LSCP

Lincolnshire Safeguarding Children Partnership

Lincolnshire Child Death Overview Procedure

May 2019

Lincolnshire Safeguarding Children Partnership

http://www.lincolnshire.gov.uk/lscb

Contents

Glossary

Child Death Review process (CDR)	The entire process undertaken to thoroughly investigate the death of a child, from initial incident through to national learning.
Child Death Overview Panel (CDOP)	The panel held to carry out the statutory review of all child deaths on behalf of the Child Death Review Partners.
Child Death Review Meeting (CDRM)	The child death review meeting is a multi-professional meeting where all matters relating to an individual child's death are discussed by the professionals directly involved in the care of that child during life and their investigation after death.
Child Death Review Partners	The organisations responsible for ensuring that the Child Death Review Process is undertaken within their locality. These are usually the Local Authority and CCG(s) within the area.
Stillbirth	A baby born without signs of life after 24 weeks gestation.
Late foetal loss	Where a pregnancy ends before 24 weeks gestation.
Termination of pregnancy	An induced abortion to end a pregnancy using a medical or surgical procedure. The terms abortion and termination of pregnancy are often used interchangeably.
LSCP	Lincolnshire Safeguarding Children's Partnership
SIDS	Sudden Infant Death Syndrome
SIRG	Significant Incident Review Group (Sub-Group of LSCP)
SUDI/C	Sudden Unexpected Death in Infancy/Childhood.

1. Introduction

1.1 The death of a child is a devastating loss that profoundly affects all those involved. The tragedy is that many child deaths are preventable and every preventable death is one death too many. The process of systematically reviewing all children's deaths is grounded in respect for the rights of children and their families, with the intention of learning what happened and why, and preventing future child deaths[1].

This Procedure sets a minimum standard for a Child Death Review process (CDR) as outlined in chapter 5 of the Government guidance Working Together to Safeguard Children (2018).

The child death review process includes the whole pathway from the initial response to provide care for the child and their family, and undertake initial investigations, any detailed reviews or investigations, through to the 'child death overview' which takes a summary view of all the factors and seeks to capture any learning that could benefit the whole population of children in future. This is best explained by the diagram below, taken from the Child Death Review statutory and operational guidance[2] (page 13).

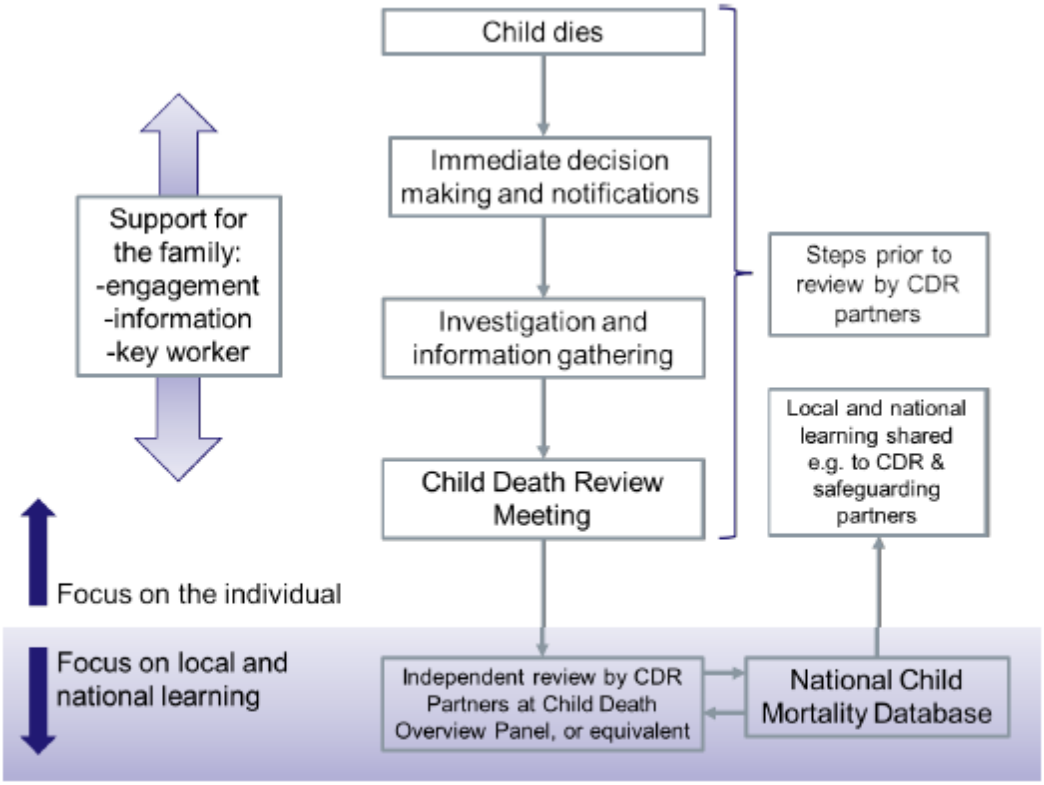


Figure 1 Chart illustrating the full process of a child death review. This includes both the statutory responsibilities of CDR partners to review the deaths of children at an independent multi-agency panel (described here, and throughout, as review at CDOP or equivalent), and the processes that precede or follow this independent review. Further explanation is below.

2. Context

2.1 Statutory Requirements

[1] Working together to Safeguard Children, HM Government, 2018.
[2] Child Death Review statutory and operational guidance, HM Government, 2018.

Under the Children Act 2004 (the Act), as amended by sections 24-28 of the Children and Social Work Act 2017, 'child death review partners' (CDR partners), defined as local authorities and any clinical commissioning groups for the local area, must make arrangements to review all deaths of children normally resident in the local area, and if they consider it appropriate, for those not normally resident in the area. In addition to having to make arrangements to review child deaths:

1. They must make arrangements for the analysis of information from deaths reviewed.
2. They should identify any matters relating to the death or deaths that are relevant to the welfare of children in the area and to public health and safety. In doing so, they must consider whether it is appropriate for any action to be taken by anyone in relation to their findings. If they find action should be taken, they must inform the necessary person.
3. They must prepare and publish reports on:
a) what they have done as a result of the arrangements, and
b) how effective the arrangements have been in practice.
4. They can request information from a person or body that will enable or assist the review process, and the person or body must comply with the request. If they do not, the child death review partner can take legal action to enforce the request made.
5. Child death review partners may make payments directly towards expenditure incurred in connection with child death review, or by contributing to a fund out of which payments may be made. They may provide staff, goods, services, accommodation or other resources to any person for purposes connected with child death review.

2.2 CDR partners are responsible for ensuring that a review of each death of a child normally resident in their area (and where appropriate for the death in their area of a child not normally resident in their area) takes place. This should be carried out through a Child Death Overview Panel (CDOP).

2.3 The functions of CDOP are:

- to collect and collate information about each child death, seeking relevant information from professionals and, where appropriate, family members;
- to analyse the information obtained, including the report from the CDRM, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths;
- to make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children;
- to notify the Child Safeguarding Practice Review Panel and local Safeguarding Partners when it suspects that a child may have been abused or neglected;
- to notify the Medical Examiner (once introduced) and the doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction;
- to provide specified data to NHS Digital and then, once established, to the National Child Mortality Database;
- to produce an annual report for CDR partners on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process; and

- to contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.

2.4 CDOP has responsibility for reviewing the deaths of nearly all live born children up to and including the age of 17 years (see exceptions below). This includes the death of any live-born baby where a death certificate has been issued. A child death review must be carried out for all children regardless of the cause of death.

A review should not be undertaken for:

- *stillbirths* (a *baby born without signs of life after 24 weeks gestation)*
- *late foetal loss (where a pregnancy ends before 24 weeks gestation)*
- *terminations of pregnancy (of any gestation) carried out within the law, even if signs of life were present.*

In the event that the birth was not attended by a healthcare professional, initial enquiries should be undertaken to determine whether or not the baby was born alive. If these enquiries determine that the baby was born alive the death must be reviewed.

2.5 The statutory responsibility for conducting the review lies with the 'child death review partners' in the area in which the child was normally resident. When a child dies outside of an area in which they were not normally resident, the CDOP chairs for each area involved should discuss and decide where lessons are more likely to be learned. For example:

- A child who was normally resident in Lincolnshire dies in a tertiary care hospital outside the county, and is reviewed by the Lincolnshire CDOP.
- A child normally resident in another area dies in Lincolnshire whilst on holiday. Their death is reviewed by their home CDOP with input from Lincolnshire agencies that had contact with the child.

To avoid unnecessary additional burden on resources and to promote clear lines of accountability, it is not recommended that the two CDOPs conduct individual reviews. However, the two CDOP Chairs should negotiate and agree how learning from the review/s will be shared across both areas. Local organisations that had involvement with the child in each area should cooperate in contributing to the information needed to undertake a child death review.

2.6 Children who die in hospital will normally be reviewed by the CDOP for the area in which they were usually resident. N.B. A large proportion of neonatal deaths occur in tertiary health care centres outside of Lincolnshire, for example Nottingham University Hospital or Sheffield hospitals. In the majority of these cases where this was due to normal patient treatment pathways, the review should take place within Lincolnshire, unless there are exceptional circumstances.

2.7 In the case of a looked after child, the Safeguarding Partners for the area of the local authority looking after the child should take lead responsibility for conducting that child death review, involving other areas with an interest or whose lead agencies have had involvement.

2.9 When a child, who is normally resident in the area dies abroad, it is the responsibility of CDOP to review the circumstances of the death. It is the duty of panel members and partner agencies to notify the designated person should they become aware of any such cases.

3. **Constitution** (see also Terms of Reference at Appendix 1)

3.1 The Child Death Overview Panel is a sub-committee of the Lincolnshire LSCP, which discharges the duty to review all child deaths on behalf of the Child Death Review partners.

3.2 Key agencies that are involved in the care of all children across Lincolnshire will be members of the Child Death Overview Panel. These are drawn from organisations represented on the LSCP

3.3 The Lincolnshire LSCP will select one of its members to chair the panel and vice chair to support this role.

3.4 CDOP is accountable to the LSCP.

4 Membership

4.1 The CDOP will have a fixed core membership with flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate.
The following will be core members of the CDOP:

- Designated paediatrician for unexpected deaths in childhood (and a hospital clinician if the designated doctor is a community doctor or vice versa)
- Health (Community/Hospital)
- Public health
- Safeguarding (designated doctor or nurse)
- LA children's social care;
- Clinical Commissioning Group responsible for Safeguarding;
- Police
- Nursing and/or Midwifery
- Primary Care (GP or health visitor)
- Lay representative (when available)

Additionally invited members

- LCC Safeguarding for Children Lead
- Children mental health services representative
- LSCP Business Manager
- HM Coroner
- SUDIC Lead
- Lincolnshire Road Safety Partnership

- Education
- Ambulance Services

4.2 Attendance by professionals may vary dependent upon the cases for review e.g. whether there are neonates or older children in education due for review, or where there is a specific mode of death such as suicide or road traffic collision.

4.3 Other members will be co-opted as and when appropriate to allow the membership of the CDOP to better reflect 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. Housing, Early Years, Bereavement services etc.).

4.4 Quoracy demands attendance by lead professionals from health and local authority as a minimum. In practice, attendance is required from a hospital and a community doctor, midwifery, children's health services and children's social services for a panel to be able to conduct a full review.

5 Frequency of panel meetings

5.1 The frequency of panel meetings should enable the circumstances of all child deaths to be discussed within 6 weeks following receipt of the Child Death Review Meeting (CDRM) such as the SUDIC or hospital mortality meeting, or from conclusion of a Coroner's inquest.

5.2 For the most part, the meetings should take place on a monthly basis. Where the number of deaths is low, the panel meeting can be deferred for up to 3 months (minimum 4 panel meetings a year).

5.3 Where other investigations are ongoing that will be likely to inform the overview, such as criminal investigations or serious case review, the case may be deferred until 6 weeks after these have been concluded.

6. Consent, confidentiality and record keeping

6.1 All CDOP papers will be anonymised.

6.2 The basis for receiving and processing information about a child who has died for CDR purposes is statutory and therefore cannot be refused by a parent or guardian. Therefore it is disingenuous to seek consent as it cannot be refused. Best practice however is to inform families of the process and explain its purpose. This should be carried out by the named support worker during the initial investigation and support phase. The vast majority of families are supportive and even amidst their own tragic circumstances, often wish to benefit others through any learning that can be gained.

6.3 Although a deceased person is no longer subject to the General Data Protection Regulations and does not have a legal right to withhold their personal information, the utmost care should be taken with all personal and sensitive information as though the person held such rights. In addition, records may refer to other living family members. Information should only be shared with those who need to know, as governed by the *Caldicott Principles*, the *General Data Protection Regulations* and *Working Together to Safeguard Children*.

6.4 All LSCP member agencies must be aware of the need to share information on all child deaths to enable the Safeguarding Partners to carry out their statutory duty.

6.5 Members and their deputies attending on behalf of organisations agree to share information in line with Working Together and adhere to Information Governance and ensure compliance with the General Data Protection Regulations.

6.6 All new members and observers to the panel will complete and sign the standard LSCP confidentiality form.

6.7 Member agencies agree that the LSCP is the data controller for each individual case summary, but not individual agency records. A summary is a collated form detailing information from all agencies that has been inputted into the eCDOP tool.

6.7.1 If a summary relates to a Serious Case Review, the data will be retained no longer than the Date of Birth of the child plus 75 years.

6.7.2 If a summary relates to a review that has not been subject to a Serious Case Review and the child has died, then the records should be kept for no longer than 15 years after the Date of Death.

6.8 In no case will any CDOP member disclose any information pertaining to any individual case which has been dealt with by the CDOP outside the meeting, other than pursuant to the mandated agency responsibilities of that individual or for the purposes of joint investigations. Public statements about the general purpose of the child death review process may be made in line with the LSCP process for managing media interest as long as they are not identified with any specific case.

7. Death review procedures

7.1 Notification

7.1.1 Professionals in all agencies have a responsibility to notify the relevant CDOP, where the child lived, of the death of any child of which they become aware. They also have a duty to share information for the purposes of reviewing the child's death, and to participate in local review arrangements when they have been involved with the child or family.

7.1.2 Notifications must be made using the eCDOP system. All relevant partner agencies will be issued with a log in to enable this process to take place.

In exceptional circumstances a notification may be made by telephone or secure email only and recorded on eCDOP at the earliest opportunity by the CDOP co-ordinator.

7.2 Information gathering

7.2.1 The CDOP coordinator is responsible for gathering agency reports relevant to the child who has died. Requests for agency reports will be made using the eCDOP system within 5 working days of notification but will usually be sent the same day where possible.

7.2.2 Agency responses should include a full report or nil return where they had no involvement with the child or family.

7.2.3 Prompts will be automatically generated via the eCDOP system at 2, 4 and 8 weeks from the initial request. If an agency has not responded within 10 working days of the third prompt, this will be escalated to the Chief Executive or equivalent of that organisation and the CDOP chair of the area in which the organisation sits.

Where it is unclear which agency reports are key sources of information, this should be agreed in discussion with the CDOP chair and/or Vice chair.

Contributions and information from parents, family members and/or significant others should have been invited by the named support worker following the child's death. It should also have been made clear that due to the anonymised nature of the reviews, individual feedback to families is not possible but that any learning will contribute to reducing the likelihood of avoidable deaths for children in the future.

7.3 **Preparation for review**

7.3.1 Once all agency returns have been completed, the CDOP coordinator should summarise the key events in the child's life, including their medical history and family circumstances. This will be presented in the form of a timeline, with dates and times where available.

7.3.2 This information will be entered and held using the secure eCDOP system. The system will automatically produce a dashboard report showing progress against information gathering or where there are external procedures or reviews that must be completed prior to CDOP review (such as post mortem examination, coroner's inquest or learning review).

7.3.3 Once all key agency reports are received and the summary has been prepared, the case will be discussed at a pre-panel meeting between the CDOP coordinator, Chair and Vice Chair. The purpose of this meeting is to agree that sufficient relevant information is likely to be available to inform the panel review, and to familiarise all parties with the circumstances of the child's life and death.

7.3.4 Once this is agreed, the case will be assigned to the next panel meeting via the eCDOP system. This will make the Child Death Analysis form available to all invited panel members when securely logged in to eCDOP, no less than 1 week prior to the panel meeting[3].

7.4 **During the review**

7.4.1 All CDOP members will commit to reading the CDOP case papers in advance of the meeting to avoid delay in coming to a determination for each case in a timely manner.

7.4.2 The Chair, Vice Chair or other nominated person will present the key factors surrounding the child's life and circumstances leading to his/her death. The timeline should be followed to

[3] Rare exceptions may occur where it is felt that an urgent review will be of benefit to the family or could reduce risk to other children, and therefore the panel may conduct an initial review based upon partial evidence in a case less than five days following notification. Such a decision will be taken by the Chair and/or Vice Chair.

allow gaps or incongruous events to be visible. All panel members are encouraged to contribute to discussions and raise questions as appropriate.

7.4.3 The panel should endeavour to come to an agreement regarding the category of death (see child death review forms for reporting child deaths). Where consensus cannot be reached, it is preferable to seek further information and, if necessary ask the opinion of other CDOPs via secure communication channels rather than resorting to a vote. This approach also applies to the question regarding the presence of modifiable factors.

7.4.4 The panel may differ in opinion from a Coroner's inquest, or other statutory investigations. It should be remembered that the CDOP takes an overview from a multi-agency perspective and asks firstly the question 'why did this child die', then also 'what can we learn from it and do differently in the future'?

7.5 Follow up actions arising from the review

7.5.1 CDOP may make recommendations to the LSCP or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible.

7.5.2 Where new patterns or trends in local data are identified, the CDOP should report these to the Safeguarding Partners via the LSCP and consider reporting to the national panel.

7.5.3 Where a suspicion arises that neglect or abuse may have been a factor in the child's death, CDOP should refer the case to the LSCP Serious Incident Review Group for consideration of local learning review and/or report to national panel.

7.5.4 Local data, lessons and recommendations are to be reported to the Lincolnshire LSCP at least annually or more frequently, as agreed.

8. Learning from child deaths

8.1 The CDOP will monitor and advise the LSCP on the resources and training required locally to ensure an effective inter-agency response to child deaths.

8.2 The CDOP will identify any strategic issues (such as public health, community safety, health and safety etc.) and consider how best to address these and their implications for both the provision of services and for training.

8.3 The CDOP will contribute to regional and national initiatives to identify lessons on the prevention of unexpected child deaths.

9. Reporting mechanisms

9.1 CDOP must submit an annual report to the Safeguarding Partners via the LSCP to be included in the overall annual report for presentation at the AGM.

9.2 The LSCP is responsible for:

- Disseminating the lessons to be learnt to all relevant organisations;
- Ensuring that relevant findings inform local and national reports;
- 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.

Appendix 1: Terms of Reference

Lincolnshire Child Death Overview Panel Terms of Reference

1. Purpose

1.1 The Child Death Overview Panel will fulfil the requirements as described in Chapter 5 of Working Together to Safeguard Children to collect and analyse information about every death of a child aged under 18 years of age in Lincolnshire with a view to:

- identifying any matters relating to the death or deaths that are relevant to the welfare of children in the area and to public health and safety
- considering whether it is appropriate for any action to be taken by anyone in relation to their findings
- taking action to inform the necessary person

2. Functions

- to collect and collate information about each child death, seeking relevant information from professionals;
- to analyse the information obtained, including the report from the Child Death Review Meeting (CDRM), in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths;
- to make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children;
- to notify local Safeguarding Partners when it suspects that a child may have been abused or neglected;
- To notify the Significant Incident Review Group (sub-group of the LSCP) where there has been an incident that may require further review, this may include examples of good practice.
- to notify the Medical Examiner (when appointed) and the doctor who certified the cause of death (to be removed when Medical Examiner appointed), if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction;
- to provide specified data to NHS Digital and then, once established, to the National Child Mortality Database;

- to produce an annual report for CDR partners on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process; and

- to contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.

Additionally, the Lincolnshire CDOP will:

- Monitor and evaluate routinely collected data on the deaths of all children, and make recommendations for any additional data to be collected locally.

- Identify any Public Health issues, and consider with the Lincolnshire Director of Public Health and/or LSCP how best to address these and their implications for both the provision of services and for training.

- Monitor and advise the Lincolnshire LSCP on the resources and training required locally to ensure an effective inter-agency response to child deaths.

3. Membership

3.1 The following will be members of the Child Death Overview Panel; Nominees from each of the following organisations:

- Lincolnshire Community Health Service
- Lincolnshire Partnership Foundation NHS Trust
- United Lincolnshire Hospital Trust
- Clinical Commissioning Group (with responsibility for Safeguarding)
- Lincolnshire County Council (Children's Social Care)
- Lincolnshire Police
- Designated Paediatrician for unexpected deaths in childhood
- A Lincolnshire Coroner
- Lincolnshire LSCP Business Manager
- Lincolnshire County Council (Public Health)
- Lincolnshire Road Safety Partnership
- East Midlands Ambulance Service.

3.1 Other members may be co-opted as appropriate.

3.3 The Lincolnshire LSCP will select one of its members to chair the panel, annually at the AGM.

4. Constitution

4.1 The Child Death Overview Panel is a sub-committee of the Lincolnshire LSCP.

4.2 The frequency of panel meetings should aim to enable the circumstances of all child deaths to be discussed within 6 weeks following receipt of the Child Death Review Meeting (CDRM) such as the SUDIC or hospital mortality meeting, or from conclusion of a Coroner's inquest.

For the most part, the meetings should take place at least quarterly. Where the number of deaths is low, the panel meeting can be deferred for up to 3 months (minimum 4 panel meetings a year).

Where other investigations are ongoing that will be likely to inform the overview, such as criminal investigations or serious case review, the case may be deferred until 6 weeks after these have been concluded.

4.3 Administrative support will be provided by the Lincolnshire LSCP.

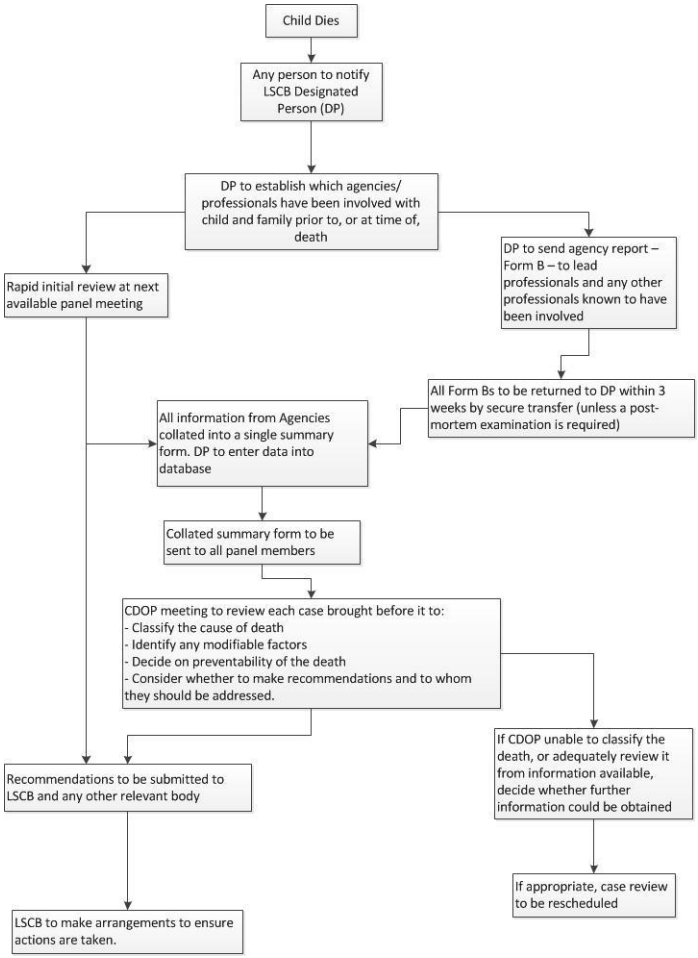
Table 1 – reports and papers needed for various circumstances of death

Circumstances of case	Core papers	Additional papers?
Deaths with an apparently clear cause, such as: • Natural progression of medical condition • SUDIC • SIDS	Core Papers (where available) include: Notes from the rapid response meeting, if a meeting was held Expert Evidence in the form of eCDOP submissions, including a nil return or summary description of agency contact with the family prior to the death, and any lessons learned or questions unanswered from agency contact Case summary providing overview notes and key points in the form of a timeline. Post Mortem (if completed) Inquest (if completed)	Only those which exist already and will be deemed appropriate by the CDOP Chair and Coordinator to assist the CDOP.
All alleged murders or violent deaths	Core papers	Any reports on outcomes of the criminal proceedings / coroner's inquest

Any death where criminal, coroner or civil proceedings or H&S Executive process are being considered as a result of the death Such cases should not come to the panel for full discussion until after these proceedings have ended.	Core papers	Any reports on outcomes of the coroner / criminal proceedings / H&S Executive enquiry, NPSA or similar investigations or reviews
Any death for which there has been an agency critical incident/ Serious Untoward Incident review	Core papers	Outcome of the SUI, Serious Untoward Incident Report and Review, Multi-agency reports, SCR reports.
Any death which remains unexplained	Core papers	
Any death where the 'parenting' or lifestyle or pre-death care, behaviour of the parent, carer or key family member is a possible contributing factor in the child's death	Core papers	May require additional reports from adult services, mental health services or substance misuse services Legal advice should be sought prior to the CDOP meeting if there are any doubts about whether it is legitimate to share this information without obtaining parental consent.
All traffic deaths	Core papers	Input to CDOP from traffic specialist – possible information about 'school travel plan' for child's school, if appropriate, etc.
All deaths resulting from	Core papers	Other relevant reports – e.g. LPFT

suicides and self-harming behaviours		Internal Investigation reports.
Drowning, death by fire, death by animal	Core papers	Other relevant reports – Police / HSE/Fire and Rescue
Accidents / unintentional	Core papers	
Despite immediate indications as to the cause of death, any death which later may be directly attributed to an earlier act of violence, assault, lapse of care or self-harming behaviour.	Core papers	Relevant incident based reports from police and possibly health
Any death which has attracted public or media interest, subject to the governance panel of LSCP	Core papers	Possibly summary of public / media coverage, to be agreed with Chair and/or Vice Chair.
Deaths arising from major incidents e.g. terrorism, major accidents	Core papers	Any relevant reports from HSE, other enquiries, investigations etc.
Any Serious Case Review into the death of a child after the SCR is complete	Core data set only (additional agency summaries will have been covered in the IMRs for the SCR)	SCR overview report Any actions of Management Sub-Group or QA Sub-Group if relevant Any outcome from any criminal proceedings if relevant

Appendix 3: CDOP Process Flow Diagram



Appendix 4 Observer Confidentiality Agreeement

LINCOLNSHIRE SAFEGUARDING CHILDREN PARTNERSHIP

CERTIFICATE OF CONFIDENTIALITY AND PRESERVATION OF INFORMATION

I, ...

hereby certify that any reports or information made available to me by the Lincolnshire Safeguarding Children Partnership, as an observer at an LSCP meeting, will remain confidential and will not, in any circumstances, be disclosed by me to another person, or agency, without authorisation by the Chair of the LSCP, or a nominated representative.

I UNDERSTAND THAT I MUST RETURN ALL PAPERS CIRCULATED TO ME FOR THE MEETING, TO THE LSCP ADMINISTRATOR AT THE END OF THE MEETING.

Signature: .....

Name: .....

Agency: .....

Date: .....