in developing appropriate preventative strategies;
- Liaise with other nursing and allied health professionals;
- Assist the CDOP in its evaluation of perinatal deaths;
- Review and evaluate the practice and learning from all involved health professionals and providers commissioned across Merseyside.
- In preparation for the CDOP Meeting read the CDOP papers which will be received approximately 5-7 days prior to the meeting;

Public Health

The public health representative will:

- Provide the CDOP with information on epidemiological and health surveillance data;
- Assist the CDOP in strategies for data collection and analysis;
- Assist the CDOP in evaluating patterns and trends in relation to child deaths and in learning lessons for preventive work;
- Inform the CDOP of public health initiatives to support child health; and
- Advise the CDOP on the development and implementation of public health prevention activities and programmes;
- In preparation for the CDOP meeting read the CDOP papers which will be received approximately 7-10 days prior to the meeting;

Consultant Community Paediatrician/Neonatologist

The Paediatrician/Neonatologist will:

- Meet with the CDOP Administrator at least two weeks prior to the CDOP meeting to provide the CDOP with information on the health of the deceased child and other family members, including any general health issues, child development, and health services provided to the child or family;

- Assist the CDOP 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 CDOP 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 CDOP meeting read the CDOP papers which will be received approximately 5-7 days prior to the meeting;

Police

The Police representative will:

- Upon receipt of the CDOP Agency Report Form B, the Police CDOP representative will retrieve any relevant police involvement with the child and family, including any child protection concerns in respect of the deceased child and other family members, which will enable them to complete the form to provide the CDOP with information;
- The completed form should be submitted to the local CDOP administrator within a requested time frame which is generally three weeks, using the Sentinel database;
- Provide the CDOP with information on the status of any criminal investigation;
- Provide the CDOP with information on the criminal histories of family members and suspects;
- Identify cases that may require a further police investigation;
- Provide the CDOP with expertise on law enforcement practices, including investigations, interviews and evidence collection;
- Help the CDOP 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 involved in individual case management;
- In preparation for the CDOP meeting read the CDOP papers which will be received approximately 5-7 days prior to the meeting;

Children's Social Care

The children's social care representative will:

- Help the CDOP to evaluate issues relating to the family and social environment and circumstances surrounding the death;
- Advise the CDOP 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; and
- Provide feedback to social workers and other local authority staff involved in individual case management;
- In preparation for the CDOP meeting read the CDOP papers which will be received approximately 5-7 days prior to the meeting;

Legal Representative:

- A representative from Local Authority Legal Services is a member of the CDOP to provide a non-medical view on the cases discussed by adding a forensic legal analysis of the information and to help interpret relevant statutory guidance and to provide guidance on the sharing of information between agencies.
- In preparation for the CDOP meeting read the CDOP papers which will be received approximately 5-7 days prior to the meeting;

Education Representative:

The education representative will:

- Assist the CDOP 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 CDOP in providing appropriate preventative strategies;
- Provide feedback to education staff involved with the deceased child and other family members;
- In preparation for the CDOP meeting read the CDOP papers which will be received approximately 5-7 days prior to the meeting;

Lay Representative/s:

The lay representative/s will:

- Participate in CDOP meetings to provide the perspective on behalf of the general public and specifically provide a voice for parents/families/carers;

- Support stronger public engagement in local child safety issues and contribute to an improved understanding of CDOP work in the wider community
- Challenge the LSCB/CDOP on the accessibility for the public, children and young people to its plans and procedures
- Help to make links between the LSCB and community groups
- In preparation for the CDOP meeting read the CDOP papers which will be received approximately 5-7 days prior to the meeting;

Appendix 2

LEGAL FRAMEWORK TO INFORMATION SHARING FOR CDOP

The sharing of information within the CDOP process 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 Panel 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 2015: Chapter 5 sets out the processes to be followed when a child dies in the LSCB areas covered by Merseyside CDOP. There are two inter-related processes for reviewing child deaths; which are a rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child; and an overview of all child deaths in the area, undertaken by a panel. Key changes include: Registrars are now required to send information to the appropriate LSCB no later than seven days from the date of registration of the child's death. LSCBs also have to make arrangements for the receipt of notifications and the publication of these arrangements, by notifying the DfE of the name and e mail address for the CDOP designated person to whom notifications are sent. There is also now a duty on Coroners to inform the LSCB of any inquest or post mortem for a child who has died.

- Human Rights Act 1998 (Article 8. 2): the right to respect for private and family 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 Merseyside CDOP, regarding the sharing of information and maintaining the confidentiality of it, necessary for the 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 available to panel members at least one week before the panel meeting via the Liverpool Safeguarding Children Board: www.liverpoolscb.org

Data collection: **initial notification; agency report form; analysis proforma**

- Having been informed of a child death Paediatric Liaison staff will notify Merseyside CDOP Team within one working day by completing the initial notification form (Form A) on Sentinel. They should provide as much information as possible, such as name, age, ethnicity, address and circumstances of death of the child or young person. At the same time as the Merseyside CDOP team are informed via Sentinel the Designated Nurse for the respective area and Consultant/Named Nurse within the relevant hospital should be informed.

- 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 CDOP Administrator.

- When a child who is normally resident in another area dies in Merseyside it is the responsibility of the Merseyside CDOP team to notify his/her equivalent in the child's area of residence. Similarly, when a child normally resident in Merseyside dies outside the area, the Merseyside CDOP team should be notified by their equivalent in the area where the child died.

- The CDOP area where the child was ordinarily resident has responsibility , in the first instance, to review the child's death and should be assisted through the provision of information from relevant agencies in the area where the child died. The sharing of the outcomes and lessons learnt can occur subject to the agreement of the respective Chairs.

- 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 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.

- When CDOP are aware of a death that has occurred abroad every effort should be made by the CDOP team to secure information to enable the child's death to be considered. In some circumstances this may not be achievable and this issue should be highlighted nationally via the Department for Education (DfE).

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. This information will be inputted into the Sentinel database and will allow the collation of all Merseyside 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 quarterly and annually, or as agreed.

Data management / storage and processing

- All LSCB partner agencies across Merseyside, with the exception of GPs and Merseyside Probation, have been trained to input into Sentinel.
- The Sentinel database system is hosted by Vantage Technologies and the necessary safeguards have been assured by them.
- System username and passwords provide access to relevant information and are audited to ensure data security.
- An information sharing and confidentiality agreement has been signed by all users.
- The Liverpool CDR system is secured behind Vantage technologies firewall at the data centre that will only allow authorised traffic to the server (e.g. HTTP and HTTPS).
- This is then further secured by only transmitting data over a SSL link that is protected using a 2048 bit EV SSL certificate.

- The server that is hosting the system is regularly patched in line with vendors recommended guidelines.

Appendix 4

CONFIDENTIALITY STATEMENT

The purpose of the Child Death Overview Panel is to conduct a thorough review of all child deaths 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 CDOP, as permitted within the stipulations of the Data Protection Act 1998, 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.

LSCB procedures for child death reviews stipulate that in no case will any CDOP member disclose any information regarding CDOP discussions 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

Appendix 5: MEMBERSHIP of MERSEYSIDE CDOP

Merseyside CDOP has a core membership with some agencies being represented on a rota basis.

Current membership:

Margaret Jones	Co-Chair	Consultant in Public Health, NHS Sefton
Jane Harvey	Co-Chair	Consultant in Public Health, NHS Wirral
Irene Wright	Merseyside CDOP Manager	Liverpool LSCB
Helen Fleming-Scott	Merseyside CDOP Administrator	Liverpool LSCB
Sandra Dean	Detective Inspector	Merseyside Police, Public Protection Unit
	CDOP/Safeguarding Specialist Nurse	Alder Hey Hospital: maternity leave since November 2011, long term sick leave.
Jez Fellick	Consultant Community Paediatrician	Arrowe Park Hospital*
Jackie Gregg	Consultant Community Paediatrician	Alder Hey Hospital*
Madeleine Pipon	Consultant Community Paediatrician	Alder Hey Hospital*
Nina Ellement	Legal Services	St Helens MBC*
Trevor Steele	Legal Services	Knowsley MBC*
Alison McDonald	Legal Services	Liverpool CC*
Vacancy	Education	Sefton MBC*
Sue Shinkfield	Education	Liverpool City Council*
Pauline Robinson	Education	St Helens MBC*
Kara Haskayne	Children's Services, Safeguarding	Sefton MBC*
Carole Rourke	Children's Services, Safeguarding	Wirral*
Maxine Curtis	Children's Services, Safeguarding	Liverpool CC*
Vacancy	Children's Services, Safeguarding	St Helens MBC*
Jan Higgins	LSCB Business Manager	St Helens*
David Robbins	LSCB Business Manager	Wirral*
Eve Smith	LSCB Business Manager	Knowsley*
Clare Lawson	LSCB Business Manager	Sefton*
Alan McCarthy	LSCB Business Manager	Liverpool*

Esther Golby	Deputy Designated Nurse	CCG Safeguarding Service
Debbie Hammersley	Designated Nurse	NHS Wirral
Crispin Evans	Safeguarding Lead	Merseycare
Margaret Goddard	Named GP	Liverpool
Marion Howel	Lay Member	Sefton LSCB
Gill Moglione	Lay Member	Liverpool LSCB

The following members attend for neonatal panels only:

Chris Dewhurst	Consultant Neonatologist	Liverpool Women's Hospital
Srinivasarao Babarao	Consultant Neonatologist	Arrowe Park Hospital
Joanne Topping	Consultant Obstetrician	Liverpool Women's Hospital

*denotes rota basis

Appendix 6

Support after the death of a child

Services specifically for those affected by the death of a child

Alder Centre
0151 252 5391
Support for anyone affected by the death of a child of any age (pre-birth to adult). Offers counselling, support groups, befriending.

Child Bereavement Charity
01494 446 648
www.childbereavement.org.uk
Support, information and training to all those affected when a child dies, or when a child is bereaved.

Child Death Helpline
0800 282 986
www.childdeathhelpline.org.uk
National freephone helpline for anyone affected by the death of a child. Calls are answered by bereaved parents.
Mon – Fri 10.00 – 13.00
Tues and Weds 13.00 – 16.00
Every evening 19.00 – 20.00

Compassionate Friends
0845 123 2304
www.tcf.org.uk
Helpline open daily 10.00 – 16.00 and 18.30 – 22.30
Support for parents and immediate family after the death of a child. Can provide local contacts and details of group meetings across the UK.

FSID (Foundation for the Study of Infant Deaths)
020 7233 2090
www.fsid.org.uk

Miscarriage Association
01924 200 799
www.miscarriageassociation.org.uk

SANDS (Stillbirth and Neonatal Death Society) 020 7436 5881
www.uk-sands.org
Helpline open Mon – Fri 10.00 – 17.00
Telephone helpline and national network of self help groups.

Winston's Wish (Support for bereaved children) 0845 203 0405
www.winstonswish.org.uk
Helpline open Mon – Fri 09.00 – 17.00
Provides advice and information for families of bereaved children.
General Bereavement Support Organisations

Aftermath Support
0845 634 4273
www.aftermathsupport.org.uk

Support for families of those killed in a road incident. Covers the Merseyside area.

Cruse Bereavement Care National Helpline
0844 477 9400
www.cruse.org.uk
Bereavement support by telephone and email.
Cruse Wirral
0151 609 0160
Bereavement counselling on Wirral. Counsellors visit people at home.

Listening Ear
0151 488 6648
Includes Butterflies Project for children who have been bereaved.

Liverpool Bereavement Service
0151 708 6706
www.liverpoolbereavement.co.uk

Roadpeace
0845 450 0355
www.roadpeace.org
Practical and emotional support for people bereaved by road crashes.
SAMM (Support After Murder and Manslaughter)
020 7735 3838
www.samm.org.uk
SAMM Merseyside
0151 207 6767

SOBS (Survivors of Bereavement by Suicide) 0844 561 6855
www.uk-sobs.org.uk
Helpline open daily 09.00 – 21.00
National helpline provides listening support and can put people in touch with a local group.

Appendix 7: CDOP Forms

7.1: Form A: Initial Notification

Merseyside Child Death Notification Form

(As agreed by Knowsley, Liverpool, St Helens, Sefton and Wirral Safeguarding Children Boards)

Name of notifier	
Agency and designation	
Contact details Telephone number Fax/e-mail details	
Date of notification	

1. Details of the child

Surname of child Other known names	
First name(s) of child	
Gender	
Ethnicity	
Date of birth	
School/Education Resource	
NHS Number	
Date and time of death	
Place of death Postcode	
Home address Postcode	

Is child? (**please answer yes/no or not known as appropriate**) Member of travelling family? Unaccompanied asylum seeker? Member of asylum seeking family? If **yes** please specify country of origin	 Yes/No Yes/No Yes/No
Legal status: Is child: Subject to Child Protection Plan? Looked after by the local authority? S20/s31	 Yes/No Yes/No
Probable cause of death and circumstances:	
Details of existing diagnoses/disabilities/ health conditions	
Death expected prior to presentation:	Yes/No
Reported to Coroner	Yes/No
Reported to Registrar	Yes/No
Coroner's Post Mortem	Yes/No
Hospital Post Mortem	Yes/No
Has a medical certificate of cause of death been issued?	Yes/No
Name of GP Contact details	

Mother's name	
Mother's date of birth	
Ethnicity of mother	
Father's name	
Father's date of birth	
Ethnicity of father	
Other carers' name/s	
Other carers' dates of birth	
Address of parents /carers if different from child	
Ethnicity of carer/s	

2. Details relating to siblings:

Name of child	DOB/Age	School/Nursery

3. Details of a person who can be contacted for further information

Name of liaison contact	
Liaison telephone number	
Liaison e-mail	
Liaison unit/place of work	

7.2 Form B: Agency Report Form

This form to be returned to CDOP Manager at:

Email: Irene.wright@liverpool.gcsx.gov.uk – SECURE FROM SECURE

Address: Gerard Majella Courthouse, Boundary Street, Liverpool, L5 2QD

Tel: 0151 233 1151 / 07739 703929

The information on these forms and the security for transferring it should be clarified and agreed with your local Caldicott guardian.

Please complete this form based on the information you have and return it quickly to the CDOP manager. If in doubt about what information to provide, please discuss with your manager.

Completing the form: The form is sent out to all agencies involved with a child and family. As such you are not expected to complete all of the form. **You are asked to complete only those sections and questions on which you hold information**. Some information is collected in tick box or yes/no format to allow collation and comparison of data, but in each section there is space for more narrative/qualitative information which will help the CDOP to more fully understand the nature of each child's death. If you do not have information for any particular item, please either circle or tick NK (Not Known) or NA (Not Applicable) or leave the item blank. It is preferable to circle or tick not known as this indicates to the CDOP that you have considered the question but have no information.

The form consists of six sections, A to F. along with supplementary forms B2 – B12 to be completed where appropriate according to the type of death.

Purpose: Form B is designed to gather information about each child's death. Its primary purpose is to enable the local CDOP to review all children's deaths in their area in order to understand patterns and factors contributing to children's deaths and ultimately to take steps to prevent future child deaths.

Confidentiality: The information requested on this form will be used for the purposes of child death review as outlined in chapter 5 of Working Together 2015. All bereaved parents are informed of these processes. The nature of the information collected means it is likely that some of the information is personal/sensitive data and therefore CDOPs should be mindful of their obligations under the Data Protection Act (DPA) 1998 when processing that information. All cases will be anonymised prior to discussion by the CDOP. All information gathered will be stored securely and only anonymised data will be collated at a regional or national level.

This page may be removed for the purposes of anonymisation prior to discussion at the CDOP

A: Identifying and Reporting Details

Full name of child			Date of birth
Child's Unique CDOP Number			Ward Child Lived in
NHS No.			Date of death
Gender	Male	☐	
	Female	☐	
Address (including postcode if known)			
Do you know if any bereavement support has been offered to the family? (if yes please provide details			

Agency Report Provided by

Agency	Name
Address	
Postcode	
Tel No	Email

B: Summary of Case and Circumstances leading to the death

This section provides information on the nature and manner of the child's death. Please complete any information which you hold on the case.

The 'Details of the Death' section is to be completed by the treating doctor involved with the child at the time of death – other professionals can complete this section if they have the information.

Details of the Death		
What is your understanding of the cause of death? (complete registered cause of death, if known, below)		
What was the mode of death?	☐	Planned palliative care
	☐	Withholding, withdrawal or limitation of life-sustaining treatment
	☐	Brainstem death
	☐	Failed Cardiopulmonary resuscitation
	☐	Witnessed event
	☐	Found dead
	☐	Not known
Expected Unexpected	☐ ☐	
Has a medical certificate of the cause of death been issued?	Yes / No / Not Known ☐ ☐ ☐	
Was this death referred to the coroner?	Yes / No / Not Applicable / Not Known ☐ ☐ ☐ ☐	
Was a post-mortem examination carried out?	Yes / No / Not Applicable / Not Known ☐ ☐ ☐ ☐ Date of PM if known / / Place of PM if known	
Has an inquest been held?	Yes / No / Not Applicable / Not Yet/ Not Known ☐ ☐ ☐ ☐ ☐ Date of Inquest if known / /	
Registered cause of death if known (for children over 28 days)	**Ia** **Ib** **Ic** **II**	

Registered cause of death if known (for neonatal deaths)	(a) main diseases or conditions in infant (b) other diseases or conditions in infant (c) main maternal diseases or conditions affecting infant (d) other maternal diseases or conditions affecting infant (e) other relevant conditions

All – please complete

Where was the child at the time of the event or condition which led to the death?	☐	Acute Hospital	☐ ☐ ☐ ☐ ☐ ☐	Emergency Department Paediatric Ward Neonatal Unit Paediatric Intensive Care Unit Adult Intensive Care Unit Other
	☐	Home of normal residence		
	☐	Other private residence		
	☐	Foster Home		
	☐	Residential Care		
	☐	Public place		
	☐	School		
	☐	Hospice		
	☐	Mental health inpatient unit		
	☐	Abroad		
	☐	Other (specify)		
	☐	Not known		

Where was the child when the death was confirmed?	☐	Acute Hospital	☐ ☐ ☐ ☐	Emergency Department Paediatric Ward Neonatal Unit Paediatric Intensive Care Unit

			☐	Adult Intensive Care Unit
			☐	Other
	☐	Home of normal residence		
	☐	Other private residence		
	☐	Foster Home		
	☐	Residential Care		
	☐	Public place		
	☐	School		
	☐	Hospice		
	☐	Mental health inpatient unit		
	☐	Abroad		
	☐	Other (specify)		
	☐	Not known		
Are you aware of the family's involvement with a Bereavement Support resource?		Yes ☐	No ☐	Not known ☐
If yes please specify resource				

Were any of the following events known to have occurred?		
☐	Neonatal Death	Complete B2 - Please complete form B2 before continuing to complete the rest of this form, as you may not be required to provide any further information through Form B.
☐	Death of a child with a life limiting condition (to be completed by the lead clinician or designated member of the palliative care team)	Complete B3
☐	Sudden unexpected death in infancy (to be completed by the SUDI paediatrician or designated deputy, and will almost always be completed at or immediately after the local case review meeting. In those rare instances in which there is no local case review meeting the SUDI paediatrician or designated deputy should complete this form at the conclusion of the investigation)	Complete B4
☐	Road traffic accident/collision	Complete B5
☐	Drowning	Complete B6
☐	Fire/burns	Complete B7

☐	Poisoning	Complete B8
☐	Other non-intentional injury/accidents/trauma	Complete B9
☐	Substance misuse	Complete B10
☐	Apparent homicide	Complete B11
☐	Apparent suicide	Complete B12

Circumstances of Death:
Please provide a narrative account of the circumstances leading to the death. This should include a chronology of significant events (e.g. contact with service; changes in family circumstances) in the background history, and details of any important issues identified. **Consider**: Events leading to the death; Early family history; Pregnancy and birth; Infancy; Pre-school; School years; Adolescence

C: The Child

This section provides information about the child and any known conditions or factors intrinsic to the child that may have contributed to the death. Please complete any information which you hold on the case.

Birth weight (gm or oz / lb)	gms lbs oz	Gestational age at birth (completed weeks)	
Booking in:	On time ☐ Late ☐ Not booked ☐		
Antenatal care:	Regularly ☐ Infrequently ☐ Not at all ☐		
Feeding	Breastfed ☐ Bottle fed ☐ Mixed feeding ☐ Other (please specify) ☐		
Last known weight (gm or oz / lb) Date	gms lbs oz / /	Last known height (ft/in or cm) Date	cm ft in / /

Any known medical conditions at the time of death? If yes, please provide details below	Yes / No / Not known ☐ ☐ ☐
Was the child fully immunised?	Yes / No / Not known ☐ ☐ ☐ Date of last immunisation / /
Any known developmental impairment or disability at the time of death? If yes, please provide details below	Yes / No / Not known ☐ ☐ ☐
Any medication at the time of death? If yes, please provide details below	Yes / No / Not known ☐ ☐ ☐

Education/Occupation	☐	Not yet in education

			☐	Nursery	
			☐	School	
			☐	College	
			☐	Not in education	
			☐	Left education	☐ Employed
					☐ Unemployed
If employed, please provide occupation					
Ethnic group	☐	White	☐ English/Welsh/Scottish/Northern Irish/British ☐ Irish ☐ Gypsy or Irish Traveller ☐ Any other White background (please specify)		
	☐	Mixed/ multiple ethnic groups	☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Any other mixed/multiple ethnic background (please specify)		
	☐	Asian or Asian British	☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Any other Asian background (please specify)		
	☐	Black/ African/ Caribbean/ Black British	☐ African ☐ Caribbean ☐ Any other Black/African/Caribbean background (please specify)		
	☐	Other ethnic group	☐ Arab ☐ Any other ethnic group (please specify)		
	☐	Not known/ not stated			
Religion (please state)					

Factors in the child:
Please provide a narrative description of any relevant factors within the child that have not already been covered. Include any known health needs; factors influencing health; growth parameters development/educational issues; behavioural issues; social relationships; identity and independence; any identified factors in the child that may have contributed to the death. Include strengths, as well as difficulties.

D: Family and Environment

This section provides details of the child's family and close environment. Please complete with any information known to you.

Please circle or tick your responses

Please insert names	**Age/DoB**	**Gender**	**Relationship to child and/or family**	**Occupation**	**Living in primary household?[1]**
		F	Mother		Y / N / NK ☐ ☐ ☐
		M	Father		Y / N / NK ☐ ☐ ☐
Other significant others *(e.g. Mother's partner; significant carer. Please number and complete any information known; further adults can be added below)*					
1					Y / N / NK ☐ ☐ ☐
2					Y / N / NK ☐ ☐ ☐
3					Y / N / NK ☐ ☐ ☐
4					Y / N / NK ☐ ☐ ☐
Siblings (*Please number and complete any information known; further siblings can be added below, please include step and half siblings)*					
1					Y / N / NK ☐ ☐ ☐
2					Y / N / NK ☐ ☐ ☐
3					Y / N / NK ☐ ☐ ☐
4					Y / N / NK ☐ ☐ ☐
6					Y / N / NK ☐ ☐ ☐
7					Y / N / NK ☐ ☐ ☐

Was the child/family an asylum seeker?	Yes / No / Not known ☐ ☐ ☐
Was the child a member of a travelling family?	Yes / No / Not known ☐ ☐ ☐

[1] If the child is living in more than one household, for example where the parents have separated, the primary household is where the child spends most of his/her time; please provide any relevant details in the narrative section.

Further family information
(In relation to the primary household or other household where the child spends a significant amount of time)

Please circle or tick your responses

	Mother	Father	Other adult 1	Other adult 2
Smoker	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐
Any Known:				
Disability, including learning disability?	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐
Physical health issues?	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐
Mental health issues?	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐
Substance misuse?	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐
Alcohol misuse?	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐
Known to police	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐	Y / N / NK ☐ ☐ ☐

Are mother and father related to each other (excluding marriage)	Yes	☐	No	☐	Please provide details.

Any known domestic violence in the household? (please provide details below)
Yes/No/Not known

Factors in the family and environment:
Please provide a description of any relevant factors known to you that have not been covered elsewhere.
Consider: family structure and functioning; wider family relationships; housing; employment and income; social integration and support; community resources.
Include strengths and difficulties

E: Parenting Capacity

The purpose of this section is to understand factors in relation to the care of the child that may have been of relevance in any way to the child's death, and also factors that may have contributed to support and nurture of the child. Please complete any information known to you.

Where was the child living at the time of their death or the event leading to their death?	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Parental home Other relatives Foster carers Private fostering Residential unit Long stay hospital Hospice Other
Who was directly looking after the child at the time of their death or the event that led to their death? (please tick all that apply)	☐ ☐	Mother Father
	☐	Other adults (please list and give adults relationships to the child)
	☐	Child/young person (please list and give age and relationships to the child)
	☐ ☐	Health care staff Others (please list below)

Was the child subject to a child protection plan?	☐ ☐ ☐	At the time of death Previously Not at all
Category of most recent child protection plan:	☐ ☐ ☐ ☐ ☐	Physical abuse Neglect Emotional abuse Sexual abuse Not known
Was the child subject to any statutory orders?	☐ ☐ ☐	At the time of death Previously Not at all
Category of most recent statutory order:	☐ ☐ ☐ ☐ ☐	Police Powers of Protection Emergency Protection Order Interim Care Order Care Order Supervision Order

	☐ ☐ ☐ ☐	Residence Order Section 20 (Children Act 1989) Antisocial behaviour order Other court order, please specify:
Had the child been assessed as a child in need under section 17 of the Children Act 1989?	☐ ☐ ☐	At the time of death Previously Not at all
Were any siblings subject to a child protection plan?	☐ ☐ ☐	At the time of death Previously Not at all
Were any siblings subject to any statutory orders?	☐ ☐ ☐	At the time of death Previously Not at all

Factors in the parenting capacity:
Provide a narrative description of the parenting capacity with any relevant factors known to you and not already covered elsewhere.
Consider issues around provision of basic care; health care (including antenatal care where relevant); safety; emotional warmth; stimulation; guidance and boundaries; stability. Include strengths as well as difficulties.

F: Service Provision

The purpose of this section is to obtain a profile of the services being offered to the child and family; the effectiveness of those services in supporting the child and family; and to identify any unmet needs or gaps in services. Please complete any information you are able to on your agency.

Details of agency involvement
Please indicate whether any of the services listed were involved with the child, or in neonatal deaths, with the mother. Where any service was involved, please provide details in the narrative section below.

Please circle or tick your responses

Agency / professional	Involved at time of death or in relation to the final illness[2]	Involved previously
Primary Health Care	Y / N / NK /NA ☐ ☐ ☐ ☐	Y / N / NK /NA ☐ ☐ ☐ ☐
Secondary / Tertiary Hospital Services	Y / N / NK /NA ☐ ☐ ☐ ☐	Y / N / NK /NA ☐ ☐ ☐ ☐
Secondary / Tertiary Community Health Services	Y / N / NK /NA ☐ ☐ ☐ ☐	Y / N / NK /NA ☐ ☐ ☐ ☐
Hospice Services	Y / N / NK /NA ☐ ☐ ☐ ☐	Y / N / NK /NA ☐ ☐ ☐ ☐
Child & Adolescent Mental Health	Y / N / NK /NA ☐ ☐ ☐ ☐	Y / N / NK /NA ☐ ☐ ☐ ☐
Police	Y / N / NK /NA ☐ ☐ ☐ ☐	Y / N / NK /NA ☐ ☐ ☐ ☐
Local Authority Children's Services	Y / N / NK /NA ☐ ☐ ☐ ☐	Y / N / NK /NA ☐ ☐ ☐ ☐
Education	Y / N / NK /NA ☐ ☐ ☐ ☐	Y / N / NK /NA ☐ ☐ ☐ ☐
Connexions	Y / N / NK /NA ☐ ☐ ☐ ☐	Y / N / NK /NA ☐ ☐ ☐ ☐
Probation	Y / N / NK /NA ☐ ☐ ☐ ☐	Y / N / NK /NA ☐ ☐ ☐ ☐
Other (please specify)	Y / N / NK /NA ☐ ☐ ☐ ☐	Y / N / NK /NA ☐ ☐ ☐ ☐

If no professionals involved at the time of death, what was the last known contact of a professional from your agency?	Professional Date of last known contact Nature of contact ☐ No known contact from this agency ☐ Not known

[2] Include all those providing services at the time of death or in relation to the final illness, even if not present at the time of the death; e.g. child on school roll; planned out patient follow up; active social work case; palliative care.

Were there any identified unmet needs / gaps in services? (if yes, please provide details below)	Y / N / NK /NA ☐ ☐ ☐ ☐
Were there any identified difficulties in family engagement with services? (if yes, please provide details below)	Y / N / NK /NA ☐ ☐ ☐ ☐

Factors in relation to service provision

Please complete any information known to you in relation to service provision that has not been covered elsewhere. **Consider** any identified services both required and provided; the nature and timing of any services provided; any gaps between child's or family member's needs and service provision; any issues in relation to service provision or uptake, positive/negative in relation to bereavement care.

Was there a formal internal review/ investigation – if yes, please state which specific agency	Y / N / NK /NA ☐ ☐ ☐ ☐

Any other internal agency investigation (please specify)

Has the death been referred to CIG/SCR group for consideration?	Y / N / NK /NA ☐ ☐ ☐ ☐

Issues for discussion Include any action or learning you consider should be taken forward as a result of the child's death; issues that require broader multi-agency discussion

7.3 Form C: Analysis Proforma

Analysis Proforma

This proforma is used by the Child Death Overview Panel (CDOP) to:

- *evaluate information about the child's death;*
- *identify lessons to be learnt; and*
- *to inform an understanding of all child deaths at a national level.*

Where prior to the CDOP meeting, a local case discussion is held, the local team may complete a draft Form C to be forwarded to the CDOP to inform their deliberations.

Agencies represented at the meeting:	
Primary Health Care	Yes ☐ No ☐
Paediatrics	Yes ☐ No ☐
Hospital Services	Yes ☐ No ☐
Mental Health Services	Yes ☐ No ☐
Ambulance Services	Yes ☐ No ☐
Police	Yes ☐ No ☐
Children's Social Care Services	Yes ☐ No ☐
Schools	Yes ☐ No ☐
Other (Specify)	
Coroner's office	Yes ☐ No ☐
Fire Service	Yes ☐ No ☐
Parent Representative	Yes ☐ No ☐

List of documents available for discussion
Multi-agency composite report

Cause of death as presently understood

Case Summary A few paragraphs at most: a summary of the background and a factual description of events leading up to death. This should be as short as possible.

1.

2. **The CDOP should analyse any relevant environmental, extrinsic, medical or personal factors that may have contributed to the child's death under the following headings.**

For each of the four domains below, determine different levels of influence (0-3) for any identified factors:

0 - Information not available

1 - No factors identified or factors identified but are unlikely to have contributed to the death

2 - Factors identified that may have contributed to vulnerability, ill-health or death

3 - Factors identified that provide a complete and sufficient explanation for the death

This information should inform the learning of lessons at a local level.

Domain - Child's needs		
Factors intrinsic to the child Include any known health needs; factors influencing health; development/ educational issues; behavioural issues; social relationships; identity and independence; abuse of drugs or alcohol; note strengths and difficulties		
Please enter relevant information		
Please tick the following boxes if these factors were present or may have contributed to the death **Condition:**		**Relevance (0-3)**
Acute / Sudden onset illness Specify:	Yes / No / NK ☐ ☐ ☐	
Chronic long term illness		

Asthma	Yes / No / NK ☐ ☐ ☐	
Epilepsy	Yes / No / NK ☐ ☐ ☐	
Diabetes	Yes / No / NK ☐ ☐ ☐	
Other chronic illness Specify:	Yes / No / NK ☐ ☐ ☐	
Disability or impairment		
Learning disabilities Specify:	Yes / No / NK ☐ ☐ ☐	
Motor impairment Specify:	Yes / No / NK ☐ ☐ ☐	
Sensory impairment Specify:	Yes / No / NK ☐ ☐ ☐	
Other disability or impairment Specify:	Yes / No / NK ☐ ☐ ☐	
Emotional / behavioural / mental health condition in the child Specify:	Yes / No / NK ☐ ☐ ☐	
Allergies Specify:	Yes / No / NK ☐ ☐ ☐	
Alcohol/substance misuse by the child Specify:	Yes / No / NK ☐ ☐ ☐	

Domain - family and environment		
Factors in the family and environment Include family structure and functioning; including parental abuse of drugs or alcohol; wider family relationships; housing; employment and income; social integration and support; community resources; note strengths and difficulties		
Please enter relevant information		
Please tick the following boxes if these factors were present or may have contributed to the death **Condition:**		**Relevance (0-3)**
Emotional/behavioural/mental health condition in a parent or carer Specify:	Yes / No / NK ☐ ☐ ☐	
Alcohol/substance misuse by a parent/carer Specify	Yes / No / NK ☐ ☐ ☐	

Smoking by the parent/carer in household or during pregnancy Specify:	Yes / No / NK ☐ ☐ ☐	
Housing Specify:	Yes / No / NK ☐ ☐ ☐	
Domestic violence Specify:	Yes / No / NK ☐ ☐ ☐	
Co-sleeping Specify:	Yes / No / NK ☐ ☐ ☐	
Bullying Specify:	Yes / No / NK ☐ ☐ ☐	
Gang/knife crime Specify:	Yes / No / NK ☐ ☐ ☐	
Pets/animal assault Specify:	Yes / No / NK ☐ ☐ ☐	

Domain - parenting capacity		
Factors in the parenting capacity Include issues around provision of basic care; health care (including antenatal care where relevant); safety; emotional warmth; stimulation; guidance and boundaries; stability; note strengths and difficulties		
Please enter relevant information **No information known other than J lived with his father and stepmother.**		
Please tick the following boxes if these factors were present or may have contributed to the death **Condition:**		**Relevance (0-3)**
Poor parenting/supervision Specify:	Yes / No / NK ☐ ☐ ☐	
Child abuse/neglect Specify:	Yes / No / NK ☐ ☐ ☐	

Domain - service provision
Factors in relation to service provision Include any identified services (either required or provided); any gaps between child's or family member's needs and service provision; any issues in relation to service provision or uptake
Please enter relevant information

Please tick the following boxes if these factors were present or may have contributed to the death **Condition:**		**Relevance (0-3)**
Access to health care Specify:	Yes / No / NK ☐ ☐ ☐	
Prior medical intervention Specify:	Yes / No / NK ☐ ☐ ☐	
Prior surgical intervention Specify:	Yes / No / NK ☐ ☐ ☐	

The CDOP should categorise the likely/cause of death using the following schema.

This classification is hierarchical: where more than one category could reasonably be applied, the highest up the list should be marked.

Category	Name & description of category	Tick box below
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.	☐
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.	☐
3	**Trauma and other external factors** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. **Excludes** Deliberately inflected injury, abuse or neglect. (category 1).	☐
4	**Malignancy** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.	☐
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.	☐
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.	☐
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease,cystic fibrosis, and other congenital anomalies including cardiac.	☐
8	**Perinatal/neonatal event** Death ultimately related to perinatal events, eg sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).	☐
9	**Infection** Any primary infection (ie, not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.	☐
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).	☐

The panel should categorise the 'preventability' of the death – tick one box.

Preventable child deaths are defined in paragraphs 7.23 and 7.24 of *Working Together to Safeguard Children*

Modifiable factors identified	The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths	☐
No Modifiable factors identified	The panel have not identified any potentially modifiable factors in relation to this death	☐
	Inadequate information upon which to make a judgement. *NB this category should be used very rarely indeed.*	☐

Issues identified in the review

List the issues identified by the review group. This list may include the absence of certain key persons from the discussion or the lack of key documents.

Learning Points

List the learning points that emerge. These may well overlap with the issues and with recommendations.

Recommendations

List any recommendations, even if already picked up as learning points or 'issues'

Specific agency

LSCB

Regional

National

Follow up plans for the family, where relevant

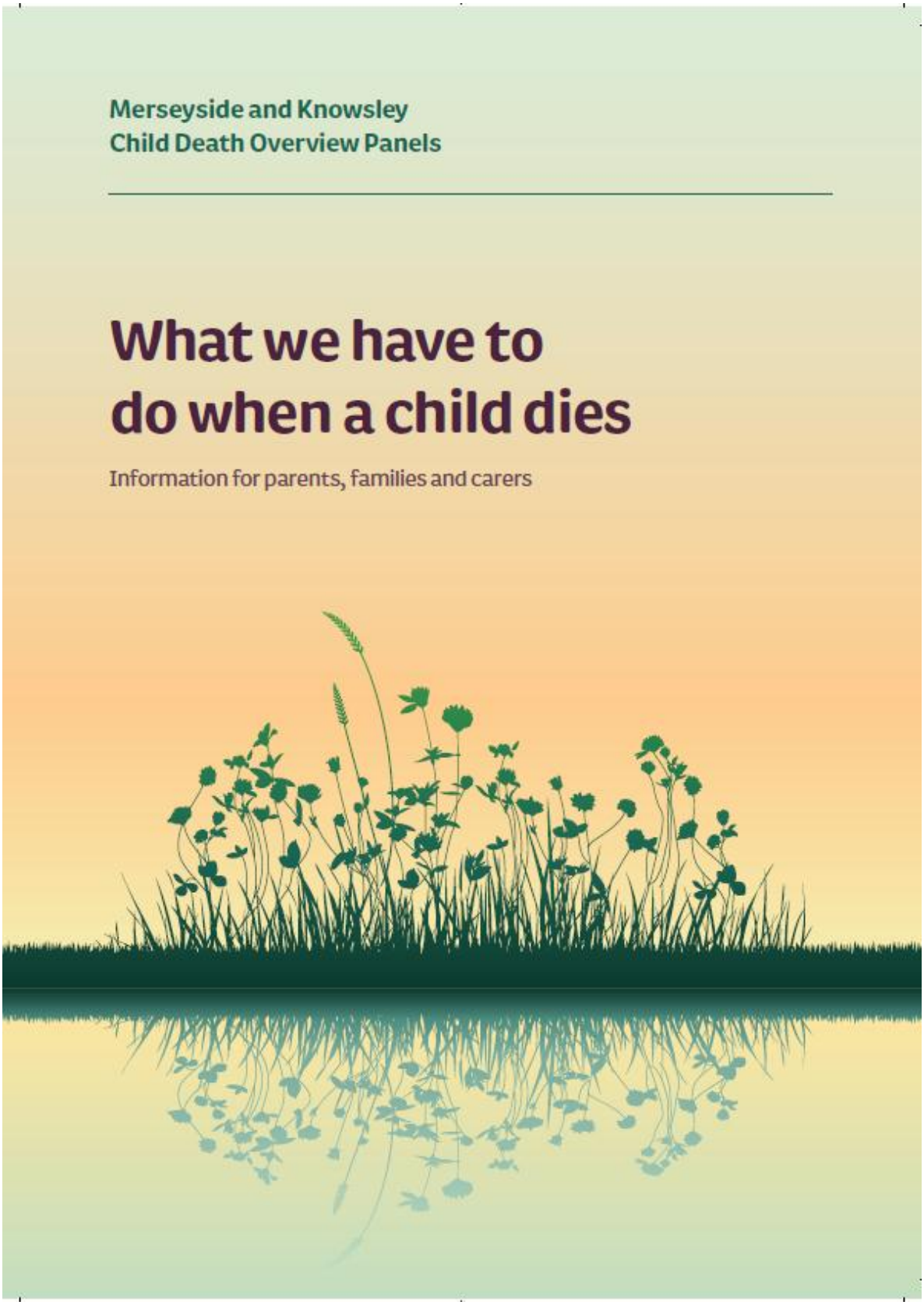
Possible Actions

Should this death be referred to another agency or Authority (e.g. Police, Coroner, Health and Safety Executive, Serious Case Review panel) for further investigation or enquiry? If so, please state

☐ Yes ☐ No ☐ Already done

If yes please specify;

APPENDIX 8: Information leaflet for parents, families and carers



This leaflet is being provided to explain to you what we have to do when a child dies.

What is a review and why is it needed?

Government legislation now requires every Local Safeguarding Children Board (LSCB) to review the death of each child or young person (under 18 years) who lived in their area. This is because, in doing so, we may find ways of doing things differently that helps other children and families in the future.

How does a review happen?

Information about each child and how they died is collected together and summarised into a short report. This information comes from records held by hospitals, local health services (GPs and health visitors), schools, police, children's services or other agencies whose staff knew the child. The report also includes something about the family so that the Panel can better understand the circumstances of the death.

A Child Death Overview Panel (CDOP) that includes doctors, other health specialists, children's services staff and the police meet regularly to look at the reports. They want to be clear about the circumstances of your child's death so they can decide whether to recommend changes or improvements to services for children that might prevent similar deaths in the future. Any recommendations are passed on to the people responsible for planning and managing services for children locally. The recommendations might also go to specialist agencies such as the fire and rescue service or traffic authorities if this applies.

The Panel is not concerned with blame but focuses on identifying if anything can be changed to prevent similar deaths in the future. The panel also looks at what support or involvement was offered to the child and their family up to the time of the death and afterwards. The Panel can recommend changes to these arrangements where need be.

How can you contribute?

The LSCBs and NHS Trusts in Liverpool, St Helens, Sefton and Wirral have agreed to have a combined Child Death Overview Panel, entitled Merseyside CDOP.

Knowsley LSCB is continuing with its own distinct CDOP.

You can contact the Panel if you wish to express your views, share any information that you might have or ask any questions. You may, if you prefer, ask somebody who is supporting you to contact the panel on your behalf to pass on your views. Contact details are provided overleaf.

It is not possible for parents, carers or family representatives to attend the panel meeting as this is a meeting of professionals to discuss not only the individual case, but also wider public health issues.

We will take your information and questions into consideration but we are not involved in deciding whether anyone is to blame. All the information we gather will be treated with the greatest respect and in strictest confidence. We promise that none of our findings, suggested changes or reports will name or identify your child or family. You are welcome to access a copy of the CDOP annual report that will be available on the website of each Local Safeguarding Children Board involved.

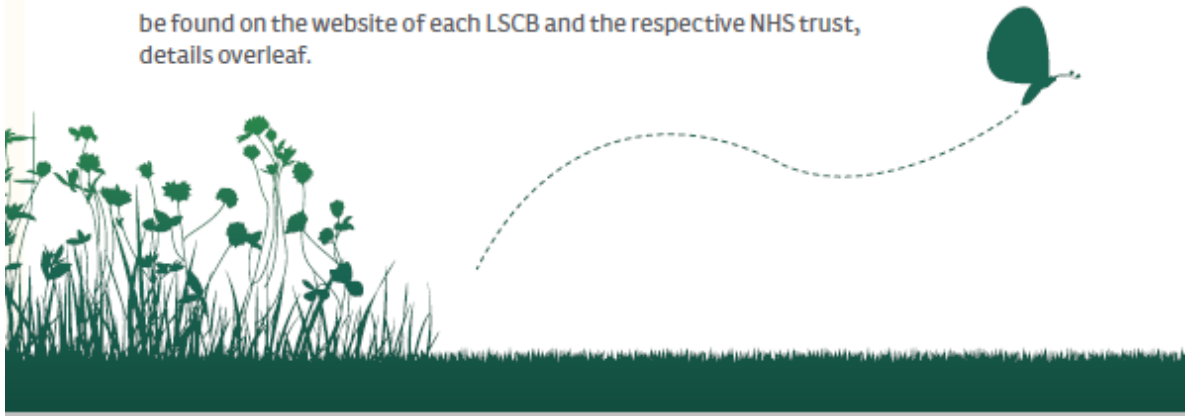
Should you want to share information or ask questions you can do so by contacting Merseyside CDOP Manager who will respond or convey them to the appropriate panel:

Telephone: 07739703929 / ~~0151 233 1151~~

e-mail: Irene.wright@liverpool.gcsx.gov.uk or

Letter: ~~2nd Floor, Millennium House, 60 Victoria Street, Liverpool, L1 6HF~~

Further information about the role of Child Death Overview Panels can be found on the website of each LSCB and the respective NHS trust, details overleaf.



Please note new contact details as follows:

Telephone: 0151 225 4956

Liverpool Safeguarding Children Board

Room 23 I Brougham Terrace I West Derby Road I Liverpool I L1 6AF