



BURY, ROCHDALE & OLDHAM

CHILD DEATH OVERVIEW PANEL

Guidance

1. Introduction

The purpose of the Bury, Oldham and Rochdale Child Death Overview Panel (CDOP) is to provide an overview of all deaths of children who are resident in the Bury, Oldham and Rochdale area.

The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

- a) collecting and analysing information about each death with a view to identifying—
 - i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);
 - ii) any matters of concern affecting the safety and welfare of children in the area of the authority;
 - iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
- (b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

The aim is for the information from the CDOP to contribute to the reduction of local childhood deaths, and serious and permanent impairment to the health and development of children and young people.

The CDOP will maintain a focus on prevention through all its work and operates under Chapter 5: Child death reviews of [Working Together to Safeguard Children 2013](#).

2. Membership of the CDOP

The CDOP has a permanent core membership drawn from the key organisations represented on LSCBs with flexibility to co-opt other relevant professional to discuss certain types of death as and when appropriate e.g. fire fighters for house fires

Core panel membership should include:

- Public Health representative
- Consultant Paediatrician
- Children's Social Care
- Police
- Education

- Mental Health Services

At any one time there should be:

- Representation from each of the three LSCBs
- The Chair plus 50% of members present
- Core representatives present from Public Health, Health and Children's Social Care

Members should prioritise attendance at CDOP at all times. Members are responsible for designating a named deputy, and if they are unable to attend, they must ensure that the deputy can attend and that they are fully briefed.

The Chair should not be involved directly in providing direct services to children and families in the area.

3. Functions of the CDOP

To receive notifications of the deaths of all children from birth to under 18 years of age who reside in the areas of Bury, Oldham and Rochdale. Each death should be notified to the CDOP of the area in which the child (or mother in the case of a neo-natal death) was normally resident. If a different panel (e.g. the CDOP for the area in which the child died) is notified, the CDOP Officer, should notify their counterpart in the area of the child's residence.

To collect a core data set of information relating to each child's death. By using the Department for Education national CDOP templates 'Agency Report Form' (Form B) and the 'Notification Form' (Form A) which will be completed by professional bodies involved in the child's life and stored on the secure AGMA sharepoint system. This may include information from: -

- Health records,
- Police,
- Children's Services (including social care and schools);
- Autopsy reports and results of further investigations;
- Relevant information in the family and social circumstances;
- Scene reports from police child abuse investigations units or accident investigators
- Etc...

The CDOP meets every 3 months to review the data on each child's death. Whilst all deaths will be notified to the panel and a core data set collected, not all deaths will be reviewed in detail. Particular consideration will be given to the review of sudden unexpected deaths in infancy and childhood; accidental deaths; suicides and any deaths from natural causes where there are potential lessons to be learnt about prevention. All deaths where abuse or neglect is known or suspected to be a factor in the child's death will be dealt with by the area LSCB.

The panel will receive reports from other reviews of child deaths, including individual case reviews for SUDI and hospital reviews of perinatal deaths. This would be a part of the collation of information, and would require only relevant information.

The CDOP will review annually the numbers and patterns of deaths in Bury, Oldham and Rochdale.

The CDOP will notify the Chair of the relevant LSCB, the coroner and the police of any cases identified where there are previously unrecognised concerns of a criminal or child protection nature; and to explore why this had not previously been recognised. Also to provide relevant information to those professionals involved with the child's family, so that they in turn can convey this information in a sensitive and timely manner to the family

The panel will identify any lessons to be learnt from individual reviews or reviews of overall patterns and trends, including any system and process issues and any public health issues. This includes monitoring professional responses to child deaths and identifying good practice as well as any gaps or deficiencies in the process

In some cases the panel may make appropriate recommendations to the relevant LSCB(s). These will also be included in the annual report which is distributed to each LSCB. This will identify any trends, and should comment on training/resource issues to ensure an effective inter-agency response to child deaths.

The panel will co-operate with regional and national initiatives

4. Coroners and Registrar

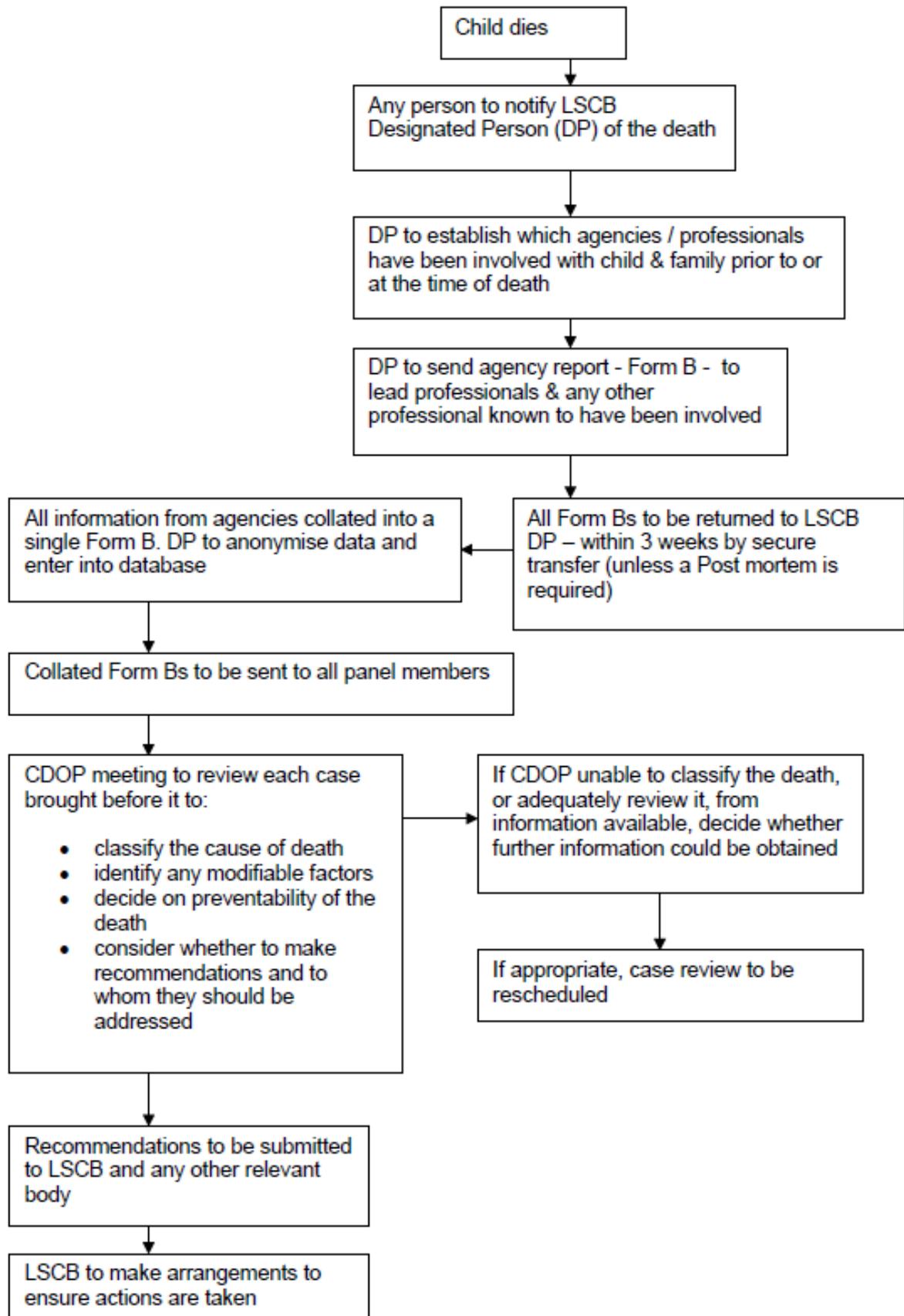
There is a clear relationship and lines of communication with the local Coronial Service and Registrar to provide the CDOP with information.

The [Coroners' Rules 1984](#) has been amended to create a new duty on the Coroner to inform the Local Children Safeguarding Board (LSCB) of the death of a child or young person about which the Coroner is either holding a post mortem examination or has made a decision to hold an inquest. This duty ('rule 57A') enables the Coroner to give information about the child's death to assist the LSCB to carry out its responsibilities to review the deaths of children through the CDOP process.

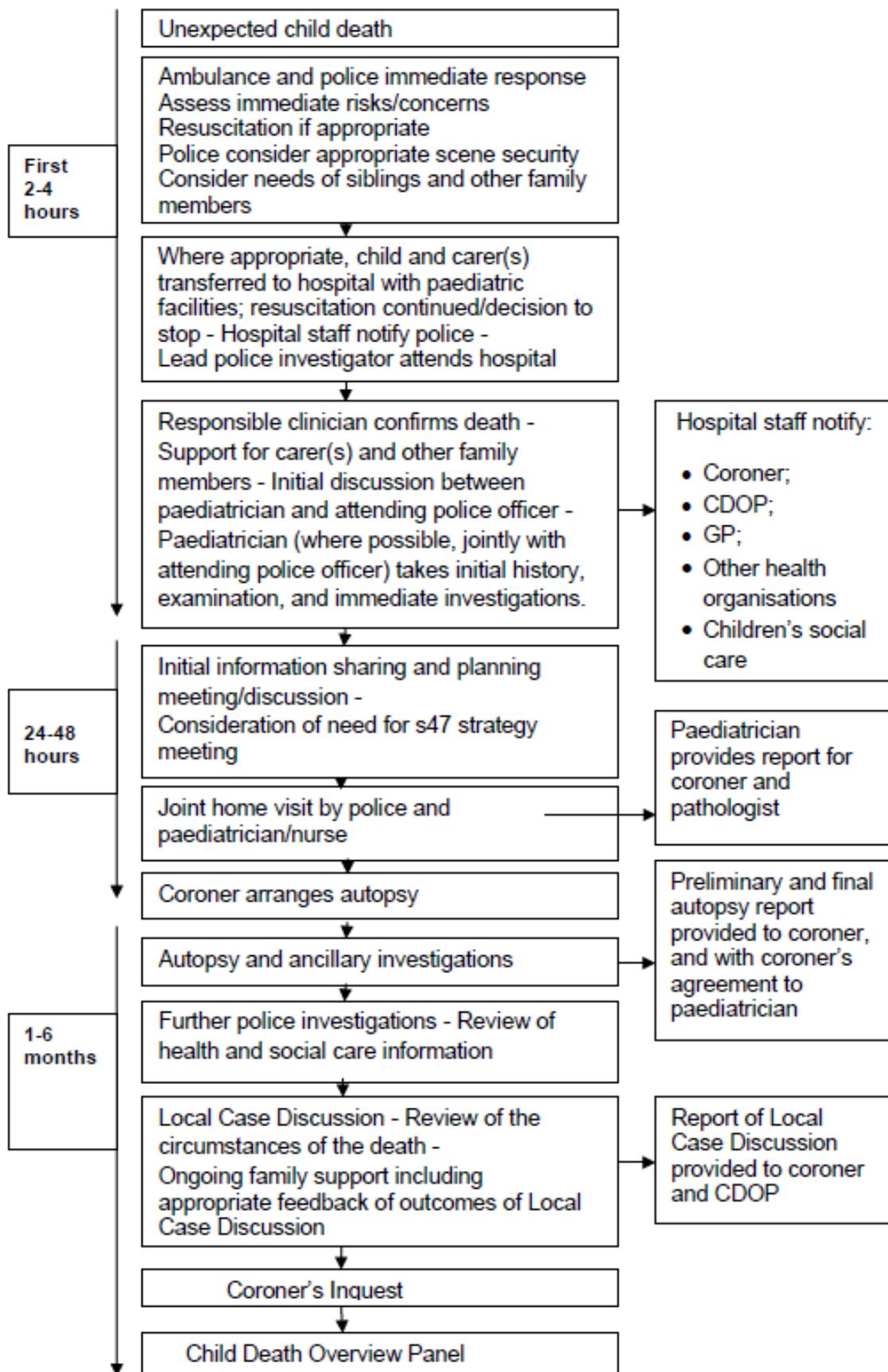
The Registrar of Births, Deaths, Marriages and Civil Partnerships will inform the relevant LSCB of child deaths, in accordance with the [Children and Young Persons Act 2008](#).

Section 32 of the [Children and Young Persons Act 2008](#) gives the Registrar General a power to share child death information with the Secretary of State. However, information about children who die abroad may not reach the Registrar General for some time after the death has occurred. Therefore the CDOP will utilise other resources such as professional contacts or the media regarding information in respect of the death of a child who is normally resident in the LSCB area and who dies abroad.

5. Process to be followed for all child deaths



6. Process for rapid response to the unexpected death of a child



The professional confirming a child's death should always notify the Designated Person for that area, by using the national CDOP template Form A Notification Form of a Child Death.

Preliminary Actions of the Designated Person:

Once the Designated Person has received a notification or referral of a child death, they will provide the CDOP Officer with a completed Form A and begin completion of the Form B. Both the Form A and Form B will be uploaded to the AGMA sharepoint system to allow agencies to view the case and supply information regarding the family's involvement with services.

The Designated Person will liaise with the CDOP Officer to inform them that there is a new referral on the secure website. When receiving a referral where the child was resident in another borough the CDOP Officer will inform her/his counterpart in the correct local authority where the child or parents are normally resident.

7. Role of CDOP Officer

The CDOP Officer will inform the nominated person for Social Care, Police, Education etc within the appropriate local authority and that they are required to complete the appropriate part of the Form A and Form B via the secure website.

When appropriate the CDOP Officer will inform the other relevant agency's such as Fire Service, Youth Offending Service, Drugs and Alcohol Team etc. to provide further information regarding specific queries relating to the circumstances leading to death.

The CDOP Officer will ensure that the minutes and the agenda are sent out one week prior to the panel meeting. Case information provided in the minutes and agenda is to be anonymised and paperwork collated at the end of each panel meeting to be disposed of securely.

At the panel meeting the CDOP Officer is to provide members with information regarding each child death operating a laptop and projector accessing the AGMA sharepoint system.

8. Role of the CDOP Chair

To ensure the Child Death Overview Panel operates effectively and within the statutory guidance.

Chair the CDOP meetings encouraging all team members to participate appropriately, ensure that all statutory requirements are met, and maintain a focus on preventive work

Facilitate resolution of agency disputes

The CDOP Chair will be responsible for informing the LSCB Chair in each authority if the Panel is not operating effectively.

To complete the tasks identified in the CDOP Chair job description.

To conduct the CDOP Meeting where there is a clear agenda and focussed on cases and discussion in a timely manner.

9. Child Death Information

Individual deaths and overall patterns of childhood deaths will be evaluated using the Form

B and Form C to determine: -

- if the deaths were preventable
- to identify modifiable risk factors (taking account of factors in the child, the parenting capacity; wider family, environmental and societal factors and service provided to or needed by the child or family) and
- to determine the best strategies for prevention.
- The CDOP will consider the information available and ascertain if they require more information to evaluate the child's death.
- Options for the Outcome of the CDOP Meeting
- The Panel has the following options: -
- to identify any case that requires a Serious Case Review
- to identify any cases where they believe a Single Agency Management Review would be appropriate
- to identify any matters of concern affecting the safety and welfare of children in the area and
- to identify any wider public health or safety concerns arising from a particular death or pattern of deaths
- Serious Case Review (SCR)

For extremely premature deaths where the child was born under 24 weeks gestation, these cases will be discussed at a preliminary meeting with the Paediatrician, CDOP Chair and CDOP Officer. In deaths where the cause of death is established as extreme prematurity and any other diagnosed conditions are linked to prematurity, these will be pre-screened and a draft Form C completed by the Paediatrician and uploaded to the AGMA secure website.

Prior to the CDOP all members will have access to the extremely premature draft Form Cs and will be asked if they have any issues or concerns that need highlighted. If the panel are in agreement the case will be closed and if any additional issues are highlighted the case will be opened for full discussion.

In some circumstances babies born extremely premature (<24 weeks gestation) may be opened up for full discussion at the CDOP e.g:

- if the child or siblings are or were previously subject to child protection plans
- where there are issues surrounding professional practice
- if parents are known to drugs, alcohol, mental health or domestic violence incidents etc

All CDOP members will read the Form B information prior to the meeting in preparation for the panel.

Once all information is collated and investigations have concluded the cases are presented to the panel. The CDOP Officer is to ensure that all investigations are complete and reports are submitted such as:

- Post Mortems
- Inquests
- Police investigation updates
- SCRs
- Single Agency Reviews
- Critical Incident Investigation etc.

The need to undertake an SCR has already been identified by the specific LSCB, and be

underway. However if the CDOP believes that there is information to suggest an SCR should take place and is/has not, then the Chair of the CDOP will inform the Chair of the relevant Board (and the relevant SCR Panel) of this matter. The SCR Panel will then follow their agreed LSCB procedures. The individual LSCB will feedback to the Panel on what action, if any, they are intending to take where a SCR is undertaken.

A copy of the SCR Executive Summary will be provided to the CDOP Chair for information.

Single Agency Management Reports

It is likely that this will have already been identified by the specific LSCB, and be underway. However the CDOP may decide that there are lessons to be learned, and Management Reports should be requested. This request will be sent, with reasons attached, to the Chair of the relevant Board and the Chair of the relevant SCR Panel. The SCR Panel will then follow their agreed LSCB procedures. The individual LSCB should feedback to the Panel on what action, if any, they are intending to take.

Matters of Concern for Children in an Area

It may be decided that there are no inter-agency issues which are required to be explored further, for example an accidental death or Sudden Infant Death may fall into this category. However, the information which is gained may influence future work and developments such as wider Public Health issues or safety concerns

There needs to be a regular review of patterns and trends of all child deaths. When any public health issues are identified, these need to be considered with the Director/s of Public Health as to how best to address these and their implications for both the provision of services and for training.

- Strategies may be considered at different levels:
- Strengthening individual knowledge and skills: assisting individuals to increase their individual knowledge and capacity to act leading to behavioural change, through education, counselling and individual support.
- Promoting community education
- Training providers to improve knowledge, skills, capacity and motivation to effectively promote prevention
- Fostering coalitions and networks of individuals and organisations to work for advocacy and health promotion
- Changing organisational practices where systems 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 CDOP will be based on the lessons learnt from the review of child deaths, will be focussed on specific, measurable actions and will include plans for monitoring implementation.
- Other Issues for discussion at Panel Meeting

The Panel should

- Monitor the appropriateness of the response of professionals to an unexpected death of a child, reviewing the reports produced by the Rapid Response Team on each unexpected death of a child and providing them with feedback on their work; the audit tool for Rapid Response to be used.

- Confidentiality and information sharing
- All members must adhere to strict guidelines of confidentiality and information sharing. Information is being shared in the public interest for the purposes set out in Working Together 2013 and is bound by legislation on data protection.
- CDOP members will be required to sign a confidentiality agreement before participating in the CDOP. Any ad-hoc or co-opted members and observers will also be required to sign the confidentiality agreement. At each meeting of the CDOP all participants will be required to sign an attendance sheet, confirming that they have understood and signed the confidentiality agreement.
- Any reports, minutes and recommendations arising from the CDOP will be made anonymous and steps taken to ensure no personal information can be identified.
- The information given to parents must be carefully managed.
- Accountability and reporting arrangements
- The CDOP is accountable to all three Local Safeguarding Children Boards.
- The CDOP is responsible for developing its work plan, which should be approved by each of the three LSCBs. It will prepare an Annual Report for the LSCBs. The individual LSCBs are responsible for publishing any relevant information from the report.

The panel members will review the child's Form B and any other supporting documentation to identify any gaps in information and highlight any issues. Once the panel agrees sufficient information has been collated members will begin completing the Form C Analysis Proforma. The purpose of the Form C is to look at any contributing factors and their relevance to the death. Members are to determine the categorisation and preventability of the death and record any finding or recommendations to be submitted to a:

- specific agency
- LSCB
- Regional
- National

The individual boards will take responsibility for disseminating the lessons to be learnt to all relevant organisations. The boards are responsible for ensuring that relevant findings inform the Children's and Young People's Plan. The individual boards are responsible to act on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.

10. Greater Manchester CDOP Database

In 2010 the 4 CDOPs of Greater Manchester (Bury, Rochdale and Oldham CDOP, Bolton, Salford and Wigan CDOP, Stockport, Tameside and Trafford CDOP and Manchester CDOP) identified the need to hold a CDOP database that would:

- securely hold information contained on the child's Form A, B & C
- have a reporting system that can pull data from the database for the purpose of analyse

The Greater Manchester CDOP Officers worked together to identify a common data set to be recorded across Greater Manchester to allow trends and strategies to be identified more easily by looking at a larger population.

It is the responsibility of the CDOP Officer to ensure that the database is maintained and that data is kept up to date and uploaded to the system on a regular basis.

11. Department of Education Annual Returns

Every LSCB is required to supply anonymised information on child deaths to the Department for Education. This is so that the Department can commission research and publish nationally comparable analyses of these deaths. CDOPs are required to provide information regarding the number of cases closed within the set timescale.

The LSCBs will supply data regularly on every child death as required by the DfE to bodies commissioned by the DfE to undertake and publish nationally comparable, anonymised analyses of these deaths. Minutes of the discussion and outcome of cases discussed will be circulated to panel members and the Chairs of LSCB upon request.

12. Informing Parents of the CDOP Process

The CDOP adopted the use of the [FSID leaflet The Child Death Review: A Guide for Parents and Carers](#). Registrars across Bury, Rochdale and Oldham have agreed to supply the leaflet to parents when registering a child death (excluding stillbirths, miscarriages and terminations of pregnancy's) under the age of 18 years.

If parents have any questions or queries regarding the CDOP process they can put this in writing to the panel who will then co-ordinate a response depending on each individual child death.