London
Child Death Overview Panel
Procedure

London Safeguarding Children Board
59½ Southwark Street
London SE1 0AL

www.londonscb.gov.uk

Contents

Acknowledgement

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

1. Introduction

1.1 This Procedure sets a minimum standard for a Child Death Overview Panel (CDOP) as outlined in chapter 7 of the Government guidance *Working Together to Safeguard Children (DCSF, 2006)* *(Working Together)*.

1.2 As described in *Working Together* and the *Local Safeguarding Children Board Guidance (DCSF, 2006)*, there are two inter-related processes for reviewing child deaths. Either process can trigger a serious case review.

1.3 The processes are:

- A 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, this is detailed in the *London Rapid Response Procedure (London Board, 2009)*.
- An overview of the deaths of all children (birth up to 18th birthday, excluding babies stillborn) normally resident in the LSCB area/s, undertaken by a panel drawn from key organisations represented on the LSCB - this Procedure applies.

1.4 Each Local Safeguarding Children Board (LSCB) has a responsibility for convening and maintaining a CDOP.

Interface with local, national and regional processes

1.5 For local use this is a baseline Procedure, for Local Safeguarding Children Boards to expand on in relation to local needs.

1.6 At a national level, the DCSF have developed a number of templates for LSCBs to use to assist collecting information about child deaths: Form A for initial notification, Form B (1-11) for agency reports and Form C for analysis at the panel meeting.

1.7 LSCB Chairs in London have agreed that London will use the Forms B and C. These are available to download from http://www.ecm.gov.uk/search/TP00045/.

> However, for initial notification London will use the initial notification form available at www.londonscb.gov.uk/child_death. This is in place of the DCSF Form A.

2. Context

2.1 When a child/ren dies within the area in which s/he normally resides, the LSCB 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; and
- 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 statutory responsibility for conducting the review lies with the LSCB where the child normally resides. To avoid unnecessary additional burden on professionals and the child's family, 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.

3. Core purpose

3.1 The CDOP will undertake an overview of all child deaths within the locality. This process uses a standard set of data (see www.everychildmatters.gov.uk/socialcare/safeguarding/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, with priority given to those deaths that are both unexpected and unexplained.

3.3 Where necessary, the CDOP has the authority to recommend that a serious case review should be undertaken by the LSCB. If there is to be a serious case review, it will be undertaken by the LSCB where the child normally resides, with the final decision taken by the LSCB Chair.

4. Membership

4.1 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;
- Community child health or designated nurse for safeguarding children;
- LA children's social care;
- Police;

4.2 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. London Fire Brigade, adult mental health services, education / early years, bereavement services etc.

4.3 The CDOP Chair should be accountable to the LSCB, but should not be involved in providing direct services to children and families in the LSCB area.

5. Frequency of CDOP meetings

5.1 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 reflect the number of child deaths in the LSCB area.

5.2 The CDOP should ensure that all other processes (e.g. coronial enquiries, legal proceedings etc) have concluded before reviewing a child death, although data collection should continue in the meantime.

6. Notification of child deaths

6.1 Each CDOP must nominate a 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. The police public protection desk has a key role in informing the SPOC of child deaths.

For notification of unexpected child deaths see the *London Rapid Response Procedure (London Board, 2009)*.

6.2 The details of each borough's SPOC must be reported to the London Safeguarding Children Board to enable a list to be kept up to date on www.londonscb.gov.uk/child_death/spoc/.

7. Deaths of children out of area

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

7.2 The CDOP in the area where the child was normally resident will review the death and liaise with the area where the child died, where appropriate. For children not normally resident in London, the CDOP Chair for the area where the child died should also write to the CDOP conducting the review to ensure that any lessons are shared. The CDOP Chair for the area where the child was normally resident is responsible for ensuring that this process operates effectively. To avoid unnecessary additional burden on professionals and the child's family, it is not recommended that the two LSCBs conduct individual reviews.

7.3 If it is unclear in which CDOP area the child normally resided (such as in cases of shared care arrangements in different boroughs), the relevant CDOP Chairs should negotiate and agree who will lead the review. If no agreement can be reached, the CDOP chairs involved should escalate the issue to their respective LSCBs, for agreement to be reached by the LSCB Chairs. Timescales should not be allowed to slip, therefore until any dispute is resolved, the case must be treated as the responsibility of the disputing LSCB in whose area the child was last known to have been alive *(note: this point is currently subject to approval)*

7.4 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 (see the *London Rapid Response Procedure (London Board, 2009)*.

7.5 Children who die in hospital will be reviewed by the CDOP for the area in which they were normally resident.

7.6 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 professionals who had involvement with the child before and immediately following the death and, where relevant, the child's family members.

d) 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.

e) Assess the cases with regard to the threshold criteria to enable specific cases to be reviewed in depth (see Threshold criteria in appendix 2)

f) Ensure that individual case discussions have taken place regarding unexpected child deaths.

g) 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.

h) Scrutinise the recommendations from the reports compiled by the designated doctor for unexpected deaths.

i) Identify any common themes from individual cases and consider these in more depth.

j) Consider whether the death was preventable, if so how such deaths might be prevented in the future.

k) Identify any patterns or trends in the local data and report these back to the LSCB.

l) 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*).

m) Alert the Chair of the 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.

n) Inform the Chair of the LSCB where specific new information should be passed to the coroner or other appropriate authorities.

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.

p) Monitor the support and assessment services offered to families of children who have died.

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

r) 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;

s) Co-operate with regional and national initiatives to identify lessons on the prevention of unexpected child deaths e.g. the *London learning from information about child deaths initiative* and the Confidential Enquiry into Maternal and Child Health (CEMACH)[1].

t) Ensure each partner agency of the LSCB 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.

9. Consent and confidentiality

9.1 Information in CDOP meetings will not be anonymised.

9.2 It is best practice to seek consent before processing information about any individual, but it will be legitimate to share information with the designated paediatrician for unexpected deaths in childhood / the CDOP SPOC without seeking parental consent. It should only be shared with those who need to know, as governed by the *Caldicott Principles*, the *Data Protection Act* and *Working Together*.

9.3 CDOPs should have arrangements in place for parents and carers to 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.

9.4 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.

9.5 Members of the CDOP must sign a confidentiality agreement, including sharing and securely storing information (see model confidentiality statement in appendix 3) when they join the CDOP. This agreement will be reviewed at each meeting.

9.6 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 LSCB process for managing media interest (see the *London Rapid Response Procedure (London Board, 2009))*, as long as they are not identified with any specific case.

10. Professional and family support

10.1 The CDOP Chair should consider what information 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.

10.2 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 (see information around care of the bereaved family in the *London Rapid Response Procedure (London Board, 2009))*.

11. Learning from child deaths

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

[1] See www.cemach.org.uk/

11.2 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.

11.3 The CDOP will contribute to regional and national initiatives to identify lessons on the prevention of unexpected child deaths e.g. the *London learning from information about child deaths initiative* and CEMACH.

12. Reporting mechanisms

12.1 Each CDOP must submit an annual report to its respective LSCB.

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.

Appendix 1: Model terms of reference

These terms of reference are presented as an example that LSCBs may wish to adapt for their own local CDOP.

…….. *[name of borough]* **Safeguarding Children Board**

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 …….. *[name of borough/s]* (the area) 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 7.4 of *Working Together to Safeguard Children (2006) (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.

2. Objectives

Notification and data collection

2.1 The CDOP will seek to:

a) Ensure, in consultation with the …….. *[name of borough]* coroner's office, 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 and, where relevant, to seek additional information from professionals and family members;

e) Ensure that these information gathering processes minimise distress to families; and

f) Co-operate with regional and national initiatives to identify lessons on the prevention of unexpected child deaths e.g. the *London learning from information about child deaths initiative* and the Confidential Enquiry into Maternal and Child Health (CEMACH)[2].

Case assessment and review

Case level

2.2 The CDOP will seek to:

g) Evaluate specific cases in depth, and identify any issues of concern or lessons to be learnt; and

h) 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.

Population level

2.3 The CDOP will seek to:

i) Evaluate data on the deaths of all children normally resident in the area, 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:

j) 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 Child Death Rapid Response Team and providing the professionals concerned with feedback on their work (for a description of a rapid response service see the *London Rapid Response Procedure (London Board, 2009)*);

k) 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

l) Monitor the support and assessment services offered to families of children who have died.

Prevention and advocacy

2.5 The CDOP will seek to:

m) 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

[2] See www.cemach.org.uk/

structural factors affecting children's well-being to ensure a thorough consideration of how such deaths might be prevented in the future;

n) 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;

o) Identify and advocate for needed changes in legislation, policy and practices to promote child health and safety and to prevent child deaths.

p) Increase public awareness and advocacy for the issues that affect the health and safety of children; and

q) 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) 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 how the two CDOPs will report to each 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 of senior management representation from:

- Designated paediatrician for unexpected deaths in childhood;
- Public health;
- Community child health or designated nurse for safeguarding children;
- LA children's social care;
- Police;

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 agency representative:

5.5 The bereavement representative can:

- Advise the panel on ongoing bereavement support needs for the family or others involved;
- Be an advocate for the family;
- Assist the panel in monitoring and evaluating the appropriateness of professional responses to child deaths;
- Provide support to other panel members, ensuring appropriate member care; and
- Facilitate the provision of support to other professionals involved in individual case management.

6. Duties of the CDOP Chair and manager

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;
- Facilitating resolution of agency disputes; and
- Ensuring that this process operates effectively.

6.2 The CDOP manager will be responsible for the smooth running of all child death review processes. 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 and monitor the effective running of the notification, data collection and storage systems;
- Determine meeting dates and send meeting notices to team members;
- Obtain names and compile the summary sheet of child deaths to be reviewed and distribute to team members two to three weeks prior to each meeting;
- Select, in consultation with the CDOP Chair, cases for in-depth review by the CDOP, following the principles set out in core functions;
- Ensure that notifications of child deaths are available for team review;

- Ensure that new members receive an orientation to the panel prior to their first meeting;
- Ensure that all new CDOP members, ad hoc members and observers sign a confidentiality agreement;
- Encourage the sharing of information for effective case reviews;
- Compile and disseminate notes from each CDOP meeting;
- Maintain the rota for the Child Death Rapid Response Team;
- Complete and submit an annual report to the LSCB; and
- Monitor the outcome of recommendations and prevention initiatives and activities.

7. Confidentiality and information sharing

7.1 Information discussed at the CDOP meetings will not be anonymised prior to the meeting, it is therefore 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, observers and administrative and clerical staff 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.

8. Accountability and reporting arrangements

8.1 The CDOP will be accountable to the chair of the LSCB.

8.2 The Child Death Overview Panel 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 and 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 LSCB will supply data regularly on every child death as required, e.g. by:

- The London learning from information about child deaths initiative to collate and analyse information about child deaths across London, in order to identify lessons on the prevention of child deaths; and
- The Department for Children, Schools and Families 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.

Appendix 2: Threshold criteria

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

Level 1 – Scope: where the child's death is 'anticipated / 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 the deaths for review, and the majority are likely to be neonates. It is suggested that occasionally there should be a more detailed review of a random selection of some of these more 'straightforward' cases to look at them in more depth. The selection could be theme based on the cause of death (e.g. SUDI, cancer, congenital, other, etc).

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).

Level 3 (serious case review) – Scope: whilst it is not the business of a CDOP to re-discuss the information contained in a serious case review, lessons and recommendations from any serious case review need to be incorporated into the overall planning and strategy (including policy and staff development) arising from all child deaths. The serious case reviews should also be included in the annual report of the CDOP.

The decision to undertake a serious case review is made by the Chair of the Local Safeguarding Children Board.

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.

Local data collection and analysis / London learning – All the agreed child and family specific data in relation to the death, preventability scoring and summary outcomes and recommendations must be recorded as per the *Child death information and evaluation booklet* (Appendix 3 of the *London Rapid Response Procedure (LSCB, 2008)*).

This information should input into a simple local electronic database (Access or Excel) which is consistent across London and allows the collation of all London child death data by the London Safeguarding Children Board for annual strategic analysis and recommendations.

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

Type of case	**Core papers**	**Additional papers?**	**Process and planned outcome**
Level 1			
Straightforward deaths Natural Expected SUDI SIDS	*Child death information and evaluation booklet* Notes from the rapid response meeting, if a meeting was held Brief (A4) summary descriptions of agency contact with the family prior to the death, and any lessons learned or questions unanswered from agency contact – suggest 3 or 4 headings for this summary *(If possible case summary prepared by CDOP co-ordinator providing overview note and key points for the CDOP review sent out in advance of meeting – resource and skills issue.)*	Only those which exist already and will be deemed – by Chair and CDOP Co-ordinator – to assist the CDOP. To be kept to a minimum and should have been summarised in the *Child death information and evaluation booklet* or the agency summary.	All CDOP members under contract to read the CDOP papers in advance of the meeting to avoid CDOP meeting being delayed by reading time. Any significant questions or omissions to be communicated to CDOP Chair in advance of the meeting and if these cannot be answered, case withdrawn from the CDOP discussion for outstanding issue to be resolved / answered. Brief summary discussion – 10 – 15 minutes Panel summary under agreed headings – or as agreed at London level - to be attached to the data to be sent to London Safeguarding Children Board e.g. clinical issues, preventability lessons social / cultural lessons recommendations

Level 2			
All alleged murders or violent deaths	Core papers	Any reports on outcomes of the criminal proceedings / coroner's inquest	Full discussion 30 – 45 minutes CDOP summary under agreed headings to be attached to the data to be sent to London-wide data collector / body e.g. – clinical issues, – preventability – clinical lessons – social / cultural lessons – systems lessons – practice lessons (pre and post death) – recommendations As above, it will be helpful to have a London wide approach to the outcome summary from the CDOP discussion, to be developed over time under some agreed headings to aid review and data collection.
Any death where criminal, coroner or civil proceedings or H&S Executive process are being considered as a result of the death Such cases cannot 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 After legal proceedings have concluded it will be necessary to obtain the relevant court's permission before documents filed in the proceedings can be disclosed to the CDOP. Legal advice should be sought prior to the meeting.	
Any death for which there has been an agency critical incident/ Serious Untoward Incident review	Core	Outcome of the SUI, Serious Untoward Incident Report and Review	
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.	

Level 2 continued			
All traffic deaths	Core papers	Input to CDOP from traffic specialist – possible information about 'school travel plan' for child's school, if appropriate, etc	Full discussion 30 – 45 minutes
All deaths resulting from suicides and self harming behaviours	Core papers	Psychiatric review of the papers?	CDOP summary under agreed headings to be attached to the data to be sent up London-wide
Drowning, death by fire, death by animal	Core papers	Other relevant reports – police / HSE? LFB etc	e.g. – clinical issues, – preventability – clinical lessons – social / cultural lessons – systems lessons – practice lessons (pre and post death) – recommendations
Accidents / unintentional	Core papers		
Any death where the death although 'later' may be directly earlier attributed to an act of violence, assault, lapse of care or self-harming behaviour some time before but which may not have been the immediate cause of death at the time of the death	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 LSCB	Core papers	Possibly summary of public / media coverage	It would be helpful to have a London wide approach to the outcome summary from the CDOP discussion, where possible over time to be developed under some agreed
All deaths notified to DCSF / Ofsted under the notification system	Core papers		

Deaths arising from major incidents e.g. terrorism, major accidents	Core papers	Any relevant reports from HSE, other enquiries, investigations etc	headings
Level 3 (serious case reviews)			
Any SCR into the death of a child after the SCR is complete	Core data set only But no additional agency summaries as this 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	Note the lessons and outcomes only for aggregation into the CDOP overall work

Appendix 3: Model confidentiality statement[3]

This statement must be signed when a Panel member joins the CDOP. It must also be signed by all Panel members at each meeting of the CDOP.

The purpose of the Child Death Overview Panel is to conduct a thorough review of all preventable child deaths in …… *[enter LSCB area here]* 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 London Procedures for *Rapid Response* and for *Child Death Overview Panels* and the …… *[enter local safeguarding children board name]* protocols for child death reviews stipulate that in no case will any CDOP member disclose any information pertaining to any individual case outside the meeting other than pursuant to the mandated agency responsibilities of that individual. Any information obtained or recommendations or decisions made by the CDOP shall be treated as confidential by the undersigned. Public statements about the general purpose of the child death review process may be made in line with the LSCB process for managing media interest (see paragraph 6 of the LSCB London Rapid Response Procedure), as long as they are not identified with any specific case.

Any information obtained or recommendations or decisions made by the CDOP shall be kept in a place of special security.

Panel members who receive information but do not attend the meeting undertake to confidentially destroy or securely return all papers to the Panel.

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

Name	Agency	Signature	Date

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