

# **Berkshire Child Death Overview Panel Procedure**

**April 2011**

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### Acknowledgement

The Berkshire CDOP thanks Bromley Primary Care Trust and the London Safeguarding Children Board for providing the basis for this procedure.

## 1. Introduction

This Procedure sets the standard for the Child Death Overview Panel, (CDOP) as outlined in chapter 7 of the Government guidance *Working Together to Safeguard Children (DCSF, 2010)*.

There are two inter-related processes for reviewing child deaths. Either process can trigger a serious case review.

1.1 The processes are:

**Rapid response** by a team of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child.

**An overview of all child deaths** (birth up to 18th birthday, excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) in the Berkshire LSCB areas, undertaken by a panel drawn from key organisations represented on the LSCBs. This will include children who suffered with life limiting or life threatening conditions (LL/LT conditions).

1.2 The Berkshire Local Safeguarding Children Boards (LSCBs) have a responsibility for convening and maintaining a Berkshire CDOP. All LSCBs have delegated governance of the CDOP to the meeting of the LSCB Chairs.

## 2. Context

2.1 When a child dies within the area in which s/he normally resides, the LSCBs must collect and analyse 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) of the Local Safeguarding Children Board Regulations 2006*;
- any matters of concern affecting the safety and welfare of children in the area of the authority.
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area.

2.2 When a child dies outside of the area in which s/he normally resides, the two LSCBs may, in some cases, decide to conduct individual reviews (see paragraph 7.2).

### Definitions

**An unexpected death** is defined 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 (DCSF, 2010).

**Preventable child deaths** are defined as those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

## 3. Core purpose

3.1 The CDOP will undertake an overview of all child deaths within the locality (excluding those deaths set out in paragraph 1.1).

This process uses a standard set of data (see

<http://www.education.gov.uk/childrenandyoungpeople/safeguarding/safeguardingchildren/childdeathreview>)

based on information available from those who were involved in the care of the child, both before and immediately after the death, and other sources such as:

- Case summaries from health records;
- Case information from police, LA children's social care and education; and
- Post mortem reports.

3.2 The CDOP has responsibility for reviewing the deaths of all children (excluding those deaths set out in paragraph 1.1), with priority given to those deaths that are both unexpected and unexplained.

3.3 If there is to be a serious case review, it will be undertaken by the LSCB where the child normally resides, with the decision taken by the LSCB Chair for that area.

#### **4. Membership**

4.1 The CDOP will be chaired by someone not involved with operational management of any service represented on the CDOP.

4.2 There will be a fixed core membership on the CDOP, which is drawn from the key organisations represented on the LSCB. The minimum should be senior management representation from:

- Designated paediatrician for unexpected deaths in childhood;
- Public health;
- Designated Child Protection Nurse
- LA children's social care;
- Police;

4.3 Other members will be co-opted as and when appropriate. This may be so that the membership of the CDOP better reflects the characteristics of the local population, to provide a perspective from the independent or voluntary sector or to contribute to the discussion of certain types of death e.g. Fire Brigade, adult mental health services, education / early years, bereavement services etc.

#### **5. Frequency of CDOP meetings**

The CDOP should hold meetings on a regular basis to enable the circumstances of each child death to be discussed in a timely manner. The frequency of the meetings should be every two to three months and reflect the number of cases; this should be set out in the Terms of Reference [see appendix 1](#).

#### **6. Notification of child deaths**

6.1 The CDOP Administrator (CDA) will be the single point of contact (SPOC) to be informed of all child deaths in the LSCB area, regardless of whether the child is resident in the area.

#### **7. Deaths of children out of area**

7.1 When a child dies in the area s/he is not permanently resident in, the SPOC for the area in which the child died will inform the CDOPA in the area the child normally lived.

7.2 The Chairs of CDOP in the area where the child was normally resident and the CDOP where the child died will decide, depending on the circumstances, which CDOP will review the death. The reviewing CDOP will liaise with

the other as necessary. If a dispute arises, the CDOP where the child was normally resident will carry out the review. The two CDOPs may, in some cases, decide to conduct individual reviews. In these cases, the Chairs of both CDOPs must negotiate management of the two reviews to ensure that there is a uniform response.

- 7.3 Information sharing between two CDOPs when a child dies out of his / her normal residency area, is in addition to informing the coroner within 1 working day, and immediate notification of the designated paediatrician for unexpected deaths in childhood if the death was unexpected.
- 7.4 If a child dies unexpectedly out of his/her normal residency area, the designated paediatricians for unexpected deaths in childhood from both areas will jointly decide on who will lead on the rapid response procedures.
- 7.5 The CDOP Chair is responsible for ensuring that this process operates effectively.
- 7.6 Children who die in hospital should be reviewed by the CDOP for the area in which they lived. The reviewing CDOP is responsible to inform the CDOP where the hospital is located.
- 7.7 The CDOP must review the circumstances of children who are normally resident in the area but who die abroad.

## 8. Key functions

- 8.1 The key functions of the CDOP are to:
- a) Receive notification on all child deaths occurring in the local area.
  - b) Collect and collate an agreed national minimum data set.
  - c) Seek information from all professionals who had involvement with the child before and immediately following the death.
  - d) Ensure that parents and family members are informed that their child's death will be reviewed and are given the opportunity to contribute to the review process.
  - e) Evaluate the data available and identify 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.
  - f) Assess the cases with regard to the threshold criteria to enable specific cases to be reviewed in depth (see [Threshold Criteria in appendix 2](#)).
  - g) Ensure that individual case discussions have taken place regarding unexpected child deaths.
  - h) 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, making a full record of this discussion and providing the professionals with feedback on their work.  
Where there is an ongoing criminal investigation, the Crown Prosecution Service must be consulted as to what it is appropriate for the CDOP to consider and what actions it might take in order not to prejudice any criminal proceedings.
  - i) Scrutinise the recommendations from the reports compiled by the designated doctor for unexpected deaths.
  - j) Identify any common themes from individual cases and consider these in more depth.
  - k) Consider whether the death was avoidable, if so how such deaths might be prevented in the future.
  - l) Identify any patterns or trends in the local data and reports these back to the LSCBs.
  - m) Consider the [Framework for the Assessment of Children in Need and their Families \(Department of Health et al, 2000\)](#) to assess any child, parent, social or environmental factors which could contribute to developing an understanding of the individual child's death ([Sidebotham and Fleming, 2007; p20-24](#)).
  - n) Where a child either in custody or under the supervision of the Youth Offending Team (YOT) dies, the Local Management Review undertaken by the YOT in relation to this death should feed into the child death processes initiated by the CDOP.

- o) Alert the Chair of the relevant LSCB about any deaths where, on evaluating the available information, the CDOP considers there may be grounds to undertake further enquiries, investigations or a serious case review and explore why this had not previously been recognised.
- p) Inform the Chair of the relevant LSCB where specific new information should be passed to the coroner or other appropriate authorities.
- q) 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.
- r) Monitor the support and assessment services offered to families of children who have died.
- s) Monitor and advise the LSCBs on the resources and training required locally to ensure an effective inter-agency response to child deaths.
- t) Identify any public health issues and consider, with the Director/s of Public Health, how best to address these and their implications for both the provision of services and for training;
- u) Co-operate with regional and national initiatives to identify lessons on the prevention of unexpected child deaths and the Confidential Enquiry into Maternal and Child Health (CEMACH)<sup>1</sup>.
- v) Ensure each partner agency of the LSCBs identifies a senior person with relevant expertise to have responsibility for advising on the implementation of the local procedures on responding to child deaths within their agency.

<sup>1</sup> See [www.cemach.org.uk/](http://www.cemach.org.uk/)

## **9. Consent and confidentiality**

- 9.1 Information in CDOP meetings will not be anonymised.
- 9.2 Information will be shared in accordance with the Overarching Information Sharing Protocols in existence in each LSCB area. Parental consent is not required for this. It should only be shared with those who need to know as governed by the *Caldicott Principles*, the *Data Protection Act* and *Working Together*. Persons with parental responsibility (*Children Act 1989*) should be advised that the child's death will be subject to a review in order to learn any lessons that may help to prevent future deaths of children. This must be handled sensitively. It should normally be done by the doctor confirming the child's death to the parents and followed up with a letter. See [letter for parents in appendix 3](#).
- 9.3 All LSCB member agencies must be aware of the need to share information on all child deaths to enable the LSCB to carry out its statutory duty.
- 9.4 Members of the CDOP must sign a confidentiality agreement, including sharing and securely storing information (see [template of confidentiality statement in appendix 4](#)) when they join the CDOP.
- 9.5 In no case will any team member disclose any information regarding team discussion within the CDOP 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.

## **10. Professional and family support**

- 10.1 Before the CDOP meets, the Chair should consider what explanatory information is sent to the child's family see [letter to parents in appendix 3](#).
- 10.2 The CDOP Chair should consider what feedback is given 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.
- 10.3 The CDOP Chair should ensure that information is also received and evaluated by the CDOP regarding the services and immediate support offered to families of children who have died.

## **11. Learning from child deaths**

- 11.1 The CDOP should monitor and advise the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths.
- 11.2 The CDOP should identify any public health issues and consider, with the Director(s) of Public Health, how best to address these and their implications for both the provision of services and for training.
- 11.3 The CDOP should contribute to regional and national initiatives to identify lessons on the prevention of unexpected child deaths e.g. CEMACH.

## **12. Reporting mechanisms**

- 12.1 The CDOP must submit an annual report to the Berkshire LSCBs each April. This information should include the total numbers of deaths reviewed, recommendations made by the panel about required future actions to prevent child deaths, and any further description of the deaths that the panel deems appropriate.
- 12.2 The LSCB is responsible for:
  - Disseminating the lessons to be learnt to all relevant organisations;
  - Ensuring that relevant findings inform the *Children and Young People's Plan*;
  - Acting on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children; and
  - Ensuring that data relating to child deaths is submitted to relevant regional and national initiatives to identify lessons on the prevention of unexpected child deaths.

### Berkshire Child Death Overview Panel Terms of Reference

#### 1. Purpose

- 1.1 Through a comprehensive and multidisciplinary review of child deaths, the Child Death Overview Panel (CDOP) aims to improve the understanding of how and why children in Berkshire die and use the findings to take action to prevent future child deaths and more generally to improve the health and safety of the children in the area.
- 1.2 In carrying out activities to pursue this purpose, the CDOP will meet the Local Safeguarding Children Board (LSCB) functions, as set out in paragraph 7.13 of *Working Together to Safeguard Children (2010)* (*Working Together*), in relation to the deaths of any children normally resident in the area:
- (a) Collecting and analysing information about each death with a view to identifying –
    - (i) any case giving rise to the need for a serious case review
    - (ii) any matters of concern affecting the safety and welfare of children in the area
    - (iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area
  - (b) Establishing procedures for ensuring a coordinated response to an unexpected child death.
  - (c) Make recommendations to the Local Safeguarding boards on modifiable child deaths.
  - (d) To produce an annual report

#### 2. Objectives

##### Notification and data collection

- 2.1 The CDOP will seek to:
- a) Ensure, in consultation with the Berkshire coroner's office, local Registrars and Medical Examiners, that local procedures and protocols are developed, implemented and monitored, in line with the guidance in Chapter 7 of *Working Together* on enquiring into unexpected deaths;
  - b) Ensure the accurate identification of every child death in the area;
  - c) Ensure uniform, consistent reporting of the manner and cause of every child death in the area;
  - d) Collect and collate the agreed national minimum data set of information on all child deaths in the area
  - e) Establish mechanisms for appropriately involving parents and other family members in the child death overview and rapid response processes
  - f) Ensure that these information gathering processes minimise distress to families; and
  - g) Co-operate with regional and national initiatives to identify lessons on the prevention of unexpected child deaths e.g. the Confidential Enquiry into Maternal and Child Health (CEMACH.org.uk).

##### Case assessment and review

##### Case level

- 2.2 The CDOP will seek to:
- h) Review each case of child brought before it where it will:
    - Classify the cause of death;
    - Make a decision as to the preventability of the death;
    - Identify any modifiable factors; and
    - consider any recommendations that may be made about actions which could be taken to prevent such deaths in the future and to whom those recommendations should be made;
  - i) Evaluate specific cases in depth, and identify any issues of concern or lessons to be learnt;
  - j) Contact the relevant LSCB Chair if it is thought that the criteria for a SCR might apply

- k) Where concerns of a criminal or child protection nature are identified, ensure that the police and coroner are aware and inform them of any specific new information that may influence their inquiries; notify the Chair of the relevant LSCB of those concerns and advise them on the need for further enquiries under section 47 of the *Children Act 1989*, or to recommend a serious case review.
- l) Decide what information will be shared with the family and how this can be done sensitively and appropriately

#### **Population level**

2.3 The CDOP will seek to:

- m) Evaluate data on the deaths of all children normally resident in the area (excluding those deaths set out in paragraph 1.1 of the Berkshire CDOP Procedures), 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.

#### **Service improvement**

2.4 The CDOP will seek to:

- n) Improve agency responses to child deaths through monitoring the appropriateness of the response of professionals to each unexpected death of a child, reviewing the reports produced by the Serious Case Review Team and providing the professionals concerned with feedback on their work
- o) 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; and
- p) Monitor the support and assessment services offered to families of children who have died.

#### **Prevention and advocacy**

2.5 The CDOP will seek to:

- q) Identify significant risk factors and trends in individual child deaths and in the overall patterns of deaths in the area, including relevant environmental, social, health and cultural aspects of each death, and any systemic or structural factors affecting children's well-being to ensure a thorough consideration of how such deaths might be prevented in the future;
- r) Identify any public health issues and consider, with the Directors of Public Health and other provider services, how best to address these and their implications for both the provision of services and for training;
- s) Identify and advocate for needed changes in legislation, policy and practices to promote child health and safety and to prevent child deaths.
- t) Increase public awareness and advocacy for the issues that affect the health and safety of children; and
- u) Monitor and advise the Local Safeguarding Children Boards on the resources and training required locally to ensure an effective inter-agency response to child deaths.

### **3. Scope**

3.1 The CDOP will gather and assess data on the deaths of all children from birth (excluding those babies who are stillborn planned terminations of pregnancy carried out within the law) up to their 18th birthday who are normally resident in the area. This will include neonatal deaths, expected and unexpected deaths in infants and in older children. Where a child normally resident in another area dies within the area, that death shall be notified to the CDOP in the child's area of residence. Similarly, when a child normally resident in the area dies outside the area, the CDOP should be notified. In both cases, an agreement should be made as to which CDOP (normally that of the child's area of residence) will review the child's death and how they will report to the other.

#### **4. Panel membership**

4.1 The Child Death Overview Panel will have a permanent core membership. Other members may be co-opted to contribute to the discussion of certain types of death when they occur. Core membership will consist:

- Chair (who must be appointed by the LSCB Chairs);
- Public health representative;
- Consultant paediatrician;
- Other PCT representation, as appropriate;
- Senior Police representation;
- Local authority children's social care;
- Neonatal specialist e.g. representative from midwifery, obstetrics, neonatal care;
- A representative from a bereavement counselling agency.

The CDOP Administrator will attend all meetings, provide papers and take minutes

#### **5. The role of core CDOP members**

##### **Public health**

5.1 The public health representative can:

- Provide the panel with information on epidemiological and health surveillance data;
- Assist the panel in strategies for data collection and analysis;
- Assist the panel in evaluating patterns and trends in relation to child deaths and in learning lessons for preventive work;
- Inform the panel of public health initiatives to support child health; and
- Advise the panel on the development and implementation of public health prevention activities and programmes.

##### **Paediatrician**

5.2 The paediatrician can:

- Provide the panel with information on the health of the child and other family members, including any general health issues, child development, and health services provided to the child or family;
- Help the panel interpret 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 autopsy findings and results of medical investigations;
- Advise the panel on medical issues including child injuries and causes of child deaths, medical terminology, concepts and practices;
- Provide feedback and support to medical practitioners involved in individual case management; and
- Liaise with other health professionals and agencies.

##### **Police**

5.3 The police representative can:

- Provide the panel with information on the status of any criminal investigation;
- Provide the panel with information on the criminal histories of family members and suspects;
- Identify cases that may require a further police investigation;
- Provide the panel with expertise on law enforcement practices, including investigations, interviews and evidence collection;
- Help the panel evaluate any issues of public risk arising out of the review of individual deaths;

- Liaise with other police departments, and the Crown Prosecution Service; and
- Feedback to police officers involved in individual case management.

### **Children's social care**

5.4 The children's social care representative can:

- Provide the panel with information on any social care involvement with the child and family, including any child protection concerns;
- Help the panel to evaluate issues relating to the family and social environment and circumstances surrounding the death;
- Advise the panel on children's rights and welfare, and on appropriate legislation and guidance relating to children;
- Identify cases that may require a further child protection investigation, or a serious case review;
- Liaise with other local authority services; and
- Provide feedback to social workers and other local authority staff involved in individual case management.

### **Bereavement Service Representative**

5.5 The representative from the bereavement counselling agency can:

- Advise the panel on how to appropriately inform and involve parents and other family members
- Advise the panel on what information is appropriate to share with parents and families and an appropriate manner in which to convey this
- Represent to the panel the views of parents and families in general, and if relevant specific parents or families
- Assist the panel in identifying appropriate support for bereaved families

## **6. Duties of the CDOP Chair**

6.1 The Chair of the CDOP is responsible for:

- Chairing the CDOP meetings, encouraging all team members to participate appropriately;
- Ensuring that all statutory requirements are met;
- Maintaining a focus on preventive work;
- Selecting cases for in-depth review by the CDOP, as part of the in core functions
- Ensure that new members receive an orientation to the panel prior to their first meeting;
- Facilitating resolution of agency disputes; and
- Ensuring that this process operates effectively
- Communicating the outcomes of decisions
- Provide an annual report to the Berkshire LSCBs

6.3 The CDOP Administrator is responsible for:

S/he will:

- Be the designated person to whom the death notification and other data on each child death in the area should be sent;
- Ensure the effective running of the notification, data collection and storage systems;

- Book venues for panel meetings and send invitations to panel members;
- Obtain names and compile the summary sheet of child deaths to be reviewed and distribute to panel members at least two weeks prior to each meeting;
- Ensure that notifications of child deaths are available for panel review;
- Ensure that all new CDOP members, ad hoc members and observers sign a confidentiality agreement;
- Take and disseminate notes from each CDOP meeting;
- Feed data of every child death in the area to the ContactPoint once it is established.

## **7. Confidentiality and information sharing**

- 7.1 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 *Working Together* and is bound by legislation on data protection.
- 7.2 CDOP members will all 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.
- 7.3 Any reports, minutes and recommendations arising from the CDOP will be fully anonymised and steps taken to ensure that no personal information can be identified. (Please refer to the Information Sharing and Assessment Protocol.)

## **8. Accountability and reporting arrangements**

- 8.1 The CDOP will be accountable to the chairs of the LSCBs.
- 8.2 The CDOP is responsible for developing its work plan, which should be approved by the LSCBs. It will prepare an annual report for the LSCB, which is responsible for publishing relevant, anonymised information.
- 8.3 The LSCB takes responsibility for disseminating the lessons to be learnt to all relevant organisations, ensuring that relevant findings inform the *Children & Young People's Plans* and acting on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.
- 8.4 The CDOP will supply data regularly on every child death as required, e.g. by:
- The learning from information about child deaths initiative to collate and analyse information about child deaths across Berkshire, in order to identify lessons on the prevention of child deaths; and
  - The Department for Education to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of child deaths.

## **9. Conflict resolution**

- 9.1 The CDOP Chair should encourage panel members to form a consensus in their assessment of child deaths (e.g. whether a case should have been handled differently or whether the criteria for a serious case review, as set out in *Working Together* Chapter 8, are met in the opinion of the CDOP). However, where a consensus is not agreed, the Chair's decision is final.

## **10. Quoracy/Dispute/Conflict of Interest.**

- 10.1 The LSCBs retains the right of membership/operation, if for any reason a resolution cannot be agreed, the issue will be taken to Chairs/Leads of the Berkshire Groups.

## Appendix 2: Threshold criteria

There are two levels or types of child death cases for the members of the Child Death Overview Panel (the CDOP) to consider.

For all deaths, the panel will use information collated from Form Bs to:

- Classify the cause of death using the categorisation schema produced by DfE
- Make a decision as to the preventability of the death
- Identify any modifiable factors
- Consider any recommendations that may be made and to whom these should be addressed. (These include recommendations to escalate to Serious Case Review or about actions which could be taken to prevent such deaths in the future.)

Form C will be used to facilitate this discussion.

**Level 1** – Scope: where the child’s death is ‘anticipated / not unexpected’ and likely to be more ‘straightforward’, with no additional complicating factors.

These are likely to be the substantial number of the deaths for review, and the majority are likely to be neonates. The panel may consider whether groups of similar deaths should be discussed at designated panel meetings.

**Level 2** – Scope: where there are additional factors in relation to the child’s death. The CDOP will require papers additional to the core papers. The range of types of deaths meeting level 2 are listed below (this is not exhaustive):

- Any death that remains unexplained
- All deaths subject to the Rapid Response process
- All deaths resulting from:
  - Deliberately inflicted injury, abuse or neglect
  - Suicide or deliberate self-inflicted harm
  - Trauma and other external factors.
- Any death that has attracted public or media interest, subject to the governance panel of LSCBs.

Additional papers may include:

- The minutes from Rapid Response meetings
- Additional DfE B forms or reports from services working with the child/family
- Any reports on outcomes of Serious Case Reviews/ criminal proceedings/ coroner’s inquest or other investigations or reviews
- Possible summary of public/media coverage

**Process** – All CDOP members contract to read the CDOP case papers in advance of the meeting to avoid delay in scheduled meeting time. Any glaring questions or omissions should be communicated to the CDOP Chair in advance of the meeting and if they cannot be dealt with before the meeting, the case is withdrawn and deferred to a subsequent panel with the required information / documents provided. This process requires secure communication systems to share information in a timely way.

CDOP will not be able to complete a review if the outcome of a Coroner's inquest is still pending.

**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 should input into a secure electronic database for all across Berkshire and allows the collation of all Berkshire child death data for annual strategic analysis and recommendations.

**Reporting** – Local data, lessons and recommendations to be reported to each Local Safeguarding Children Board at least annually or more frequently, as agreed.

## Appendix 3: Template for letter to parents

### Template for letter to parents CDOPs can adapt for all child deaths

Dear

I am writing to you as the chair of Berkshire Child Death Overview Panel to inform you of the local child death review processes. First may I express my condolences on the tragic death of < insert name >.

From April 2008, the government requires Local Safeguarding Children Boards (LSCBs) to carry out a review of all child deaths in their area. Government Guidance *Working Together to Safeguard Children* sets out the processes by which all children's deaths will be reviewed

<http://www.education.gov.uk/childrenandyoungpeople/safeguarding/safeguardingchildren/childdeathreview>).

The purpose

of these reviews is to see whether we can learn lessons from children's deaths in order to improve the health, safety and well being of children in our area and ultimately, hopefully, to prevent further child deaths.

As part of this process your child's death has been notified to the panel. Basic information on your child will be collected by the panel for the purposes outlined above. All the information we collect will be treated with respect and in confidence. While all children's deaths are notified to the panel, some are selected for a more in depth Review where we feel there may be particular lessons for us to learn. For these, more detailed information will be collected and considered by the panel. When the panel identifies any lessons that could lead to practical action for children, it will make recommendations to the Local Safeguarding Children Board and other agencies. Each year the panel will publish a report which will be publicly available. I want to assure you that no identifiable information about your child will be published in the annual report or made available outside the panel.

Many parents, following the death of their child, have significant questions and concerns. Many want to ensure that something good can come out of their child's death that may help other children and families. I would therefore like to give you the opportunity to contribute to the work of the Child Death Overview Panel. I would like you to consider whether there are any issues that you would like the panel to discuss. These may be issues around the circumstances leading to <name>'s death, or around the support you as a family received either before or following <his/her> death.

If you have any questions or comments, or would like any further information, please contact the CDOP administrator in writing at the address given above.

Yours sincerely

Chair of the Berkshire Child Death Overview Panel

**Appendix 4: Model confidentiality statement - Core Members to sign at first meeting.**

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

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

The Berkshire Procedures for *Rapid Response* and for *Child Death Overview Panels* and the six LSCBs in Berkshire protocols for child death reviews stipulate that in no case will any team member disclose any information regarding team discussion outside the meeting other than 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

This Child Death Overview Panel Confidentiality Statement, was designed by University of Warwick

## Appendix 5: Data Security

Information should always be transferred and stored securely. The following email addresses should be used in transferring personal information concerning child deaths

### **NHS staff**

Using only the nhs.net network, send information to: [be-pct.cdopadmin@nhs.net](mailto:be-pct.cdopadmin@nhs.net)

*NB The nhs.uk network is not secure.*

### **Non-NHS staff**

Those who work outside the NHS but have an existing Criminal Justice Secure eMail (CJSM) account can also send information securely using this email account to the same email address

[be-pct.cdopadmin@nhs.net](mailto:be-pct.cdopadmin@nhs.net).

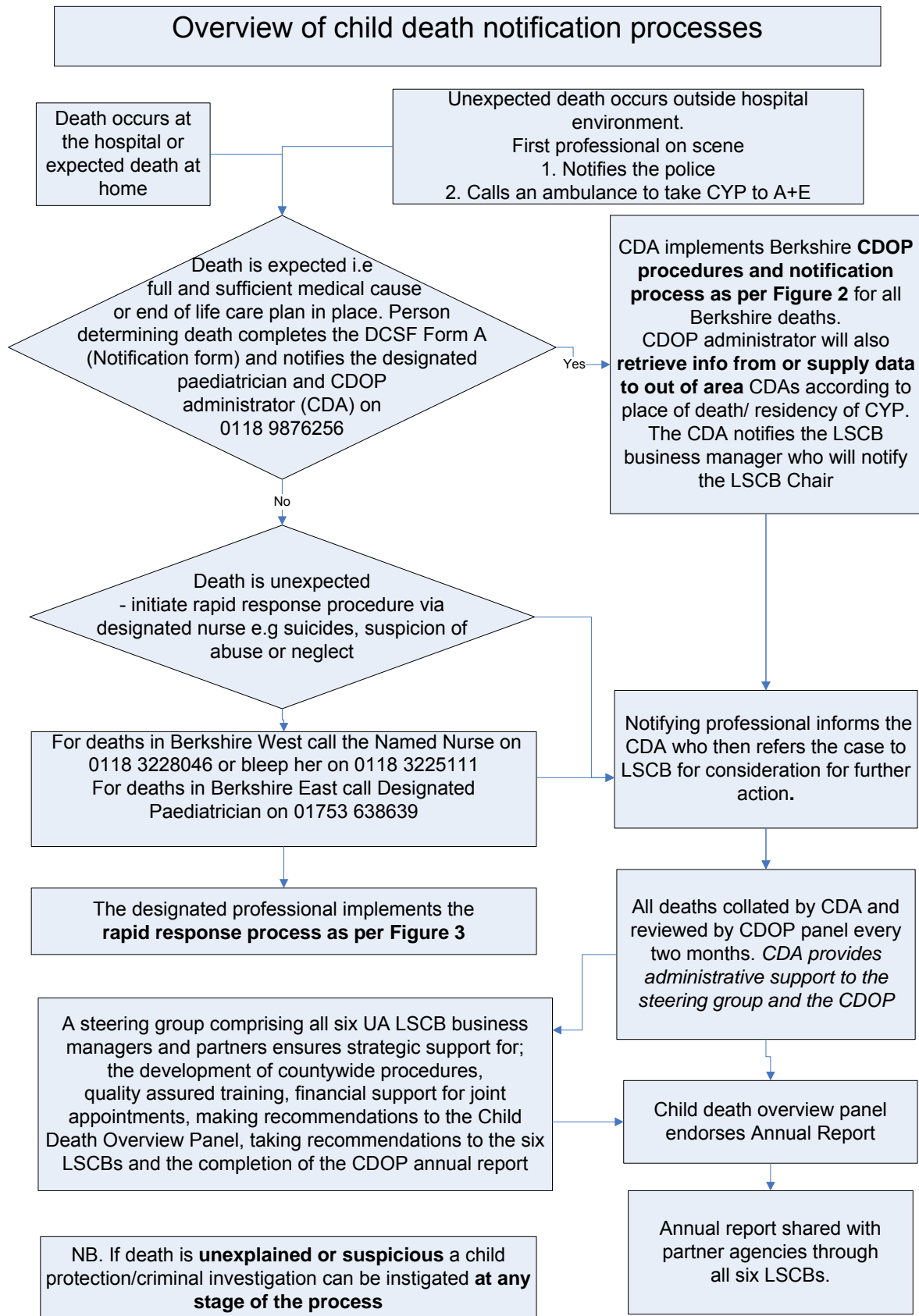
Most local authorities have CJSM accounts

Those who do not have a secure email can sign up to a CJSM account on request for child death review purposes. The CDOP administrator can advise on this process.

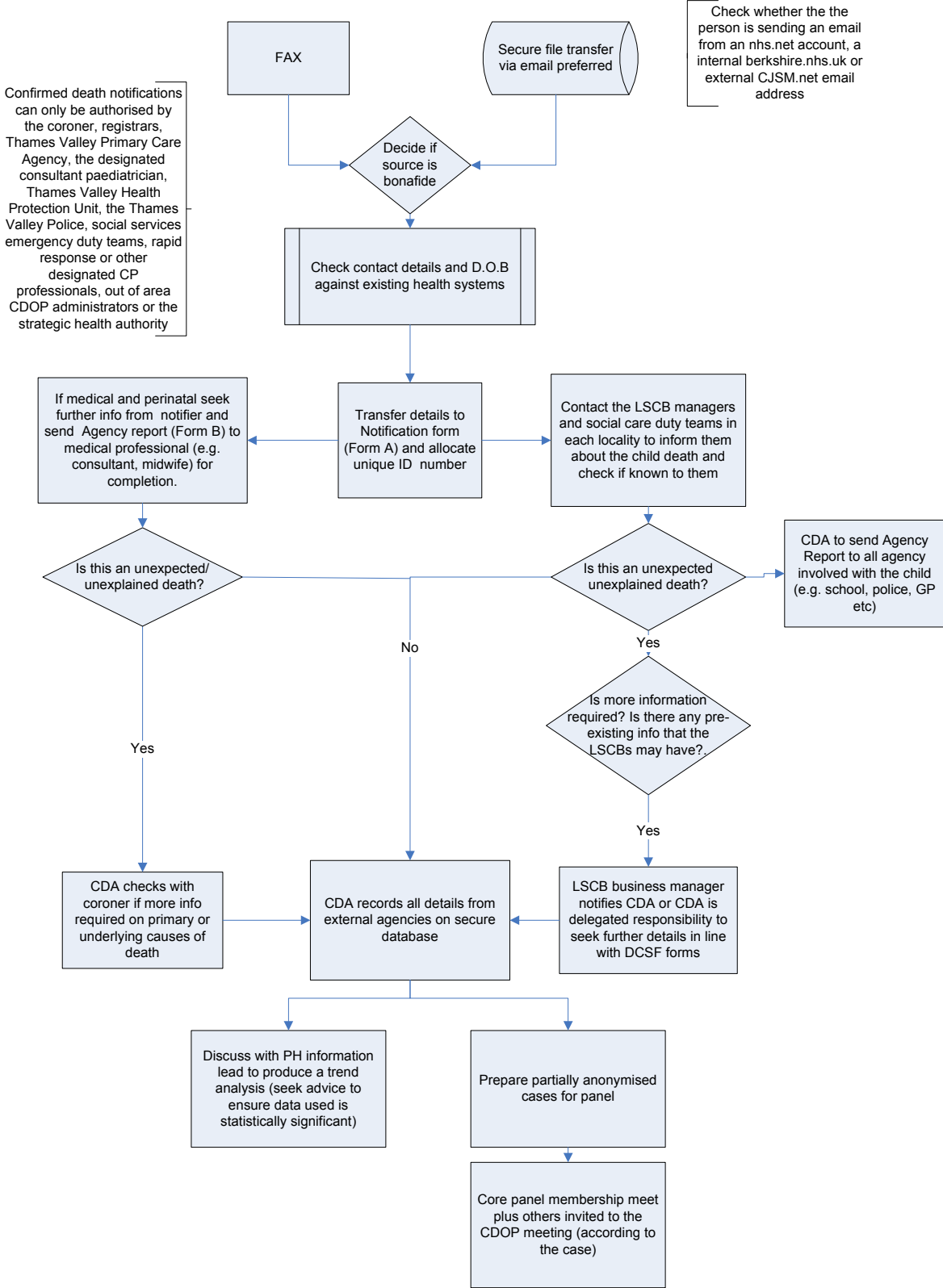
The data will be held will be securely by Berkshire East PCT and will be backed up on a daily basis according to NHS Berkshire Shared Services (BSS) practice. The database will be password protected and only the following personnel will have access:

- CDOP Administrator
- The Manager of the CDOP Administrator
- BSS Analyst
- BSS Senior Information Security Officer

It will be the responsibility of the Panel to ensure that the data is kept for no longer than is necessary (and of the administrator to remind it of this). In the first instance, the data will be kept for a maximum of 25 years but the necessity for retaining it for this length of time will be reviewed periodically and certainly within 10 years.



Operating Procedure for CDOP administrator (CDA)



Rapid response process for all unexpected child deaths in Berkshire East

