Research Report DCSF-RR036

Preventing Childhood Deaths

A Study of 'Early Starter' Child Death Overview Panels in England

Peter Sidebotham, John Fox, Jan Horwath, Catherine Powell and Shahid Perwez

University of Warwick with the Universities of Sheffield and Southampton

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Abbreviations

CAMHS - Child and Adolescent Mental Health

CDOP - Child Death Overview Panel

CDRT - Child Death Review Team

CEMACH - Confidential Enquiry into Maternal and Child Health

CESDI - Confidential Enquiry into Stillbirths and Deaths in Infancy

DCSF - Department for Children Schools and Families

DfES - Department for Education and Skills

FIMR - Fetal and Infant Mortality Review

LSCB - Local Safeguarding Children Board

NSPCC - National Society for the Prevention of Cruelty to Children

PCT - Primary Care Trust

SHA - Strategic Health Authority

SIDS - Sudden Infant Death Syndrome

SUDI - Sudden Unexpected Death in Infancy

SUDC - Sudden Unexpected Death in Childhood

Please note that all quotes from participants in the study are presented in *italics* in anonymised form.

Executive Summary

The publication in 2006 of *Working Together to Safeguard Children* (hereafter *Working Together*) set out in detail new processes in relation to reviewing child deaths (HM Government, 2006a). This set the scene for England to become the first country in the world to have national standards and procedures for the investigation and management of unexpected child deaths and for reviewing all child deaths. Evidence from the United States and elsewhere suggests that formal review processes such as these could serve a valuable public health function in providing contemporary and comprehensive information on patterns of child death, promote action to prevent child deaths, and support wider aspects of inter-agency working to safeguard children and promote their welfare.

Whilst there appeared to be good evidence for the value of such processes, there was limited experience in this country in carrying out such reviews. The Department for Children, Schools and Families (DCSF, formerly DfES) therefore commissioned this study to inform the introduction of the new child death review processes. The research team investigated the experience of Local Safeguarding Children Boards (LSCBs) in implementing the child death review processes, evaluating four basic components of the child death review processes:

A. Establishing systems - the experience of LSCBs in establishing the mandate, protocols, membership and leadership, and operational practices of the Child Death Overview Panel;

B. Data collection - an evaluation of systems for notification and data collection, including the use of the CEMACH forms and other data collection systems;

C. Data analysis - comparison of different tools used for analysing the data collected, and approaches to identifying trends, patterns and issues;

D. Outputs of the child death review processes - how authorities plan to use the information to inform children's services planning and inter-agency working to safeguard and promote the welfare of children.

Key Findings

From a sample of 60 (42%) LSCB chairs responding to an initial questionnaire in October 2006, 84% either had developed or were in the process of developing a rapid response protocol, although a proportion of these only related to infant deaths rather than all unexpected child deaths. In contrast, only 3 boards had already established a child death overview panel, with a further 36 (60%) in the process of developing one. These results suggested a significant gap, at that stage, in progress towards achieving the requirements for child death review laid out in *Working Together*.

From those LSCBs responding to the initial questionnaire, 9 study sites were selected to represent a wide demographic spread, a range of ethnic groups, and a mix of metropolitan, urban and rural areas. An initial audit demonstrated inadequate systems for notification of child deaths and the need for multiple sources of notification. A range of different approaches to reviewing childhood deaths were reported including local case discussions, hospital mortality reviews and Serious Case Reviews. Child health and children's social care were the agencies most committed to the process with good commitment from other hospital staff, Coroners and police, but less involvement from other agencies / individuals.

There was a general sense of enthusiasm within the study sites for developing the child death review processes, and teams were keen to develop something that they saw as being worthwhile. Crucial to the success of these processes appeared to be the engagement of motivated individuals from a range of agencies, and good working relationships between those individuals. In contrast, one of the major barriers to developing these processes has been a lack of understanding or commitment from some professionals. There was some frustration at a perceived lack of central guidance early on, in addition to that set out in *Working Together*, but at the same time, enthusiasm for being involved in developing new processes and being able to work these out locally. The process of development required some form of scoping study, and was aided in some areas by the appointment of a project manager, or small working group with a clear action plan for developing their panel.

The purposes laid out in Chapter 7 of *Working Together*, namely to ensure there is a co-ordinated multi-agency response to an unexpected death and to review all child deaths with a view to identifying individual cases needing a Serious Case Review, as well as broader matters of concern affecting the safety and welfare of children and other wider public health or safety concerns, were reflected in the expressed purposes of the developing panels. In many cases these purposes hadn't yet been formally documented in protocols or terms of reference, but were nevertheless seen as important. Those interviewed were clear that they did not want this to be seen as a blaming exercise, but rather as an opportunity to learn lessons and improve outcomes for children.

Although the development of the Child Death Overview Panels had different origins, with some being initiated outside the LSCB remit, it was clear that accountability should go through to the Local Safeguarding Children Board as set out in *Working Together*. Boundary issues generated concerns in a number of areas, but were not perceived as being insurmountable. Different models of collaboration between LSCBs were being considered, although at the time this study ended, how these would work in practice had not been clarified.

All the study sites were working towards a model of having a small core membership reflecting the key professionals involved and a wider co-opted membership, bringing a breadth of knowledge and expertise to the panel.

Core membership should be kept to a minimum. The most common core members observed were paediatricians, children's social care, the police, nursing and public health. Other agencies may sit on the panel as core or co-opted members and could include any agency involved in the provision of services to children or families. Typically co-opted members would only attend those meetings where cases relevant to their particular skills would be discussed. All members should be of sufficient seniority to be able to contribute meaningfully to the analysis of the deaths, and to be able to speak for and influence the agency or professional group they represent. Lay membership is seen as important, but appropriate ways of achieving this have not been developed.

One of the most significant drivers for establishing a functioning Child Death Overview Panel is having good working relationships and an atmosphere of trust between the team members. This is particularly important given the sensitive nature of the topics being discussed and the multi-agency nature of the panels. The role of panel chair is a generic one, which could be filled by anyone with good chairing skills, rather than needing to come from any specific discipline. However, the chair does need to be supported on the panel by those with specific knowledge in different fields, particularly medical knowledge, but also knowledge of legal processes and wider children's issues. The observations of the research team along with comments from the interviews suggested a number of key competencies of an effective chair, including: independence; a broad knowledge base in relation to children's issues; ensuring that everybody on the panel participates in the process; ability to deal with conflict; giving direction but not controlling; an ability to make sense of complex issues; and a clear sense of the purpose of the child death review processes.

Whilst most sites had protocols for the rapid response process, many of which had been developed on a sub-regional basis, there were still areas requiring development, particularly in relation to extending the process to cover unexpected deaths in older children as well as infants. In contrast few of the sites had developed clear protocols for their Child Death Overview Panel and this was seen as an important area for development.

There was an identified need to clarify the inter-relationship between the Child Death Overview Panel and any other review processes taking place. This was particularly important in relation to the rapid response process, any criminal investigations, Serious Case Reviews, and any internal hospital mortality reviews. Panels were clear that it was not appropriate to duplicate work, but that the different processes had different remits and could feed into each other. In particular, the rapid response was seen as a directly operational response relating to individual cases, information from which would feed into the Child Death Overview Panel. For those cases where there were suspicions about the cause of death, there would be separate criminal investigations which should be completed before a panel review. However, in these cases it is likely that a Serious Case Review would be initiated, which is able to go into far more depth than a child death overview, but may cover different aspects from it. The importance of clear pathways, and good liaison between professionals was repeatedly observed.

Resource issues were important in relation to setting up the panels. At the time of the study, no central funds had been provided for these processes, although both the Department of Health and DCSF have since each announced 3 years of allocated funding. In the meantime several panels had been creative in seeking funds from their LSCB, PCTs or other sources. Most panels envisaged using funds to support the appointment of an administrator, and someone in a more senior managerial role, with responsibility for collating and analysing data as well as supporting the chair. In addition to these personnel however, significant time was required from professional members of the panels, and teams were having to look creatively at how these people could allocate sufficient time to the child death reviewing process.

Although audit and governance were seen as crucially important, none of the study sites had got very far with establishing such systems. There was general agreement, in keeping with Chapter 7 of *Working Together,* that lines of accountability needed to go through to the chair of the LSCB, but some suggestion of accountability also to executive boards of the constituent agencies. Most teams envisaged a system of annual reports, supplemented by more specific reports where particular issues were identified. Issues around confidentiality and data security were raised, but had not been clarified by any of the teams at the time of the pilot.

The statutory requirement to review all deaths from birth to 18 years (excluding stillbirths) raised some difficulties in relation to the two extremes of the age range. In most sites there appear to be hospital-based systems in place to review neo-natal deaths. There was agreement that these reviews should not be duplicated, but that there needed to be pathways for linking these into the remit of the Child Death Overview Panel, and for broadening the scope of these reviews. None of the sites had clarified how they would achieve this. At the other end of the age range, there may be difficulties in obtaining notification of older adolescent deaths, and there was recognition that different professionals may need to be involved in reviewing these cases.

Working Together is clear that the review process should include all child deaths. However, there was a consistent view, reinforced by our observations, that it was not possible to review all deaths in great depth. Most sites were developing some system for selection of cases for more in-depth review; with notification and some form of categorisation of all deaths. For most sites, the option of extending this process to include near misses was not feasible; instead they looked at other fora through which important near misses could be reviewed. Although none of the sites were using a system for classifying whether a particular death was preventable, potentially modifiable factors were identified in a substantial proportion of those reviews observed by the research team.

There were significant issues around notification, data collection and storage identified in all the research sites. Prompt notification required a simple but robust system of engaging multiple sources including front-line health staff, the PCT, the police and the Coroner. Subsequent information gathering was potentially a time consuming process involving many professionals in providing information, and a central co-ordinator to collate that information. The CEMACH data collection tool was considered by some to be useful, but by others to be either too complex to complete, or insufficient in the amount and nature of the information provided. It appeared to be important to combine both quantitative data with more qualitative or narrative information in order to meet the requirements of both the panel analysis, and any central collation of data. Alongside the development of data collection tools, panels will also have to consider issues of secure data storage and processing.

Further work needs to be done to clarify procedures for information sharing, data protection and freedom of information. Most chairs felt that members of the panel would be bound by the information sharing procedures within their own agencies and the wider LSCB and as such there may not be the need for separate agreements. However, specific agreements may be important particularly for any lay members and those who are not members of the LSCB. Parental involvement was seen to be important, but the precise manner in which parents are informed of the process, enabled to contribute, and informed of the outcomes need to be thought through carefully.

The panels observed in this study were meeting between 4 and 10 times a year, and typically devoted from 2-3 hours per meeting. Within that, there appeared to be the capacity to review between 2 and 7 cases, with anything from 5-10 minutes up to an hour or more on each case. There were apparent dangers in going into too much depth and in effect trying to carry out an investigation into the child’s death, rather than an overview of lessons to be learnt. It was clear from the observations of the researchers that team members must be sufficiently briefed with information circulated in advance of the meeting, and that the panel discussion must be based on summarised information, not reviewing original case records.

At this early stage in the development of a national process for child death review, none of the panels had clearly developed systems for analysing the information. There seemed to be a need for some guidance and training on this in order for it to be a worthwhile process. Certain principles were clear however: that the process must be multi-disciplinary, involve professionals of sufficient seniority to make informed judgements, informed by sufficient but not excessive case information, and must feed into wider regional or national analysis.

All the panels involved in the study were very clear that this process should be focused on outcomes and a preventive agenda. In spite of the early stage the Panels were at and the small number of cases reviewed, a number of significant outcomes were observed. This included public awareness campaigns, community safety initiatives, training of professionals, development of protocols, and lobbying of politicians. The examples seen served to emphasize the potential for these panels to be significant drivers for safeguarding and promoting children's welfare.

Conclusions

Drawing on the results of this project, along with the literature review and our personal observations of child death review processes in the United States, and discussions with many other professionals across this country, the study team was able to draw some conclusions on how the child death review processes outlined in Chapter 7 of *Working Together* can be best put in place by LSCBs. This project has incorporated many of the principles of action research, with results being fed back to the participants as the project has progressed, and developments being discussed and disseminated more widely, particularly through two series of regional seminars, hosted by DCSF in spring and winter 2007 and by being made available on the DCSF website. Some of the proposed structures have already been incorporated into training materials produced for DCSF by the research team. The findings from this study, together with those from the CEMACH study *Why Children Die: Pilot Study 2006* (Pearson (ed), 2008) have also informed the development of data collection templates for use by LSCBs. These resources are both available on the ECM website (http://www.everychildmatters.gov.uk/socialcare/safeguarding/childdeathreview/).

It is hoped that these findings will support LSCBs as they implement the child death review procedures set out in *Working Together.*

Implications of the findings for Local Safeguarding Children Boards

1. In defining terms of reference for their CDOP, LSCBs should include the purposes and functions of the panel, membership, chairing and administration, relationships with other processes, information sharing, outputs and lines of accountability;
2. Mechanisms are required for LSCBs to appropriately inform and involve parents and other family members in the child death review process;
3. The appointment of an administrative team will be essential to support the working of the CDOP;
4. it is important that Child Death Overview Panels meet on a regular basis to review all deaths of children normally resident in their area;
5. LSCBs will need to establish operational procedures for the smooth running of the child death review processes in accordance with *Working Together* and for monitoring their implementation and output. These would include procedures for notification, information gathering, collation and analysis of the information gained, overviews of all deaths, and outcomes;

6. The LSCB will have to establish systems for safe storage and use of data gathered for the child death overview processes;
7. It is important for LSCBs to ensure that training is provided for all members of the CDOP, including co-opted members;

Implications for further research

8. There is a need for further systematic research into the outcomes of child death reviews, both in this country and internationally;
9. As the child death review processes are established in this country, they should be properly evaluated.

Chapter 1 - Introduction

The publication in 2006 of *Working Together to Safeguard Children* (hereafter *Working Together*) set out in detail new processes in relation to reviewing child deaths (HM Government, 2006a). This set the scene for England to become the first country in the world to have national standards and procedures for the investigation and management of unexpected child deaths and for reviewing all child deaths. The guidelines in *Working Together* were based on the Kennedy Report into the management of SUDI (RCPath and RCPCH, 2004). The Government announced it would set up these new processes in its response to the Inquiry into the death of Victoria Climbié (Cm 5730, 2003) and the Green Paper, *Every Child Matters* (Cm 5860, 2003).

The LSCB Regulations (Paragraph 6, SI No 2006/90) set out that Local Safeguarding Children Boards (LSCBs) are expected to put in place procedures, both to respond rapidly to individual unexpected childhood deaths (The Rapid Response), and to review all childhood deaths in a systematic way (The Child Death Overview Panel). The LSCB functions in this respect are as follows:

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

- *(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);*
- *(ii) any matters of concern affecting the safety and welfare of children in the area of the authority; and*
- *(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area;*

(b) putting in place procedures or ensuring that there is a coordinated responsibility by the authority, their Board partners and other relevant persons to an unexpected death.

Evidence from the United States and elsewhere suggests that formal review processes such as these may lead to the development of evidence-based interventions to prevent child deaths in the future (Durfee et al., 2002, Bunting and Reid, 2005, Rimsza et al., 2002, Onwuachi-Saunders et al., 1999, Gellert et al., 1995). This evidence suggested that a similar system operating in the UK could serve a valuable public health function in providing contemporary and comprehensive information on patterns of child death, promote action to prevent child deaths, and support wider aspects of inter-agency working to safeguard and promote the welfare of children. Whilst there appeared to be good evidence for the value of such processes, there was limited experience in this country in carrying out such reviews. Various projects were commissioned which would support LSCBs in taking forward this new area of work.

In 2006 the Confidential Enquiry for Maternal & Child Health (CEMACH) undertook a pilot study of child death review processes in five regions of the UK (Pearson, 2008, CEMACH, 2006). The current DCSF study was set up to complement the CEMACH study and, in particular, to explore at a local level the experience of LSCBs in carrying out child death review processes. There are a number of important differences between the CEMACH pilot and the DCSF study. First, the confidential nature of their enquiry meant that reviews carried out by CEMACH would be less publicly accountable and could not be used to feed into the investigative process and assist with death certification (Bunting and Reid, 2005). Secondly CEMACH, being an independent body established by eight Royal Colleges, and funded and commissioned by the National Patient Safety Authority, inevitably has a very strong health focus, whereas the child death review teams proposed by DCSF are to be truly multi-agency in nature and convened by the LSCBs. Third, the CEMACH pilot has important differences in scope, being carried out at a regional rather than local level, and specifically excluding neonatal deaths. Finally, there is no clear pathway to link the CEMACH findings into preventive strategies for safeguarding and promoting the welfare of children. In contrast, the child death review teams in this study, coming under the auspices of the LSCBs, have the potential for direct links with the wide range of agencies involved in safeguarding and promoting the welfare of children, and to feed into children and young people’s plans through local strategic partnerships. Both studies therefore are important and their respective researchers collaborated closely to jointly inform the future development of child death review processes across the country.

Chapter 2 - Background and Literature Review

Although the death of a child has always been a matter of concern for the family and society in general, the concept of reviewing individual child deaths in a systematic way is a relatively recent development. The first documented systematic and multi-agency response to child deaths appears to have been initiated in 1978 by Los Angeles County (Durfee et al., 1992). From there child death review processes spread across the USA so that by the early 1990s, 40% of the US population was served by a child death review team (Durfee et al., 1992). By 2007 all but one state had established child death review teams (Covington, T, personal communication).

These Child Death Review Teams (CDRTs) were initially set up to address a problem of underestimation of child abuse fatalities (Webster et al., 2003, Crume et al., 2002). Paediatricians and child maltreatment researchers in many countries agree that child maltreatment is under represented in mortality statistics and that there are impediments to awareness, official recognition and recording of the relationship between child maltreatment and death (May-Chahal et al., 2004, Gellert et al., 1995, Webster et al., 2003, Creighton, 2001, Wilczynski, 1994). Estimates of the proportion of sudden unexpected deaths in infancy (SUDI) caused by abuse vary considerably although many authors suggest up to 10% may be frank homicide, with maltreatment (abuse or neglect) being a contributory (though not necessarily causal) factor in a similar proportion (Levene and Bacon, 2004, Sidebotham et al., 2005, Fleming et al., 2000).

Although one of the stated purposes of the US child death review processes was better ascertainment of child maltreatment deaths, recognition that such deaths are a minority of all deaths has led to a wider remit (Covington et al., 2005). In 1998, over 19,000 children aged 1 to 18 years died in the United States. Seventy four percent of these deaths were as a result of injuries of which approximately 30% were classified as intentional (homicide, suicide) and 70% as unintentional (Webster et al, 2003). The Program Manual of the National Center for Child Death Review in the States describes child death review as a process that works to understand child deaths in order to prevent harm to other children. It is a collaborative process that brings people together at a state or local level, from multiple disciplines, to share and discuss comprehensive information on the circumstances leading to the death of a child and the response to that death (Covington et al., 2005). Inherent in this definition is the concept that a large number of child deaths are preventable; not just deaths from maltreatment, but also other unintentional injury deaths, and deaths from natural causes.

Durfee et al (2002) describe a preventable death as ‘one in which, with retrospective analysis, the review team determines that a reasonable intervention (e.g. medical, educational, social, legal, psychological), might have prevented the death. Reasonable is defined by taking into consideration the conditions, circumstances or resources available.’ Work in several parts of the United States has indicated that a large proportion of childhood deaths could be considered preventable. For example, Rimsza et al (2002), reviewing

4800 deaths in Arizona from 1995-1999 concluded that overall 29% were preventable, this figure rising to 38% if neonatal deaths were excluded. Similarly Onwuachi-Saunders et al (1999) found that of the 607 children and young people aged 21 and younger who died in Philadelphia in 1995, 37.2% of the deaths were considered preventable. Of the injury deaths, 95% were considered preventable. These findings are repeated in data from the UK. For example, of 180 deaths in children aged under 5 from 1996-2002 in Wolverhampton, 34 (19%) were deemed to be preventable (Moore, 2005). There remain wide variations in child mortality across the UK and it has been estimated that if all regions of the country shared the mortality rates of the best, over 1,000 infant deaths and nearly 500 child deaths could be prevented each year (Sidebotham and Fleming, 2007).

There have been two strands to reviewing child deaths in the UK, both of which have had a significant impact on the current developments. First, health based approaches to infant and child mortality review. Although there is a long established history of hospital mortality reviews, there is little published literature on the subject. Many hospitals regularly carry out audits or internal reviews of some, but rarely all, child deaths. More commonly, infant mortality reviews are well established as a means of improving perinatal care, both in the UK and in many other countries (McIlwaine et al., 1979, Anon, 1982, Koontz et al., 2004). These reviews are seen as a powerful tool to improve both local practice, and to drive wider public health approaches to reducing infant mortality. In the United States, they have more recently been standardised in a National Fetal and Infant Mortality Review Program (FIMR); this program encapsulates many of the principles envisaged for the UK child death review processes as illustrated in Table 1.

Table 1: Some Key FIMR Concepts (from Koontz et al., 2004)

- Systematic evaluation of individual cases
- Identification of a broad range of factors, not just medical factors
- Inclusion of information not available through routine quantitative methods
- Cases viewed as sentinel events illustrating system and resource issues
- Avoidance of preventable / non-preventable classifications of deaths due to the ambiguity of these categories and because the intent of the case review is to identify opportunities for change
- Avoidance of blame
- Population oriented with a defined sub-state geographic area as the focus
- Two tiered process that promotes separate teams being responsible for the analytic function and the action function
- Multi-disciplinary involvement.

In the UK, a national programme for perinatal mortality review was established in 1992 through the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI). The aim of this confidential enquiry was to improve understanding of how the risks of death in late fetal life and infancy, from 20 weeks of pregnancy to one year after birth, might be reduced (CESDI, 2001). The CESDI studies produced regular annual reports and carried out specific studies into particular groups of deaths, including one of the most comprehensive epidemiological studies into sudden unexpected deaths in infancy (SUDI) (Fleming et al., 2000). In 2003, CESDI, together with a confidential enquiry into maternal deaths, were combined into a new body, the Confidential Enquiry into Maternal and Child Health (CEMACH).

The second main strand to child death review in the UK has been an equally well established system of reviewing deaths from abuse and neglect (Tudor and Sidebotham, 2007). One of the first institutional responses to such deaths took the form of a 'public inquiry approach' which differed significantly from the present multi-agency review system. Since the first in 1944, a large number of such inquiries have taken place and are summarised in two overview publications (Department of Health, 1991, Department of Health and Social Security, 1982). During the late 1980s and early 1990s there was a move away from the large-scale inquisitorial style of inquiry to locally based Serious Case Reviews undertaken by local Area Child Protection Committees (Department of Health and Social Security, 1988, Children Act, 1989). Government guidance at the time stipulated that whenever a case involves an incident leading to the death of a child where child abuse is confirmed or suspected, or a child protection issue likely to be of major public concern arises, there should be an individual review by each agency and a composite review by the Area Child Protection Committee (Home Office et al., 1991). Three studies in the 1990s collated material from a number of Serious Case Reviews (Falkov, 1995, Reder, 1993, Reder and Duncan, 1999). These studies highlighted a number of common themes, including issues around parental mental health, other parental and wider family factors, and failures in the systems and processes for protecting children.

In line with trying to bring clearer standards and more consistent approaches to the process, there has been a move to collate the findings of these reviews through biennial analyses in order to identify common themes and trends, to draw out key findings and assess their implications for policy and practice both locally and nationally. The first of these biennial reviews was published in 2002 (Sinclair and Bullock, 2002), with two further reviews published in 2008 (Brandon et al., 2008, Rose and Barnes, 2008). Typically in this country, Serious Case Reviews have focused on deaths from severe physical assaults or extreme neglect, rather than other forms of maltreatment-related deaths (Sinclair and Bullock, 2002, Reder and Duncan, 1999, Reder et al., 1993). However there is some suggestion that more recently, a broader approach has been taken to include suicides, deaths related to domestic violence incidents, and other deaths related to but not directly caused by maltreatment (Brandon et al., 2008, Rose and Barnes, 2008).

The purpose of these Serious Case Reviews has predominantly been on learning lessons to improve inter-agency working to safeguard and promote the welfare of children (HM Government, 2006a). Typically these reviews are the responsibility of a standing sub-committee of the Local Safeguarding Children Board. The process is time consuming, but systematic and thorough. There is no doubt that Serious Case Reviews have over the years had a major impact on child protection practice in the UK. However, they have been criticized for emphasizing a culture of blame, although this was never the intention of such reviews, and for repeatedly flagging up similar issues, with little positive action resulting (Munro, 2005, Axford and Bullock, 2005, Parton, 2004, Brandon et al., 2008, Rose and Barnes, 2008).

There is a small but growing body of evidence on the effectiveness of child death review processes, although much of this relates to activity stemming from the process rather than specific outcomes for children. In a review for the NSPCC, Bunting and Reid identified a number of benefits, including improved multi-agency working and communication; more effective identification of suspicious cases and a decrease in inadequate death certificates; a more complete and accountable process; and a broader and more in-depth understanding of the causes of child death with a move away from a narrow and stigmatising focus on child abuse, to a public health model which focuses on the prevention of all child deaths (Bunting and Reid, 2005). In a questionnaire survey of recognised experts in 24 different countries, Axford and Bullock identified a large number of reported benefits of child death reviews, but expressed some caution in extrapolating from these anecdotal reports. They concluded that child death inquiries do produce both immediate and intermediate outcomes, particularly through shaping policy, guidance, training and, to some extent, practice; but because of the dearth of robust evidence, it is less clear whether there are benefits for ultimate outcomes measured in terms of children’s well-being (Axford and Bullock, 2005). Drawing on our own and other’s reviews of the literature there would appear to be a clear need for a systematic evaluation of the outcomes of child death review processes on an international basis, and to build in robust systems of evaluation for the new processes in the UK.

Chapter 3 - Project Aims and Objectives

The overall aim of this DCSF commissioned study was to inform the introduction of the new child death review processes. The research team investigated and evaluated the utility of the new processes set out in *Working Together* to determine:

1. The experience of authorities in implementing the child death review processes, together with estimates of costs;
2. Whether the CEMACH draft data set is fit for purpose;
3. Staffing implications and professional training requirements; and
4. Implications for the child death review processes of any lack of co-terminosity of agency boundaries.

Within these overall aims, the study team evaluated four basic components of the child death review processes:

A. Establishing systems - the experience of LSCBs in establishing the mandate, protocols, membership and leadership, and operational practices of the CDOP:

B. Data collection - an evaluation of systems for notification and data collection, including the use of the CEMACH forms and other data collection systems;

C. Data analysis - comparison of different tools used for analysing the data collected, and approaches to identifying trends, patterns and issues;

D. Outputs of the child death review processes - how authorities plan to use the information to inform children's services planning and inter-agency working to safeguard and promote the welfare of children.

Chapter 4 - Methods

In line with the aims and objectives of this study, a qualitative research approach utilising ‘multiple methodologies’ was used drawing on different techniques in three distinct phases. The methods used were designed to maximise collection of appropriate data, cutting across disciplines, fields, and subject-matter, and to confirm the validity of the data obtained through a process of triangulation (Lofland and Lofland, 1995, Flick, 1992). Data were collected through a combination of questionnaires, interviews with key informants and structured observations of meetings along with an evaluation of submitted protocols and documents.

Phase I

A short questionnaire (Appendix 1) was distributed to all 144 LSCBs operating in England. The questionnaire was designed to clarify the current position of LSCBs in relation to implementing the processes outlined in Chapter 7 of *Working Together*, including any protocols for rapid responses to unexpected childhood deaths; development of a Child Death Overview Panel; and training, as well as enabling the research team to identify which LSCBs might be suitable and willing to participate in the in-depth study. 60 of the 144 LSCBs responded (42%), of which 24 indicated a willingness to participate in the in-depth study. From these 24, 9 sites were selected to reflect a spread of geography, population, ethnic composition, levels of deprivation and participation in the CEMACH study. The 9 sites were then visited by a member of the research team to explain the project needs and requirements and to hold initial discussions around the progress made so far.

Phase II

An Audit Tool (Appendix 2) was developed, drawing on material from the US National Center for Child Death Review (www.childdeathreview.org). The chairs of the 9 CDOPs completed and returned these Audit Tools along with copies of any protocols currently in use or under development. The audit tool was designed to capture preliminary information about the existing status of the CDOPs in the study and included information on: population; geography; age range and types of deaths; current processes in place for mortality review and responding to unexpected child deaths; the individuals and agencies involved in developing the CDOP; and any factors that had proved instrumental, along with possible barriers and constraints, to development of the CDOP.

Phase III

The final phase of the project involved qualitative techniques of non-participant observations and semi-structured interviews. The non-participant observation involved two members of the research team attending a meeting of the CDOP and making notes on the meeting using a structured proforma (Appendix 3). The focus of the observation was on the structure and process of the meeting, rather than on details of the cases discussed. At least one

CDOP meeting was attended for each site, with the exception of two which had not progressed to holding full meetings within the timescale of the project.

This technique was supplemented by in-depth qualitative interviews (Appendix 4) with the chair of each CDOP. In some cases, the interview was conducted jointly with the chair and any other leader who had been equally instrumental in establishing and/or running the CDOP. The interview schedule was designed to clarify the processes and structures involved in developing and running the CDOP, along with the background knowledge and skills necessary for chairing the panel.

Data Analysis

A combination of different tools was used to analyse the data. The questionnaire, audit tool, interview transcripts and observation notes were subjected to a mix of qualitative and quantitative analysis using the Statistical Package for Social Sciences (SPSS) and N-Vivo, a qualitative software package allowing detailed analysis of the large quantities of interview data collected during the project. The analysis divided into two broad domains: team development, systems and structures; and the process and function of the child death review. Initial scrutiny of the interview transcripts and field notes enabled the research team to develop a coding framework reflecting the key themes identified within each of the two domains. Following coding of the data, different team members analysed the interview data, identifying consistent themes, outriders and examples of good practice. The outcomes of this further analysis were then discussed by the research team and the wider project steering group allowing the perspectives of different professionals, policy members and other stakeholders to inform the interpretation of the results. Field notes from the structured observations, along with any protocols, minutes, agendas, and reports supplied by the sites, were reviewed by the research team and compared with the interview data in a process of triangulation. The collated results were distributed to the sites, enabling them to contribute to the interpretation of the results and to question or clarify any issues arising from the analysis.

Ethical issues and confidentiality

The project was discussed with the local research ethics committee and it was agreed that as an evaluation of those LSCBs who were at the beginning stages of implementing the child death review processes, it fell within the bounds of audit rather than research. Nevertheless, the research team recognised that there were significant issues around confidentiality with the overview panels themselves and the research team being privy to confidential and identifiable sensitive information. Each site was advised to ensure they had fully addressed any ethical issues raised by the process of child death review and sought local advice on information sharing, confidentiality and consent. In contrast to the CEMACH study, data were not anonymised prior to panel meetings. The research team followed strict ethical guidelines agreed in advance with the project steering group and with each site. Field notes were taken during each meeting using the structured proforma for non-participant observation (Appendix 3). No identifiable details (names, addresses or specific dates) were recorded in relation to any of the cases discussed. Agreement to the presence of observers at the meetings attended was sought from all members of the panel and all were given the opportunity to ask the observers to leave if particularly sensitive material was being discussed. In all sites, panel members were happy with the arrangements and the research team were not asked to leave any of the panel meetings. Any papers pertaining to individual cases were returned to the panel chair at the end of the meeting, and no case material was retained by the research team. Any agendas or minutes supplied to the team were scrutinised by the project manager and all identifiable information removed.

Participation in the interviews was carried out with fully informed consent of the interviewees. The interview schedules did not require any identifiable client or professional information to be collected. After the field notes and interviews had been transcribed, all transcripts were reviewed by the researcher and project manager to ensure no identifiable data were included. In one case details of a child’s death were altered for the purposes of this report, as it was felt to be potentially identifiable information.

Chapter 5 - Results

1. Initial questionnaire

144 questionnaires were sent to chairs of LSCBs in October 2006. Sixty questionnaires were returned, a 42% return rate. These were received from a variety of professionals, including many LSCB managers. The low response rate may have been in part because the questionnaire was not passed on by the LSCB chair to those responsible for developing child death review processes, or that little progress had been made at that stage for establishing the processes.

Nineteen (32%) of the LSCBs who responded reported that they had developed a joint agency protocol for the management of sudden unexpected death in childhood, with a further 31 (52%) in development. Of those protocols already in place or under development, 29 (58%) covered unexpected deaths of all children (0-18), 9 (18%) were focusing only on infant deaths (0-2), while others had not specified an age range. The definition of 'children' was not consistent and varied across Boards; some had extended it to 19 years, while others had restricted it to 0-16 or 0-17 years. Only 3 (5%) boards had developed a CDOP, with a further 36 (60%) in the process of development. Of those that had developed or were developing a panel, 17 (44%) were focusing on all deaths, while 6 (15%) were covering only unexpected deaths. Half (30) of the Boards had a SUDI Paediatrician to assist them. The majority of the Boards (40) had received no formal training in the management of unexpected child deaths, although some board members from a number of areas had attended or were planning to attend the Warwick University Advanced Course in the Management of Unexpected Childhood Death.

Further comments from the returned questionnaires indicated some ongoing concerns around funding and resource / capacity implications; some LSCBs were awaiting further guidance from the then DfES before planning their processes.

Key Findings

From a sample of 60 (42%) LSCB chairs responding to an initial questionnaire in October 2006, 84% either had developed or were in the process of developing a rapid response protocol, although a proportion of these only related to infant deaths rather than all unexpected child deaths. In contrast, only 3 boards had already established a child death overview panel, with a further 36 (60%) in the process of developing one. These results suggested a significant gap at that stage in progress towards achieving the requirements for child death reviewing processes set out in *Working Together*.

2. Recruitment of research sites

Twenty four respondents indicated that their Board would be prepared to participate in a pilot. Of these, 8 were chosen initially: Birmingham, Bristol, East Sussex, Halton, Oxfordshire, Salford, Southwark and Wakefield, to reflect a spread in terms of geography, population, ethnic mix, levels of deprivation and whether or not they were part of the CEMACH study (Appendix 5). Subsequently Harrow was added as two of the sites (Bristol and Southwark) were unable to establish a CDOP within the timescale of the project. The leads for Child Death Overview Panels in each site were visited by members of the research team during December 2006 and January 2007 to explain the project and hold initial discussions around their progress in developing child death review processes. Field notes were made of these visits, and the visits were used to facilitate completion of the audit tool.

3. Preliminary audit

All 9 sites completed the preliminary audit tool (Appendix 6).

The returns confirmed the demographic spread of the sites, with populations ranging from less than 120,000 (Halton) to nearly 1,000,000 (Birmingham); a spread of ethnic groups, with between 1% (Halton) and 30% (Birmingham) of the total population belonging to black and minority ethnic (BME) groups; and a mix of metropolitan, urban and rural areas. No site crossed any Strategic Health Authority (SHA) or police force boundary, although it appears that all the SHAs and police force areas included more than one LSCB and could therefore relate to more than one CDOP. The research team were aware of other areas (for example Coventry, Warwickshire and Solihull) where a combined CDOP may involve more than one police force. Most CDOPs relate to just one Local Authority and one Primary Care Trust (PCT), the exceptions being Birmingham which covers 4 PCTs, and Bristol which covers 4 Local Authorities and 4 PCTs. It was not clear from this audit whether any LSCBs planned to combine with other LSCBs for their CDOP, although subsequent interview data confirmed that some were and the researchers were aware of joint panels developing elsewhere in the country. Most sites related to more than one hospital; this raises issues where the LSCB area does not have a tertiary hospital and so severely ill children, and those requiring an autopsy are transferred out of area. Conversely, at least one site included a tertiary hospital, so would be dealing with children from other Local Authority areas.

Where data were provided based on estimates or known childhood deaths, they did not completely match the ONS data for 2005 (Appendix 7). This may just represent different time frames or technical issues in the way the data are collected and processed. Discrepancies arose particularly in relation to deaths in the < 28 days and 15-19 age groups, which are under-ascertained by some LSCBs. Two sites provided figures which were higher than the ONS figures which may reflect inherent delays in the system of death registration.

Most sites commented that the systems for notification of deaths are inadequate and they were therefore exploring multiple sources of notification and data collection to ensure a comprehensive data set. Both CEMACH pilot sites (Bristol and Birmingham) commented on the efficiency and robustness of the CEMACH system. Various different sources of notification were mentioned, including:

- The Child Surveillance Teams or Decision Support Teams of the PCTs which appear to provide a good basis for notification of most childhood deaths, though there would appear to be potential gaps;
- Coroners in some areas were approachable and willing to explore ways of sharing information;
- The police in some areas currently have tools for gathering data on all unexpected deaths and could set up a system for passing information to the CDOP;
- Data held by Children's Social Care in relation to child deaths can easily be shared with the CDOP, but will be limited to those known to them;
- In some areas public health have systems for collecting and collating data on child deaths;
- Hospital records departments could provide information on deaths, but would need to receive specific requests to do so;
- Whilst it is recognised that the Registrars of Births, Deaths and Marriages hold details of all child deaths, there is currently no legal basis for registrars transferring child death information to LSCBs (this is being addressed through the Children and Young Persons Bill); and
- There were systems in place in one site for data collection on perinatal deaths through a local perinatal unit.

At the time of the study all research sites had protocols for responding to unexpected childhood deaths in place, many having been operational for several years, although in two sites these were still in draft / pilot phase. Many protocols covered areas greater than the LSCB area. Most had been set up between police, health and social care and are agreed, or agreement is being sought from all statutory LSCB agencies. Most protocols covered only unexpected deaths under 2, though in some cases with potential to extend them to unexpected deaths in older children.

At the time of the study, a range of reviews of children's deaths were taking place, but with no consistency. These included local case discussions for SUDI, local case discussions for other unexpected child deaths, infant mortality reviews in hospital and by the perinatal unit, other hospital mortality reviews and domestic violence reviews. Serious Case Reviews, as outlined in Chapter 8 of *Working Together* tend to be covered by standing sub-committees of the LSCBs, with the exception of two LSCBs whose panels were convened on an ad-hoc basis. Numbers of Serious Case Reviews were mostly small, with the exception of one LSCB which commissioned approximately 10 per year.

In developing their Child Death Overview Panels, child health and children's social care were the only agencies universally involved in planning and fully committed to the process. There appeared to be good commitment from other hospital staff, and police, and from some Coroners, with less involvement from other agencies or individuals. Only one team had involved community or parent representatives in planning.

A number of factors were identified which appear to have been instrumental in helping to establish child death review processes:

- having a local champion who was prepared to ensure systems were in place and who took responsibility for managing the process;
- good commitment from most agencies / organisations and from individual professionals;
- good relationships with the Coroner and other professionals;
- already having some structures in place, e.g. a protocol for SUDI / SUDC, a Serious Case Review standing committee, or current tools for data collection;
- defining terms of reference for the panel at an early stage in the process;
- the impact and success of the CEMACH pilot;
- regular meetings of the planning team;
- strong administrative support;
- defined responsibilities for child death review processes within people's job plans;
- agreed funding from LSCB / constituent agencies.

Several barriers to implementation were identified:

- funding and time implications;
- obtaining information on children dying outside the Local Authority area;
- lack of effective administrative support;
- the need for a minimum data set and guidance about data to be collected;
- avoiding making professionals feel they are being investigated;
- the lack of systems / mechanisms for accidental deaths, medical deaths and suicides;
- constraints of a large population and high numbers of deaths in one area;

- dealing with multiple hospitals and professionals;
- issues of confidentiality;
- a lack of willingness to engage with the process by some professionals;
- the timescale for implementation being seen as unrealistic;
- the need for training of professionals involved.

Key Findings

The 9 research sites represented a wide demographic spread of the sites, with populations ranging from less than 120,000 to nearly 1,000,000; a range of ethnic groups; and a mix of metropolitan, urban and rural areas. The initial audit demonstrated inadequate systems for notification of all child deaths, and the need for multiple sources of notification. A range of different approaches to reviewing childhood deaths were reported to be already in place including local case discussions, hospital mortality reviews and serious case reviews. Child health and children's social care were the agencies most committed to the new child death reviewing processes with good commitment from other hospital staff and police. A number of factors were identified by the pilot sites as having helped promote or develop their team, along with various barriers to implementation.

4. Interviews, structured observations, and document analysis

Interviews were held with the chairs of all 9 research sites. In two sites the chair was interviewed along with another key member of the panel (a paediatrician and the LSCB chair). A total of 9 panel meetings at 8 sites were attended by members of the research team. The results from the three main strands of data analysis (interviews with chairs, structured observations of panel meetings, and analysis of provided documents) have been combined in a process of triangulation and fall within a number of themes within two overarching domains: the systems and structures in place to support the child death overview process; and the actual process and function of the panels.

A - Systems and Structures

1. Developing the CDOP

There were very few explicit references in the interview data to developing the CDOP and our analysis of this rested more on notes from the observations. There was a general sense of enthusiasm within the pilot sites, and teams were keen to develop something that they saw as being worthwhile. The chairs and other panel members conveyed a sense of being on a journey and having to find their way forward. Whilst challenging, this also engendered a sense of breaking new ground as expressed by these chairs:

It is a new task for us and a new area of work and that's making links in areas that we haven't before, so some of it feels like un-chartered territory, but I think we have had a lot of support from all agencies locally and we haven't come up against any brick walls, we've generally had enthusiasm and support.

It's breaking new ground you see and we're just learning, forging our way in the dark really… and we know there's other people doing it now which really helps, so we're just learning as we go.

A lot of the issues around developing the CDOP related to establishing the membership and commitment from agencies. Some of the more successful areas attributed their progress to having good working relationships between professionals, whilst for other teams the presence of motivated individuals was seen to be crucial to the successful development of processes.

In contrast, one of the major barriers to developing these processes has been a lack of understanding or commitment from some professionals. There was a sense of frustration from some teams where individuals have not engaged in the process. This was seen in terms of a lack of understanding, fuelled by a perceived lack of a clear lead from government:

There is a lot of tension and conflict… but because we haven't had a governmental lead, people are very able to effectively undermine stuff because they're frightened it's new work and they don't know what they are doing. So all you need is another negative comment… somebody said to me "why should we be paying all this attention to dead children? I'd rather spend my time looking after live children" … when you get those kind of comments you need to have the knowledge and framework [to counter that] and a lot of people haven't got that yet.

There was also notable frustration at not being better informed centrally about 'how to do it' - borne out by references to the 'lack of a frame of reference', concern that lots of places were having to develop their own processes in parallel, and a sense that there should be greater co-ordination and more central guidance than that set out in Chapter 7 of *Working Together*. It was notable that the research was taking place at a time of significant change, with further information about the child death reviewing processes being disseminated through a series of regional seminars.

One of the early tasks identified in terms of developing the new processes was for a panel to carry out a scoping exercise, to clarify what information was known about child deaths in their area, how that information could be obtained and determine what networks were in place. Training was also seen as important, to support developing procedures and establishing people's roles.

A final area of development has been the importance of commissioning, with some sites developing business cases for local development plans. In spite of the 2 year lead-time between the publication of *Working Together* and the requirement to have these processes in place, there was some frustration with a perceived lack of central guidance or co-ordination early on as expressed by this chair:

'There's also enormous frustration at the Department of Health and DCSF, [they] don't seem to have spoken to each other so that the commissioning process … is completely adrift in timescales in relation to this and the people who were commissioning services had no idea that this was happening.'

However, the announcement in October 2007 that preventable child deaths would be one of the measures of the Public Service Delivery Agreement 13: *Improve children and young people's safety* (HM Government, 2007) was welcomed and perceived as helping in this respect.

There was also a sense of frustration at spending a lot of time developing the process, rather than actually carrying out any child death reviews. This was something that was observed by the team in several visits, where the majority of the agenda was devoted to developmental issues rather than reviewing the allocated cases. It would appear to be helpful in this respect to separate out the development function from the actual panel, and, as with one site, have a separate working group to develop the structures and processes. Two of the sites had produced development plans outlining areas needing to be addressed, with clear actions that needed to be carried out to establish their system. The appointment of a project officer or fixed term development post has helped to facilitate this process in some of the sites.

Key Points

There was a general sense of enthusiasm within the research sites for developing the child death review processes, and teams were keen to develop something that they saw as being worthwhile. Crucial to the success of these processes appeared to be the engagement of motivated individuals from a range of agencies, and good working relationships between those individuals. In contrast, one of the major barriers to developing these processes has been a lack of understanding or commitment from some professionals. There was some frustration at the perceived lack of central guidance early on, in addition to that set out in *Working Together*, but at the same time, enthusiasm for being involved in developing new processes and being

able to work these out locally. Developing the child death reviewing processes required some form of scoping study, and was aided in some areas by the appointment of a project manager, or small working group with a clear action plan for developing their panel.

2. Purpose

In spite of having made a start, many of the study sites had not, at the time of the study, formally established their purpose or remit, or saw this as an evolving or changing process. There was general agreement however that this was important. One chair expressed the importance of people understanding the vision of these processes:

I think people … will need to understand what's the purpose of CDOP … so it's not just seen as a chore that is a government imposed initiative, but that it actually has a benefit in what we're trying to achieve.

Where purposes were agreed, these were in keeping with the purposes as set out in Chapter 7 of *Working Together* and focused around learning lessons. This was described in one LSCB protocol as: *to gain an understanding of the circumstances of the child's life, including the possibility of abuse or neglect (and thus providing a safety net to identify possible Serious Case Reviews). One output will be the learning of common lessons which will be useful in the formulation of public health strategies*.

Two respondents suggested two interrelated purposes: the wider public health function of learning lessons to inform practice, and the more specific purpose of looking for avoidable factors in an individual death. These were seen as separate functions of an individual case review (as part of the rapid response process) and a child death overview function:

The remit of the overview panel as a whole which clearly is around learning lessons from all children's deaths to inform practice and so on for the future and looking at public health concerns and so on. The remit of the panel looking at individual deaths, we will set that remit as looking for avoidable factors in that death.

That group [the rapid response team] *is there to look at the operational implications for children [within] the deceased child's circuit … and so in that sense they have one remit which is quite distinct to what we would be doing.*

Some interviewees found it easier to describe what the panels were not there for. Most agreed the purpose of the panels was not to apportion blame, but rather to learn lessons. This can be a difficult balance, and there may be times where the panel has to directly address failings, or identify where services could be improved as described by this chair:

It's not to challenge a diagnosis, it's not to identify failures… I am wanting information that will allow me to develop preventative strategies. So, I'm looking for … the broader experiences of that child, during the child's life but *also surrounding the death…it's not an investigation, it's not challenging their diagnosis…, it's not highlighting individual failures, although we may in a preventative way highlight things such as training.*

Key Points

The purposes laid out in Chapter 7 of *Working Together*, namely to review all child deaths with a view to identifying individual cases needing a Serious Case Review, as well as broader matters of concern affecting the safety and welfare of children and other wider public health or safety concerns, were reflected in the expressed purposes of the developing panels. In many cases these purposes had not, during the course of this project, been formally documented in protocols or terms of reference, but were nevertheless seen as important. Those interviewed were clear that they did not want this to be seen as a blaming exercise, but rather as an opportunity to learn lessons and improve things for children.

3. Structure

The study sites fell broadly into two groups in relation to the structure of the CDOP. First, those where a child death review process had developed independently of the LSCB, and the panel was seen as separate from but relating to the LSCB; and second those where the LSCB had taken the lead in developing the child death review processes in response to *Working Together* (2006*),* and the CDOP was seen as a sub-group of the LSCB, often growing out of an established sub-committee or other group. Both models appeared to work well, although *Working Together* (Paragraph 7.7) is clear that the panel should be a sub-group of, and therefore accountable to, the LSCB. One team which started from a public health exercise envisaged becoming a sub-committee of the LSCB from April 1st 2008.

The *Working Together* guidance, stating that responsibility for reviewing a child's death rests with the LSCB in the Local Authority where the child would normally be resident (Paragraph 7.51), was being applied consistently. However, there was no doubt that geographical boundaries could raise difficulties, both in terms of ensuring that the responsible CDOP is notified of a child's death, and enabling appropriate lessons to be learned in the right places. This could also cause problems in terms of workload, for example one LSCB that received notifications of all child deaths from a tertiary hospital in their area, regardless of the child's place of residence.

For most teams their approach to dealing with these issues was to ensure there was good communication with neighbouring authorities, and to strive for regional or sub-regional protocols or agreements to facilitate collaboration. For other LSCBs, the option of joining forces with neighbouring LSCBs was attractive, both in helping to address some of the boundary issues, and in capitalising on resources, particularly personnel, whose responsibilities may stretch over more than one Local Authority, as illustrated by this interviewee:

We have now got agreement with two neighbouring LSCBs… with whom we share a Coroner that they would like to run a combined CDOP and we're optimistic that one of the public health leads for those two areas would chair the final panel when it is up and running… We have got agreement from the three LSCBs involved that they will fund admin support and we're looking at three days a week admin support to be recruited and appointed, in the near future.

Some panels set out from the beginning to develop a combined CDOP, but others were not keen on combining forces, even if their population numbers were relatively small, as expressed by this interviewee:

If [the Safeguarding Board] is co-terminous with a Primary Care Trust, you've got the links there with general practitioners … You're looking at ideally co-terminosity with your local health service provider which is a bit more difficult but, you're about making the process work by having sensible boundaries and sensible geography and if you start looking at the notional half a million population … it generates too many cases, because it becomes… too onerous… if we were to amalgamate with another safeguarding board to get to the half million the convener would be sending out to people that they may not know well, and I think for this type of information, knowing who you're sending it to is pretty important in terms of… what you're prepared to write down.

Indeed, even for one of the teams that was looking at a combined panel, there was a recognition that trying to extend too widely could be counterproductive: *But even in relation to the overview panel there were concerns from people covering two police forces, covering three emergency departments, EDTs covering seven health trusts or whatever, whether things would get slightly more complex.*

There were particular geographical issues in London, which had not been resolved within the time frame of our study. Different models of collaboration were being considered.

There is an issue in London about how the panels will operate across London because of the different agencies, so we have only just this week come to a decision about the London structure in terms of there being an overview panel and then a series of sub-regional panels below that, and we've got to do a final piece of work to decide which boroughs will be the sub-regional panels that will come together.

Key Points

Although the development of the Child Death Overview Panels had different origins, with some being initiated outside the LSCB remit, it was clear that accountability should go through to the Local Safeguarding Children Board as set out in *Working Together*. Boundary issues generated concerns in a number of areas, but were not perceived as being insurmountable. Different models of collaboration between LSCBs were being considered, although at the time this study ended, how these would work in practice had not been clarified.

4. Membership

Comparing the interview data with the structured observations, certain commonalities emerged between the teams, but also some discrepancies between aspired and actual membership. All teams appeared to be opting for a model of core membership with additional co-opted or ad-hoc membership as described by this chair:

What we'll have is a core membership and then an invited membership according to the nature of the cases to be discussed… We don't envisage that you have all those people there all the time, but we have a core group, and… a middle group who will be called upon regularly and then there will be a team of liaison people around each agency who will then feed the information and may come in for a particular single case rather than for a whole panel meeting.

Membership has tended to come from existing LSCB groups, and in several sites, appears to have been drawn from those who are most enthusiastic, or built on existing relationships. In many cases panel membership appears to have been influenced by availability, or the knowledge and skills base of individuals. In one team this was carried out as a structured review of all LSCB membership. This team was clear that the membership should be established by the LSCB.

Involvement of some core members, particularly public health and Coroners, has proved difficult. This may be related to vacancies or a lack of commitment from those in post, but to a large extent it came down to time pressures. There may be particular issues for agencies that cross boundaries, such as the police, although this is no difference in relation to the CDOP than it is for other LSCB business.

Those professionals most commonly named for core membership include public health, Coroners (or more commonly Coroner's officers), children's social care, police, and paediatricians (most commonly the designated doctor for child protection). Some teams appeared to be striving to include all possible representatives on their panel including the ambulance service; education; CAMHS; the PCT; the City Council; legal services; Connexions and CAFCASS. The danger was that this could end up with an unwieldy membership, particularly representing health, as illustrated by the following quote:

We have a Coroner's Officer… from Social Care we have a manager… and [the Child Protection lead]… and the police… from the child abuse investigation team… and today the Detective Chief Inspector of the territorial police… And from primary care we have the designated nurse… who represents the health visitors but also, really ought to be representing the GPs. I'd like to get a named GP to attend but it's just, we haven't managed to achieve that yet. I've also tried to get people from maternity, midwives or… I've asked [the named nurse for child protection] but she's also a nursing manager… I also wonder the Registrar… we used to have the Director of public health… the Commissioner for the PCT.

Some teams have included members specifically to represent child protection from within children's social care or the named or designated professionals within health. For other teams, they have tried to limit the core membership, recognising that some professional groups, whilst having a valid input, will not participate in all reviews. Police representation is typically from the child protection unit, but one team also had the neighbourhood police involved. Hospital services are seen as important because of the large number of cases that come through hospitals.

Ad-hoc or co-opted membership included education; drug and alcohol teams; CAMHS; and adult mental health. The co-opted members were typically seen in terms of attending with a specific remit according to the nature of the cases being discussed. There were some professional groups around which there is uncertainty on whether to include as core or ad-hoc members including education; the Coroner; and midwifery.

At most sites, members appear to be relatively senior and experienced professionals including divisional managers or an LSCB manager. This is seen in terms of the representatives having credibility and the right degree of knowledge and experience. Members may also serve other roles, such as managing the Children and Young People's Strategic Partnership. One team suggested a public health trainee or newly appointed consultant representing the Director of Public Health, but, whilst being on a CDOP may provide a useful training opportunity, others felt that trainees or inexperienced staff should not be agency representatives on the panel as they would not have the right expertise or influence. One of the chairs described this in the following terms:

I think there has got to be a credability, that the people who are going to sit on the panel will be people who are experienced enough in understanding the issues…you wouldn't be looking for a brand new paediatrician, it's not someone coming for a learning experience, it's someone who's got a richness of experience to both analyse and contribute and provide some leadership.

The issue of independence was also seen as important, and different approaches to this were suggested; such as having representatives from neighbouring trusts taking it in turns so as to comment on each other's work. Another approach to ensuring some independence and objectivity is to include lay representatives on the panel. Only one interviewee mentioned lay membership however, and had not yet achieved this. No interviewees mentioned parental involvement.

Of the 9 panel meetings we observed, there were between 4 and 11 team members present (median 7) representing a range of agencies (Table 2) with one outlier, a combined sub-regional group with 22 members.

Table 2: Representatives on observed panels

Paediatrics	9 panels
Children’s social care or other LSCB representative	8 panels
Police	7 panels
Nursing	6 panels
Public health	4 panels
Education	3 panels
CAMHS	2 panels
Others (including infant health, pathology, hospital services, ambulance services, probation, youth offending and legal services)	5 panels

Key Points

All the study sites were working towards a model of having a small core membership reflecting the key professionals involved and a wider co-opted membership, bringing a breadth of knowledge and expertise to the panel. Core membership should be kept to a minimum. The most common core members observed were paediatricians, children’s social care, the police, nursing and public health. Other agencies may sit on the panel as core or co-opted members and could include any agency involved in provision of services to children or families. Typically co-opted members would only attend those meetings where cases relevant to their particular skills would be discussed. All members should be of sufficient seniority to be able to contribute meaningfully to the analysis of the deaths, and to be able to speak for and influence the agency or professional group they represent. Lay membership is seen as important, but appropriate ways of achieving this have not been developed.

5. Team functioning

One of the most significant drivers for establishing a functioning CDOP appeared to be having good working relationships and an atmosphere of trust between the team members. This was particularly so where the team grew out of established relationships. However, a close-knit group can prove difficult for new members, particularly those professionals who are not used to working within a multi-agency framework.

Good working relationships and an atmosphere of trust appear to be particularly important given the sensitive nature of the topics being discussed, which can leave individuals feeling vulnerable.

The difficulties of team functioning are highlighted by the multi-agency nature of the group, which combines professionals from very different cultures and backgrounds. One chair saw this as an important area for team development:
There may need to be some understanding about different analytic approaches and that different people approach things in different ways…

there may be forensic approaches, there may be diagnostic approaches… there's going to have to be some training that will help people understand that other members of the panel will bring a different perspective.

The panel chair was mostly seen to be a fairly generic role, which could be filled by anyone with good chairing skills, rather than needing to come from any specific discipline. However, some teams identified advantages in having some medical knowledge, if not in the chair, at least in someone at a senior level to advise the chair, and there was a common agreement that the chair also needed a broad knowledge base in relation to children's issues including safeguarding. One of the keys to good chairing was the ability to engage all members of the panel, so that all felt they had something valid to contribute. Another core skill was an analytical approach, being able to make sense of complex issues.

One chair described very clearly the skills needed by an effective chair, and the role of other members of the panel in supporting this:

I don't know that you need to have anybody from a particular profession… you've got to have a sense of what you're trying to achieve, you've got to have a sense of how to deal with group processes, to deal with conflict, to give direction where direction may be helpful but also to sit back when a process is going well… there are also the basics of the administrative side about time keeping and papers and so on. And I think it's about not using it to be autocratic and just put over your own point of view, you sometimes see chairs who really use it to kind of dictate with an audience rather than actually facilitate a process. So I think that's the skill side of the actual process in hand… I don't need to have detailed knowledge of paediatrics, what I need to know is that I've got somebody in the room who I can call upon or I can help translate information for other members of the group and that people will… feel able to say, "I don't understand that, can you explain that to me?" and similarly to go to a police colleague and say "well look can you help us here? What are the criminal justice issues around this? Or what are the prosecutory issues around this?"

The issue of independence was raised in a couple of interviews. It was seen as important for the panel chair to be independent, in the sense of not having any direct decision making involvement in any of the cases, or direct line management responsibility for front-line practitioners. However, such direct involvement may be unavoidable on the part of other panel members, and the important thing is for individual members to be able to declare any conflict of interest and to be able to trust their colleagues to be supportive.

For one of the chairs, her role in public health seemed to combine many of the required attributes, in particular independence, and the concept of being an advocate for the public:

I think [the] chair has to have a number of skills and also to be in a position to have a number of perspectives. The first is to be independent of the case and there was no way that I was going to have any direct involvement with any *cases because of my role as a PCT Commissioner. Public Health has often been seen as… independent advocates for the public's health… I don't think there's anything about the chair that requires it to be medical, nursing or any other speciality, I think it's the ability to think above the detail… and its simply for me about extrapolating the detail of the individual case and translating it into a strategic, may be a population preventative set of actions… I think you've got to be a… children's champion.*

Key Points

One of the most significant drivers for establishing a functioning CDOP is having good working relationships and an atmosphere of trust between the team members. This is particularly important given the sensitive nature of the topics being discussed and the multi-agency nature of the panels. The role of panel chair is a fairly generic role, which could be filled by anyone with good chairing skills, rather than needing to come from any specific discipline. However, the chair does need to be supported on the panel by those with specific knowledge in different fields, particularly medical knowledge, but also knowledge of legal processes and wider children's issues including safeguarding.

Our own observations and comments from the interviews suggested a number of key competencies of an effective chair, including: independence; a broad knowledge base in relation to children's issues; ensuring that everybody on the panel participates in the process; ability to deal with conflict; giving direction but not controlling; an ability to make sense of complex issues; and a clear sense of the purpose of the child death review processes.

6. Protocols and Procedures

There was very little information on protocols and procedures in the interviews; our analysis of these aspects draws more on those documents which were sent to us by the study sites and our own observations of the panels.

Some of the sites indicated that they had written protocols in place for rapid response. Typically this covered SUDI but not older children's deaths. Most of these were on a wider basis than an individual LSCB - e.g. the Pan-Cheshire protocol; the Avon & Somerset protocol; the West Midlands protocol. There was a sense in some areas that these protocols needed updating in line with the requirements of *Working Together*, particularly to enable the processes to be extended to unexpected deaths in older children, and to link in with the child death overview functions. There was also some indication that not all protocols were being fully implemented.

Two sites provided written protocols for the CDOP and both set these in the context of *Working Together* (2006). Some indicated that these were under development, and they saw this as a developing and continuing process. Having a protocol was seen as important for reasons of accountability, particularly when looking at collaboration across LSCBs. Three components to the protocol were identified: core principles; process; and structures and funding.

The document provided by one LSCB was an operational document covering systems for notification, data collection (with a data collection tool that had been developed locally), the membership and process of panel meetings. This was supplemented by a single page flow chart outlining the process. The other protocol was more of a policy document, providing working definitions, and covering the remit and responsibilities of the panel and partner agencies. This protocol had been endorsed by the LSCB and disseminated via the agency representatives on the board. This panel had also developed proformas for notification and data collection.

Key Points

Whilst most sites had protocols for the rapid response process, many of which had been developed on a sub-regional basis, there were still areas requiring further development, particularly in relation to extending the process to cover unexpected deaths in older children as well as infants. In contrast few of the sites had developed clear protocols for their CDOP and this was seen as an important area for development.

7. Relationship with other processes

One issue that stood out is how sites are making links with Chapter 8 (Serious Case Review) processes; both in a positive sense, recognising that it is something from which to draw experience, but also with some concern as to how the processes interlink. One of the clearest messages was that Serious Case Reviews were extremely intensive, demanding and time consuming and that the child death overview process couldn’t possibly, and indeed shouldn’t, aim to go into the same degree of depth.

As mentioned previously, the remit of the Child Death Overview Panel is not to apportion blame, but where failures are identified, these must be referred on to other processes, either through a Serious Case Review, or through other groups or forums. There should be clear processes for referring a case on for a Serious Case Review, either following a panel discussion or at an earlier stage if issues are identified. The process will involve a referral to the LSCB chair who takes responsibility for deciding whether a case should be the subject of a Serious Case Review. In those circumstances, the CDOP might adjourn the case until the Serious Case Review was complete, with the CDOP serving a monitoring function, or being able to look at other issues than those addressed by the Serious Case Review. Having carried out an initial overview of a child death, if concerns are identified, the CDOP may be in a good position to advise the chair of the LSCB on the scope and membership of a Serious Case Review Panel.

The Child Death Overview Panels also provide an opportunity to look at cases which do not meet the criteria for a Serious Case Review, but from which there may nevertheless be lessons to be learnt. One interesting insight came to light with a description of one case, where a decision had been made not to proceed to a Serious Case Review although it appeared that the SCR criteria had been met. In spite of the guidance in *Working Together,* there appears to be some variation in the local criteria used to decide when to initiate a Serious Case Review. Presumably by reviewing all child deaths, the CDOP will help to avoid the situation where important cases are overlooked.

The other big area of potential overlap was with the rapid response processes. The interviewees seemed clear in the distinction between the two, with the rapid response, including a final case discussion, being focused around an individual case, and identifying issues in relation to that case; whilst the child death overview took a broader remit of looking at wider lessons to be learnt from patterns or groups of deaths, but should not be involved in the details of individual case management. As such the rapid response process would feed into the child death overview process. In turn the Child Death Overview Panel can serve as a monitoring body, to oversee how well the rapid response process is working.

There are differences too between the multi-agency child death overview as outlined in *Working Together*, and other hospital based mortality reviews which are already running in many places, as described here:

The internal reviews that are already happening in many hospitals… and have been running for sometime, but they have two very different, requirements. One is to have a bird's eye view of all deaths within the district and the other is part of the internal hospital governance arrangements and therefore different information needs to be provided for each setting, you can't necessarily use the same information for both. So getting people's heads clear around that, particularly when they've been in the habit of running mortality meetings whether that's intensivists or neonatologist or whole hospital arrangements, and shifting sideways and taking the emphasis off the medical bits and did the SHO get out of bed or did somebody write down the pulse rate, towards collecting wider information about, when did this mother book for antenatal care, or what do we know about father's drug use, really much more relevant.

The issue of timing came up in relation to the different interrelated processes. The general consensus appeared to be that the Child Death Overview Panel should consider cases only after the conclusion of any rapid response process (including the final case discussion); any criminal investigation; or any Serious Case Review.

Surprisingly, none of the interviewees mentioned the relationship between the child death overview processes and the inquest. This may reflect a failure to think through the implications, or difficulties in engaging with Coroners.

Nevertheless, this would appear to be an important interface of overlap, which requires further consideration.

Key Points

There was an identified need to clarify the inter-relationship between the Child Death Overview Panel and any other review processes taking place. This was particularly important in relation to the rapid response process, any criminal investigations, Serious Case Reviews, and any internal hospital mortality reviews. Panels were clear that it was not appropriate to duplicate work, but that the different processes had different remits and could feed into each other. In particular, the rapid response was seen as a directly operational response relating to individual cases, information from which would feed into the Child Death Overview Panel. For those cases where there were suspicions about the cause of death, there would be separate criminal investigations which should be completed before a panel review. However, in these cases it is likely that a Serious Case Review would be initiated, which is able to go into far more depth than a child death overview, but may cover different aspects from it. The importance of clear pathways, and good liaison between professionals was repeatedly observed.

8. Resources

Financial

Two main resource issues were raised in the interviews, focused on finances, particularly in relation to funding key administrative and support staff; and on professional time. Those interviewed saw a need to locate and mobilise various sources of funding and to ensure they were able to channel the available money appropriately. Most developing panels appeared to be looking to their LSCB for funding, although other sources were identified by some areas; this included approaching voluntary agencies and submitting bids within PCT Local Delivery Plans. At the time of the study, no central funding had yet been allocated and this proved to be a source of frustration for the panels.

There were indications from some teams of gaps between the funds available and the work requirements of the panel. Several recognised the need for a bigger budget than originally planned. Almost all the teams considered they required extra staff to undertake research, although few teams had anticipated and set aside a separate budget for this. A lot of good will had gone into setting up the CDOPs, but it was clear that a budget was required for sustainability. It did not prove possible within this study to carry out any detailed analysis of the costs involved in setting up and running a CDOP as none of the panels observed had established clear models of how their panel would operate. However some principles were established with regard to where the areas of funding were located. Most teams identified the importance of funding a secretary or administrator, along with someone in a managerial role to oversee the running of the panel and to support the chair. Other than salaries for administrative and support staff, the main budgetary requirement mentioned was for training of members of the panel and others who may be more peripherally involved.

Personnel

Our observations and interviews suggested three crucial roles within the Child Death Overview Panel structure: those of panel chair, co-ordinator or manager, and administrator. The importance of a charismatic and strong chair to prevent drift is underlined by these research findings, but the chair should be well supported by an enthusiastic and committed manager, of sufficient seniority to co-ordinate and lead the different processes involved, and by an efficient administrator to ensure the smooth running of the panel processes. In spite of the importance given to this, only two of the panels we observed had a separate administrator present to assist with the meeting and taking minutes.

It was very clear from a number of research sites that a huge amount of preparation goes into the process, in addition to the time required for data collection, both by the panel members and by the chair or co-ordinator in order for the meetings to function well. Data collection could be carried out by a competent clerical officer, but collating and processing the information in preparation for the panel meeting depended on a co-ordinator or manager with skills in interpreting and evaluating complex social, medical and demographic data, often supported by a health professional. The time commitment required of the co-ordinator and administrator varied from a couple of hours, to two half-days or a full day, to three days in a week. Several chairs stressed the amount of time required in preparation for the panel meetings, as described here:

It takes a lot of time, I would say every meeting, the meetings usually last two hours… but they are usually preceded by, I would say, at least twelve hours of my time just collecting data.

An alternative model suggested by one site would be to appoint a research officer with a more distinct remit around information gathering and analysis:
[A Research Officer to] support the chair and to help with data gathering so that retrospectively we can do some detailed analytical thinking about what we're finding…… that Research Officer could do a lot of intelligence gathering across the Board and all it's sub committees.

Professionals

A common theme to emerge from all the interviews and our observations was that members of the panels felt stretched, particularly as these processes represented new work that had to be accommodated within already full timetables. The amount of time required by professionals on the panels was considerable, and extended beyond simply attending the meetings to gathering, reading and interpreting information. This was one of the most prominent themes in the interviews as illustrated below:

I suppose the only resource issue I could put on the table in relation to this, is that this group sits alongside a million others, so your day job is stretched now that's the issue really. This is central to the working of the Safeguarding Board, but it's a new piece of work.

Key Points

Resource issues were important in relation to setting up the panels. At the time of the study, no central funds had been provided for these processes, although the Department of Health and DCSF have since each announced 3 years of allocated funding. Several panels had been creative in seeking funds from their LSCB, PCTs or other sources. Most teams envisaged using funds to support the appointment of an administrator, and someone in a more senior managerial role, with responsibility for collating and analysing data as well as supporting the chair. In addition to these personnel however, significant time was required from professional members of the panels, and teams were having to look creatively at how these people could allocate sufficient time to the child death reviewing process.

9. Audit and Governance

Governance issues appeared to relate largely to relationships with the Board (LSCB), lines of accountability and reporting, and seemed to be linked to the production of a periodic report to the Board. Systems of audit and governance were not well developed, perhaps reflecting the early stage of this study, however their importance was recognised by many sites.

The importance of the LSCB 'owning' or 'endorsing' these child death review processes was stressed, and relates both to the development of the processes and to lines of accountability and reporting. One site mentioned the 'Lead Member' of the Local Authority being briefed on emerging issues. There was also a recognition that whilst reports would be annual, Boards would need to be informed of any major high profile issue or where important issues arose from a particular meeting. 'Sign-off' and issues of accountability were seen to rest with the either the chair of the Board, the Board Manager or the chair of the CDOP. Where systems for quality assurance already exist, for example in relation to Serious Case Reviews, it may be possible to draw on these in developing systems for the child death review processes. The importance of developing clear standards was mentioned. It was disappointing though that only one team mentioned work in relation to measuring outcomes:

I guess each meeting will have to have a way of evaluating its work rather than waiting and looking back retrospectively over 6 months work. I think I would want a system where by at the end of each meeting the panel actually reviewed what, how well do we think we've achieved what we set out to achieve today and then it would aggregate those up, into a quarterly kind of process.

There were issues raised in relation to confidentiality and data security, with an emphasis on shredding copies of case information after meetings. Little work had taken place on how to address these issues; however, one area was conscious of audit trails and the need to keep at least one full working copy of any notes made, along with systems for tracking and maintaining records, actions and recommendations.

Key Points

Although audit and governance were seen as crucially important, none of the research sites had got very far with establishing such systems. There was general agreement, in keeping with Chapter 7 of *Working Together,* that lines of accountability needed to go through to the chair of the LSCB, but some suggestion of accountability also to executive boards of the constituent agencies. Most teams envisaged a system of annual reports, supplemented by more specific reports where particular issues were identified. Issues around confidentiality and data security were raised, but had not been clarified by any of the teams at the time of the study.

B - Process and Function

1. Criteria for Review

Age Range

Although all the research sites understood that the statutory requirement was to review deaths in the age range of 0-18 (excluding stillbirths), there were some concerns about this, particularly in relation to the neonatal period and the very late adolescent period. Very little thought appeared to have been given to the issues around reviewing deaths of older adolescents. Concerns were raised in relation to the incompleteness of notification information, and the fact that different professionals may be involved with this older age group compared with the younger ones.

The issue of how to tackle neonatal deaths was being addressed differently in different sites. Some were including these in the overall CDOP process; others were treating them as a separate category to be reviewed in hospital, perhaps with the CDOP facilitating a broader review than had previously taken place; still others had not yet started to address this group of deaths. In many sites there was already some form of hospital based neonatal mortality review taking place, so the issue would be one of broadening the scope of such reviews and including them within the overall CDOP process, rather than trying to duplicate or replace a well-functioning system.

The information required for neonatal reviews was perceived to be different to that for other reviews, although some interviewees saw value in broadening the scope from the current very medical approach:

I think there may be issues for them selling it to their colleagues, particularly in the neo-natal units… from talking to our own local neo-natal unit and saying “what are you doing at the moment about reviewing child deaths?” they said “oh yes, yes we do this, this and this” and when I said “well do you look at the maternal notes?” “ do you collect information on antenatal attendance and antenatal care?” “ oh no.” And so I think if I can get the message that this is an overview panel looking at the wider aspects of the child’s welfare, not just about how a hospital looked after that baby once born, then I don’t think there will be conflict. It will be a question of saying we need a bit more information because we’re looking at things from a different angle than yourselves and we’re not duplicating.

Categories of death

The most common response to which types of death should be reviewed seemed to be ‘all deaths’, in keeping with *Working Together* guidance. However, there was at least one team that expressed a need to ‘categorise’ the deaths, and perhaps select certain categories to review in more depth. One of the drivers here appeared to be capacity, with the time taken to review deaths and the numbers of deaths occurring precluding a full evaluation of all deaths.

Where specific inclusion or exclusion criteria existed, these were typically around including unexpected deaths, or excluding deaths where there appeared to be an identified cause; whilst others felt that some specific categories, such as suicides, should always be reviewed.

Near Misses

There was only one Local Authority in our pilot which was undertaking reviews of near miss cases where there had been a potentially fatal incident. This was a small authority with relatively few child deaths in their area. For most, there just wasn't the capacity to do so, and the chairs interviewed were clear that the focus in establishing this new system should be on the death reviews rather than trying to extend the process before it even starts. There may, however, be other processes for evaluating cases where there has been a serious but non-fatal incident, such as through a quality or standards sub-group of the LSCB or through internal single agency reviews, or where the criteria are met, through a Serious Case Review, as described below:

We would still want the Standard Sub-group there to be looking at where children survive but the incident or the event the child has gone through could have equally left them dead.

The only near misses we will do is… Part Eight reviews from serious injuries if the other criteria for a Part Eight review are met.

Case Selection

Some form of case selection took place in most of the sites, drawing on the criteria outlined above. This might be based on the time available for review, or an hierarchical approach:

We select by judging by how much time we give to each death, so yes I suppose we are selecting in a way, some we'll review… in more detail than others.

We have developed a kind of hierarchy of analysis, which is more helpful to people. So for example, if we have a case where it doesn't meet the criteria for Chapter 8 review, it may be a case where we can learn lessons though and we can do an exercise relatively quickly and get the lessons out quickly. *We look at all the new cases we've had in that month and we sort of allocate them. We put in one pile [those that] we think maybe need a SCR… We put in another pile those that are clearly deaths from natural causes. We haven't really gone down the line of looking at why did this child die when it did from this natural cause? Because I know there are avoidable factors there, but we haven't done that yet. And then we've got a third pile where we feel, that on the face of it, they warrant a review because of something funny about them*.

Some teams have started or intend to carry out their reviews by dividing the deaths into specific categories and then reviewing all the deaths within one category at the same time. This approach would enable appropriate expertise to be brought in to support the panel, as described by this interviewee:
We're probably going to be looking at a neo-natal and maternity category. We're probably going to be looking at an infectious diseases category. We're going to categorise, and we're probably going to look at an accidental death category and a non-accidental child abuse category….most of us understand the point of categorising because you can bring in a neonatologist and midwives for the neonatal one or the Road Traffic Investigative Team for the other one.

At the 9 panel meetings attended by members of the research team, a total of 24 cases were discussed in detail, with between 2 and 7 cases discussed in each. Three meetings were attended at which no cases were discussed and the meeting focused solely on developmental issues for the process. In addition, two of the panel meetings briefly discussed cases that had previously been reviewed, with updated information being provided; and at two meetings, other cases were mentioned, but deferred to subsequent meetings, pending the gathering of further information. The ages of the children discussed ranged from 2 days to 19 years, with 10 being aged less than 1 year, and 9 being teenagers (Table 3). Five of the cases were deaths related to prematurity or congenital abnormalities; 7 others involved children dying of other natural causes. Of note, 2 of these were severely disabled children. Only one road traffic accident was discussed.

None of the panels actually classified the cases in terms of preventability, although it is of note that in 17 of the 24 cases issues were raised that may have indicated preventable factors in the child or young person themselves; the parents or carers; the environment; or service provision.

Key Points

The statutory requirement to review all deaths from birth to 18 years (excluding stillbirths) raised some difficulties in relation to the two extremes of the age range. In most sites there appear to be hospital-based systems in place to review neonatal deaths. There was agreement that these reviews should not be duplicated, but that there needed to be pathways for linking these into the remit of the Child Death Overview Panel, and for broadening the scope of these reviews. None of the sites had clarified how they would achieve this. At the other end of the age range, there may be difficulties in obtaining notification of older adolescent deaths, and there was recognition that different professionals may need to be involved in reviewing these cases.

***Working Together* is clear that the review process should include all child deaths. However, there was a consistent view, reinforced by our observations, that it was not possible to review all deaths in great depth. Most sites were developing some system for selection of cases for more in-depth review; with notification and some form of categorisation of all**

deaths. For most sites, the option of extending this process to include near misses was not feasible; instead they looked at other forums through which important near misses could be reviewed. Although none of the sites were using a system for classifying whether a particular death was preventable, potentially modifiable factors were identified in a substantial proportion of those reviews observed by the research team.

Table 3: Cases reviewed in the observed panel meetings

	Childs Age	Cause of death / incident as determined by the panel	Issues identified
Deaths			
1	2 d	Extreme prematurity, twin	No issues identified
2	2 d	Extreme prematurity, twin	No issues identified
3	2 w	Congenital heart defect	No issues identified
4	25 d	Multiple congenital abnormalities; twin	Issues around support / monitoring of twin
5	1 m	Tracheo-oesophageal fistula	No issues identified
6	2 m	SUDI	Initial concerns re welfare of siblings
7	2 m	Meningitis	Issues around speed of medical response; discussed with hospital staff
8	6 m	Choking	Possibility of neglect raised but discounted.
9	8 m	Unclear; premature	Issues around domestic violence
10	9 m	SUDI	Paternal alcohol use and co-sleeping
11	15 m	Choking	Concerns about advice given by ambulance control
12	2 y	Cancer: expected death	No issues identified
13	2 y	Multi-organ failure secondary to epilepsy	Missed appointments
14	3 y	Drowning abroad	Issues around safety of children in swimming pools abroad
15	6 y	Drowning abroad	Issues around safety of children in swimming pools abroad
16	15 y	Sudden collapse: presumed cardiac arrhythmia	Coroner not holding an inquest; issues around school safety and response of services
17	16 y	Pneumonia and multiple organ failure; severe disabilities; expected death	No issues identified
18	17 y	Road Traffic Accident	Alcohol and drug misuse
19	17 y	Gastroenteritis	Possible issues around primary care provision
20	19 y	Died during cardiac catheterisation; severely disabled young person	Outside standard age range, but considerable involvement of children's health and social care services
Near miss incidents			
21	13 y	Near miss: deliberate self harm	Connection with case 17
22	15 y	Near miss: deliberate self harm	Child behaviour issues; provision of secure places; management of severe deliberate self harm; awareness raising
23	15 y	Near miss: deliberate self harm	Connection with case 17
24	17 y	Near miss: serious assault	Criminal investigation ongoing

2. Data Processing

Notification

One chair summed up the views of many interviewees stating: *it is a problem identifying the deaths, we all try but it's a struggle, we don't really have a foolproof system.* There was general consensus that if members of the CDOP were to consider all unexpected deaths within the area then systems needed to be in place for gathering information from multiple sources*.*

Some specific issues were raised in relation to notification:

> 1) **Notification of deaths of children living in the area who die outside and vice versa**. One chair felt the only way of ensuring no child is missed when, for example, children may be at school in one area but live in another local area, is to take a regional approach and be notified of all. However this may not work effectively because authorities are at different stages and have different levels of awareness of what they need to be picking up. There was a sense that this may improve after April 2008. Particular problems were raised with regard to accessing information from regional hospitals about local children who had died. Two of the chairs whose area covered a regional hospital acknowledged that they needed to develop systems for passing on information about child deaths to other LSCBs.
>
> 2) **Engaging all professionals who may have information about the death of a child in the notification process was proving to be a challenge**. Particular concerns were raised about a number of professionals, notably the police. One chair explored why this may be the case, arguing that there was uncertainty as to who are the most appropriate police representatives on the panels, and whether they should be a divisional representative or a member of the central safeguarding unit? This could prove particularly problematic in large police forces covering a number of CDOPs. The second group of professionals who were not fully engaged in the process were Coroners. However, there was a sense, in keeping with *Working Together*, that it may not be necessary to have Coroners on the panel in order to engage them in the notification process.

Health data bases, particularly within the Child Surveillance Units of the PCT, were considered crucial and often the main source for gathering information about children who had died. The links with hospital systems and the LSCB's ability to access information varied. One chair stated *within the hospital we don't have any procedures so I myself have to trawl through the computer databases to identify which children have died.* However, another chair commented *if a child dies in hospital there is an agreed system for notifying the child health computer… and that information gets through.*

Some sites had already set up systems of notification through to the health child protection team. One area felt that having a joint Children's Services and Primary Care Trust facilitated notification and communication. A lot of areas appeared to rely on individual professionals and other systems, including a regional cancer network, local paediatricians, GPs and Health Visitors, and the pathology secretary. The chairs also mentioned a diverse range of other sources which assisted them in the notification process. This included word of mouth; scanning death announcements in the local paper and national press. One chair recognised the valuable information that can be obtained from the education welfare service, and another from school nurses.

During the time period of the study, no panel had managed to set up an automatic or foolproof system of notification. Several however had developed either telephone or paper systems. One panel had developed a simple notification form which was completed by the CDOP manager during a notification by telephone or was completed and e-mailed to the manager, although the security implications of sending such sensitive information by e-mail had not been addressed. This form comprised details of the referrer; the child's identification details; details of the household and other family members; the agencies and professionals involved; and brief details of the circumstances leading to referral. The form also had a section for adding any action taken on behalf of the panel and the final outcome. The form served as a basic identification form when it came to gathering information from the different agencies involved. This form has been used as a basis for developing a national notification form (Appendix 10).

Data Collection

A number of the CDOP chairs made reference to using the CEMACH forms for initial data collection and notification. These were either being completed by paediatricians, or by a CDOP co-ordinator, drawing on information provided. For those sites which were in the CEMACH pilot, using the CEMACH forms carried obvious benefits as people were already used to them. However there also seemed to be some difficulties. For some, they appeared not to provide enough relevant information to analyse the death, whilst for others they may be perceived as being too detailed and there was not enough time in panel meetings to consider all the information.

Other CDOPs used different information gathering tools, with some finding that the CEMACH format was cumbersome or not suited to the task of the CDOP. One chair described the dilemma of sending a long form to everyone who has contact with the child; rather, they had decided to send them a proforma based on the Assessment Framework (Department of Health et al., 2000):

We've had quite a lot of discussion whether you send everybody [who] might have had contact with the child a great long check list, which I don't think is helpful, whether you take my view, which is send them a proforma based on the Assessment Framework to ask them to submit information under the three main headings but do it as free text, or whether you do some sort of combination so that you leave them a little bit of space for free text but do most as a check list.

Two teams provided examples of their data collection forms. One, as described above, was based on the Assessment Framework and included sections enabling the agency to summarise their involvement; to describe any factors in the child; the parents and wider family; the wider environment; and contact with services. The other form was very simple and allowed the agency to report on the circumstances leading to death; the cause of death; details of the agency involvement; and any action being taken as a result of the child's death. The aim in both cases appeared to be that these forms, rather than any other information, would provide the information to be considered in the panel discussions.

One of the chairs also discussed the advantages and disadvantages of using chronologies stating they do not want chronologies compiled on every child but recognising that they can be extremely useful in more complex cases. Several chairs commented on how cumbersome and time consuming the chronologies for Serious Case Reviews can be, and were clear they did not want to repeat this for the Child Death Overview Panel, but rather wanted to focus on themes arising from each case. There seemed to be an important balance to be struck between getting sufficient information to make sense of the case, and not overloading people with unreasonable demands or with unnecessary information, as expressed by this chair:

It's about getting the balance between the information that you need but not over loading people as we've seen today… it is a lot of work for agencies to pull together, so we tried to keep the form as straightforward as possible, but whilst at the same time having the relevant information. But we didn't want to end up with… the size of reports meriting, same as a Part 8.

It was very clear from both the interviews and our observations that data collection could be extremely time consuming. One chair estimated at least 12 hours spent in collecting data prior to each meeting, whilst another estimated about 4 hours per case to collate the data. It would appear that a significant amount of time needs to be allowed both for agency representatives to collect and submit information, and for someone to collate it all in preparation for the panel meetings. One team requested agency reports well in advance of each meeting, and then sent out the collated notification form and all agency reports a week before each panel meeting.

Data collection was one of the major influences on the timing of reviews, indeed delays in receiving notification as well as reports from agencies was noted to play quite a significant role in deciding which cases to review and when. Some of the research sites had found that carrying out early reviews before all the information was collated simply meant that the cases had to be re-discussed at a later meeting. Although it appeared that most sites were able to get hold of relevant information for their reviews, at least one panel had experienced difficulties in getting information from specific agencies, including the police, Coroners and hospitals.

All those interviewed were clear that someone needed to take responsibility for collating information from the different sources. This could be the chair, a co-ordinator or administrator, or one of the professionals involved, typically a paediatrician.

Storage

Few of the chairs had considered the implications for storing the information gathered and were vague about the systems in place. One panel had created a database following the fields included in their data collection form. They had found that this allowed interrogation of the data at a population level. There was recognition within all the study sites that it was important to sort out secure arrangements for data collection and storage, but no sites had established a robust system.

Key Points

There were significant issues around notification, data collection and storage identified in all the research sites. Prompt notification required a simple but robust system of engaging multiple sources including front-line health staff, the PCT, the police and the Coroner. Subsequent information gathering was potentially a time consuming process involving many professionals in providing information, and a central co-ordinator to collate that information. The CEMACH data collection tool was considered by some to be useful, but by others to be either too complex to complete, or insufficient in the amount and nature of the information provided. It appeared to be important to combine both quantitative data with more qualitative or narrative information in order to meet the requirements of both the panel analysis, and any central collation of data. Alongside the development of data collection tools, panels will also have to consider issues of secure data storage and processing.

3. Liaison and Information Sharing

Issues around confidentiality, information sharing and data protection came up in a number of the interviews, but it was clear that few of the panels had formalised arrangements for dealing with these issues. For some of the chairs a code of conduct around information sharing and confidentiality appeared inherent within the professional remit of the various panels, or already captured by more general arrangements within the LSCB. There was recognition though that this may be an issue for some people, particularly for lay members of a panel as expressed by these chairs:

I think we're sharing information to improve children's welfare so it isn't a big issue for me, but I know different people have different stands. And I know from the child protection arena that if you haven't got this clarified there are always people who are standing on the side saying, you know, "what is the confidentiality issue here? and can I share this?"

There's got to be professional trust, but I think there's a suggestion that we sign up to [a confidentiality agreement], in particular when we talk about extending the membership to lay members I think that would be a good move.

All of the panels in our study were working on the basis that information about each case being reviewed would not be anonymised for the panel, and indeed could not be if professionals were to gather relevant information. However, this was countered with an expectation that individual copies of the information would be shredded and only a single record kept centrally; and that any reports or outcomes from the panel would be anonymised. One of the chairs interviewed expressed some of the issues involved as such:

Although we would want… to ensure that all the copies that the panel members have had to read in advance of a meeting [are] all destroyed. I certainly see that we would be keeping one working copy in case we ever had to go back to it, because if we produce an overview report on which we are later challenged we may have to go back to the evidence on which we based our findings… Now whether you keep that as a paper copy or whether you scan it and keep an electronic copy is academic, I mean obviously there are data protection issues as well as freedom of information issues in relation to the parents and the family members and potentially the staff involved as well, so that those are things we will have to think about and will have to go into a protocol on how we will work and I haven't got the detailed working out of that but I know it's part of our journey.

At the time of the study, none of the sites had involved parents in the review process, but all considered this an important area for development. There was general agreement that it would not be appropriate for parents to attend the panel meetings, but several chairs thought it was important to inform parents of the process and to give them an opportunity to contribute and to be informed of the outcomes. The manner in which parents are informed and involved was creating some concerns. On the one hand, approaching bereaved parents some time after their child's death could be very upsetting, but equally, not informing them of a process relating to their child did not seem appropriate. One site had produced a small information leaflet that could be given to parents, whilst others were looking at a more personalised letter informing the parents of the child death overview process and giving them opportunities to contribute (an example of a brochure and letter to parents is provided in Appendix 9).

Key Points

Further work needs to be done to clarify procedures for information sharing, data protection and freedom of information. Most chairs felt that members of the panel would be bound by the information sharing procedures within their own agencies and the wider LSCB, and as such there may not be the need for separate agreements. However, specific agreements may be important particularly for any lay members and those who are not members of the LSCB. Parental involvement was seen to be important, but the precise manner in which parents are informed of

the process, enabled to contribute, and informed of the outcomes needed to be thought through carefully.

4. Team Meetings

Conduct of Meetings

The study sites had a varied approach to the conduct of team meetings. What became clear from the researchers' observations is that there is a danger of the early part of the meeting being bogged down with the usual "committee style" procedural matters such as introductions and discussions about other LSCB business. During one meeting attended, the first 60 minutes of the 3 hour meeting was taken up with business other than child death reviews such as admin / logistical / process type discussions.

Team members should be sent sufficient information about each case to be discussed, at least a week in advance so that they are already familiar with the circumstances when they arrive. A great deal of time at some meetings was spent simply bringing members up to speed with the details of the cases. This left little time for any serious review or discussion about appropriate outcomes.

The researchers' observations of meetings found that having original case papers such as medical notes or police investigation files at the meeting can be counterproductive. This would, however, be a departure from the normal practice of many of the members who will, in other roles, regularly take case material to meetings such as child protection conferences or Serious Case Review meetings. The following two examples illustrate the potential problem:

- A member of the Primary Care Team had been invited but was unable to attend the meeting. However, the child's medical notes were lent to the children's social care delegate for use by the CDOP. Not unusually, these notes were very thick, unwieldy and full of complicated medical jargon. No-one had the relevant expertise to properly interpret the notes and a great deal of time was wasted while different delegates tried to decipher the text.
- The Coroner had initially refused to allow the CDOP to discuss cases when an inquest was planned. He subsequently changed this view but refused to supply any information pre-inquest. The police delegate, who was not part of the investigation into the death, had obtained a copy of the post mortem report and had it with him on the table. It was clear it was only there with the police on an "unofficial basis" and no-one else was given sight of it although some snippets were tantalisingly read out by the police officer. This served to make everyone a bit uncomfortable and to speculate on what the pathologist had actually concluded.

At an early planning meeting, one panel discussed the potential of taking on the role of a Serious Cases Review sub-committee, rather than acting as a trigger for any Serious Case Reviews where necessary. This perhaps highlights another danger of having original case material at the meeting which is that members may be tempted to become a desktop jury, reinvestigating the circumstances or passing judgement on operational staff. At one of the observed meetings, where there was a plan to review three cases, only one case was eventually discussed. The discussion was in depth and lasted over an hour, but at times it became a re-investigation of culpability. The meeting in effect became a mini tribunal to determine whether the carer had been neglectful or not.

Frequency and case load

The number of meetings planned to be held each year varied between the sites but the frequency was between every month and every 3 months. The number of cases to be discussed in depth varied between 3 and 10 but our observations suggest that around 3 to 5 cases is likely to be an optimum number for a 2-3 hour meeting. A chair who had experience of the CEMACH review process observed;

You can't do any more than that. You know most of us are used to doing three… The beauty of having been involved in CEMACH is that we've actually been sitting and discussing cases. If you're going to do it properly you can't do many.

It is suggested that expectations are not set too high during the early meetings, and perhaps once the systems have become streamlined and members feel more confident about limiting their discussions to their strict review function, it may be possible to increase the number of cases discussed. The observations of the research team suggested that the optimum length of time for a case discussion is between 20 and 30 minutes. In a half day meeting, therefore, it may be possible to review five cases and still allow time for coffee. This was certainly the experience of one of the panels:

We are settling into a pattern about once every three months and you can see that there's usually five or six cases plus the following up of matters arising from previous minutes and we find that, we'll be pushed today because we couldn't start, I mean normally we start at two and we're still going, going on for five, so we will be pushed today to get through all those but we will be deferring the first one. So if we say that there are, say, five cases over a three hour period and… about half an hour for each case, but clearly some are, can be discussed quickly, others need, need quite a bit longer.

One panel seemed to be developing a tiered approach whereby they would very rapidly screen and sort all deaths, then devote varying amounts of time reviewing the cases depending on the nature of the death and whether or not it would be going on to a Serious Case Review. This team found they could spend anything from 5 minutes to 2-3 hours reviewing any one death:
We're doing it in a two stage thing… we're reviewing the cases at first very quickly… if it's a death that looks as if it's in suspicious circumstances and might be a Part 8 review then we probably could spend, say, 20 minutes scoping that death in preparation [for a] Part 8 review which takes months. If it

is, on the face of it, looks like a straightforward death, like a death from a brain tumour lets say, we've had one of those or deaths from a metabolic condition, we've had one of those, they were expected deaths, then we would spend less than 5 minutes discussing the death… we're not going to review those cases to start with and then the ones that… warrant the further review, like the child that died on a playing field, then I think we're going to set aside, the idea is that we set aside probably two to three hours to review that death.

Key Points

The panels we observed were meeting between 4 and 10 times a year, and typically devoted from 2-3 hours per meeting. Within that, there appeared to be the capacity to review between 2 and 7 cases, with anything from 5-10 minutes up to an hour or more on each case. There were apparent dangers in going into too much depth and in effect trying to carry out an investigation into the child's death, rather than an overview of lessons to be learnt. It was clear from the observations of the researchers that team members must be sufficiently briefed with information circulated in advance of the meeting, and that the panel discussion must be based on summarised information, not reviewing original case records.

5. Analysis

The comments from the CDOP chairs indicated that so much time had been spent on establishing the panels and agreeing what information would be collected and from whom, that in the early stages of this study, panels were only just beginning to think about systems for analysing the information obtained and acting on the findings from the analysis. This was reflected in our observations in which few of the panels were using any structured approach to analysing the deaths.

One of the key issues highlighted was ensuring sufficient information is available to make sense of the death and learn the lessons from it. If further information is required this can lead to cases being reviewed more than once. However requesting further information needs to be balanced against trying to gather too much information which could both overwhelm the process, making it difficult to identify the real issues in the midst of too much detail, and also draw out the process, so that lessons are not learnt quickly.

Some of the sites recognised the value of a more regional or even national process to aggregate data and learn wider lessons. This was particularly so in relation to small areas, or uncommon causes of death, where an individual panel may not have sufficient information to see patterns or draw meaningful conclusions.

Three of the chairs were able to describe in detail how the analysis is undertaken. One described how their CDOP would look at a *multi-axial approach to individual deaths so, sort of medical factors, social factors, environmental factors and whether they were a major fact, a minor fact or no relevance at all.*

Only one panel used the CEMACH analysis form in their review of one case. This was used at the end of a long discussion about the case and served to focus the review; however there was a perception that this became a bit of a tick box exercise with limited value in determining outcomes. This team found it took about 20 minutes to complete the form.

Key Points

At this early stage in the development of a national process for child death review, none of the panels had clearly developed systems for analysing the information. There seemed to be a need for some further guidance and training on this in order for it to be a worthwhile process. Certain principles were clear however: that the process must be multi-disciplinary, involve professionals of sufficient seniority to make reasonable judgements, informed by sufficient but not excessive case information, and must feed into wider regional or national analysis.

6. Outcomes

Only one of the chairs acknowledged that they had not thought about outcomes. All the others had given this some consideration, although some were more advanced in their thinking than others. In the main the chairs were concerned about establishing systems for reporting back to the LSCB on the output of the CDOP and considering ways in which lessons could be learnt and applied.

Reporting mechanisms

All the chairs interviewed, bar one, anticipated reporting back at least on an annual basis to the LSCB. However, there was also recognition that an annual report may be insufficient on its own. One chair commented: *I think we would have a small summary report for each of the unexpected deaths… like a kind of closure on that piece of analysis… it would be what are the learning points from talking about child A or child B, and then they would be, something that we could aggregate up into our annual report which would be about the overall learning.*

In terms of reporting three issues had been considered and addressed by the chairs:

1. Anonymity: Although the review process itself could not be done on an anonymous basis, any reports coming out of the panel must be fully anonymised.

2. Reporting periods: Whilst most of the CDOPs were aiming to report annually to the LSCB, a number felt this was insufficient and therefore would be reporting 3-4 times per year.
3. Regional findings: This included establishing systems such as sharing annual reports to ensure the findings from one CDOP were shared with others in the region so that they could all benefit.

Learning

Discussions about learning tended to be set in the context of avoiding the blame culture which was felt to surround Serious Case Reviews; rather the emphasis was on learning the lessons to inform and develop practice. Some of the CDOPs had established systems for both referring training issues to training sub-groups and monitoring whether this training has actually taken place through, for example, the LSCB annual report.

A distinction was made between issues arising from an individual case and the broader issues arising from an overview of all deaths. Some of the panels envisaged their role encompassing both, although the main emphasis was on the broader lessons, with the expectation in most cases that the individual case issues would have been dealt with in other ways. One chair described the different levels of learning well:

First of all looking at the individual child and whether in terms of the individual child we've actually covered all bases in terms of ongoing services for them where appropriate. And that means asking about child protection issues, are they dealt with, are they still live, are they ongoing, and are those support services going in… The second thing is the more global issue to do with broader [issues], so this is the system, the kind of systematic thinking that you might be looking for… to look at the… more global issues that affect the broader population, not just the individual child… and then the third thought… was about awareness raising and training.

Where there were issues around an individual case, the role of the panel often revolved around monitoring and ensuring that all appropriate steps had been taken, including referring on for a Serious Case Review if appropriate. Other findings from the panel overview might be fed back to the individual practitioners involved, as in these examples described by one chair:

We can give you examples where a discussion of an individual case has led to the panel representative going back to one of the care givers, be it GP, be it health visitor etc… We were keen to ensure that, that family [of a child dying from a congenital malformation] had been offered genetic counselling, so I liaised with the GP… Another example was a family where both parents were learning disabled, had had a second child with the same condition that was also linked with learning disabilities and if we wanted to know again about genetic counselling, but also they had got a large family, were they… being offered family planning… were they being enabled to, to make informed decisions that were appropriate for them so, we follow up individual cases in circumstances like that. Another example was a girl who tragically choked on *her school dinner and the offer was made by the paediatrician, because the family would have been involved in bereavement counselling, but the head teacher and the teaching staff and the dinner ladies were absolutely distraught, because they failed to resuscitate, so we were able to follow up individuals like that*.

Although at this very early stage, it was not possible to formally evaluate outcomes from the panels, some significant outcomes were observed or reported as in these examples:

- The chair of one panel identified an unexpectedly high infant mortality rate which led to an audit by the PCT, identifying issues around prematurity, consanguinity and diversity, all of which could affect clinical management.
- That same team in an observed meeting had discussed two deaths of children in swimming pools abroad. This had led to some background work exploring the published literature on drownings in the UK and abroad, and the legislation surrounding swimming pool safety. A public awareness campaign was planned, working with public health, the education department and the local leisure industry; along with lobbying of an MEP to press for EU legislation in relation to swimming pool safety.
- One panel reviewed a series of near miss cases involving deliberate self harm in adolescent girls. Again some background work had been done and was presented to the board, drawing on local and national research. The findings from the panel were able to help inform and drive a collaborative project between education and CAMHS to raise awareness in schools, to train and support teachers in prevention, and to develop a joint agency protocol for the management of deliberate self harm.
- The chair of a third panel reported that their child death overview process had led to improvements in bereavement support services for families, with better management in A&E, improved communication with primary care, and information about local services for families.
- Following the death of a child from carbon monoxide poisoning, a panel reviewed their local policies on servicing of gas appliances in social housing, and raised the issue of private rented accommodation with their local child accident prevention group.

Examples were given of training that was commissioned as a result of proposals by the CDOP. This included training for midwives around safe-sleeping messages and breast feeding, and training for school staff following a death from choking in a school. Examples were also provided where findings from the CDOP raised issues that could be addressed, and in some cases were being addressed, through prevention strategies. These included children falling out of open windows, particularly during hot summers; families being identified as requiring genetic counselling; and deaths from house fires.

Crucial to the effectiveness of these strategies, according to the CDOP chairs, is having the discussion with the right people. The chair whose panel had identified the issues about children falling from windows made clear how CDOPs can develop prevention strategies in a way which was not possible before:

At the time no-one would take responsibility for it. The Safeguarding Board wasn't in this mode, the Community Safety Partnership was not interested because it wasn't a crime. ROSPA… wasn't interested because it wasn't a road traffic accident… so we had got nowhere to go with it. Whereas now we would say, we're a Safeguarding Board, actually this is our problem, we now have that responsibility so we need to do something about it…

There was an emphasis in some of the interviews on ensuring that lessons were made available to others beyond the panel, including practitioners, planners and policy makers.

Key Points

All the panels involved in the study were very clear that this process should be focused on outcomes and a preventive agenda. In spite of the early stage the Panels were at and the small number of cases reviewed, a number of significant outcomes were observed. This included public awareness campaigns, community safety initiatives, training of professionals, development of protocols, and lobbying of politicians. The examples seen served to emphasize the potential for these panels to be significant drivers for safeguarding and promoting children's welfare.

Chapter 6 - Conclusions: Implications for the operation of child death reviews in England

Drawing on the results of this project, along with the literature review and our personal observations of child death review processes in the United States, and discussions with many other professionals across this country, we are able to set out the implications of these research findings so that they support LSCBs in undertaking the child death review processes outlined in Chapter 7 of *Working Together*. This project has incorporated many of the principles of action research, with results being fed back to the participants as the project has progressed, and developments being discussed and disseminated more widely, particularly through two series of regional seminars, hosted by DCSF in spring and winter 2007 and by being made available on the DCSF website. Some of the suggested structures have already been incorporated into training materials produced for DCSF by the research team. It is hoped that these findings will support LSCBs as they undertake the child death review procedures set out in *Working Together.*

Work being carried out by DCSF to support the introduction of Child Death Overview Panels

Drawing on the outcomes of this study and that carried out by CEMACH, the Department for Children, Schools and Families is developing a range of resources to support LSCBs in the operation of their Child Death Overview Panels.

1. **Systems for notification and data collection**. A multi-agency working group was established to develop templates for national use by LSCBs in their collection of child death information. It is envisaged that these templates will work best as a web based system, enabling both local and national collation of data. The use of the templates will be reviewed prior to this next phase of work being commissioned. The templates are available on www.ecm.gov.uk/safeguarding/childdeathreview/

2. **Systems for national collation and analysis of data.** DCSF is developing a system for the national collation of the data collected through CDOPs. This system is likely to include commissioning regular analysis of national data in a similar manner to the overviews already carried out for Serious Case Reviews.

3. **Training materials.** DCSF commissioned training materials on the child death review processes. These training materials have been made available to all LSCBs. (http://www.everychildmatters.gov.uk/socialcare/safeguarding/childdeathreview/).

Implications for Local Safeguarding Children Boards

The statutory guidance for LSCBs is set out in Chapter 7 of *Working Together*. The following implications of the findings are intended to give LSCBs further advice on how best to put this guidance into practice.

1. **Each Local Safeguarding Children Board is required to establish a Child Death Overview Panel, in accordance with Chapter 7 of *Working Together*.** The optimum size of the panels, as suggested in paragraph 7.8 of *Working Together* is for a population greater than 500,000. Neighbouring LSCBs may collaborate to form a combined CDOP to achieve this population size. The results of this study suggest that teams can function effectively with both much smaller and much larger populations. LSCBs should review their own local situation and consider what configuration best fits their local needs. LSCBs should consult widely with the different agencies within their own and neighbouring Local Authority areas, in order to address any cross-boundary issues that may arise, particularly regarding the transfer of children to tertiary hospitals.

2. **In defining the terms of reference for their CDOP**, as laid out in paragraphs 7.4 and 7.55 of *Working Together* LSCBs should consider; panel membership; arrangements for chairing and administration; relationships with other processes, including the rapid response process, coronial inquiries, section 47 enquiries and criminal investigations, and Serious Case Reviews; terms of agreement for information sharing and data protection; outputs; and lines of accountability. A template for the Terms of Reference is provided in Appendix 8.

3. **The core membership of the CDOP should be made up of representatives of the key agencies on the LSCB** (paragraph 7.53 of *Working Together*) and as a minimum should include:

    - Public Health
    - Paediatrics (incorporating both hospital and community based child health services)
    - Specialist Community Public Health Nursing (Health Visitors and School Nursing)
    - Children’s Social Care
    - Police

    The optimum size of the core membership was found to be between 6 and 12 members to be effective. Representatives have to be of sufficient seniority to contribute to informed analysis of the cases, and to speak for and influence their own agency’s responses. Panels may wish to include other professionals not listed above within their core membership depending on their local situation and priorities. The core membership may be supplemented by co-opted members from other disciplines brought in as necessary to contribute to reviews within their area of expertise. Particular consideration should be given to the role of the Coroner or Coroner’s officer; education and schools; mental health services (both adult and CAMHS); ambulance services; hospital services; midwifery; primary care; palliative care services; road traffic policing; and bereavement support workers.

4. **Including lay representatives on the CDOP panel requires careful consideration.** Lay or community representatives bring a level of independence and objectivity that may be difficult to achieve simply through professional involvement. They may be able to act as advocates for parents and the community. Lay members may be drawn from voluntary or faith organisations, or from other groups within the community.

5. **It is important to establish mechanisms for appropriately informing and involving parents and other family members in the child death review process.** Parents have a right to know that their child’s death will be reviewed, and often have significant information and questions to contribute to the review process. They should always be informed of any outcomes relating directly to their child, and would normally wish to know of any actions arising out of the review process. For many parents it can be helpful to know that something worthwhile for other children has come out of their child’s death. However, this should always be done in a sensitive manner, involving those professionals who know the family, so as not to add to the family’s distress. A sample letter informing parents of the process and inviting them to participate is included in Appendix 9.

6. **An administrative team is necessary to support the working of the CDOP.** The nature of this team has to be determined by the LSCB, but the study findings support consideration being given to the following 3 roles.
    a. **A panel chair.** The chair should be the LSCB chair or his or her representative, who will be a member of the LSCB (paragraph 7.53 of *Working Together*). The panel chair should be an experienced chair and should be independent in the sense of not providing direct services to children or families in their area. The chair will be responsible for ensuring the effective running of the CDOP and will be accountable to the LSCB. He or she will be responsible for chairing all panel meetings and ensuring that all panel members are appropriately involved.
    b. **A co-ordinator or manager**. A senior officer with responsibilities for the day to day running of the child death review processes; for collating and interpreting information provided to the panel; for preparing the panel meetings; and for preparing any reports from the panel.

c. **A clerical officer** to support the chair and co-ordinator in the day to day running of the review processes. The officer will be responsible for data collection and storage, preparing and disseminating materials for the panel meetings, and for all clerical work arising from the panel.

LSCBs may wish to combine some of these roles, or may wish to share these with neighbouring LSCBs. The exact time commitments will vary according to the size of the panel and other local workload factors. As a guide, an average sized panel is likely to need at least a half time equivalent co-ordinator and a half time equivalent clerical officer, whilst the chair would need sufficient time to attend all panel meetings and an equivalent amount of time both before and after each meeting for preparation and follow up.

7. **Child Death Overview Panels are required to meet on a regular basis, as laid out in *Working Together*, paragraph 7.50, to review all deaths of children normally resident in their area.** This is likely to involve meeting, as a minimum, every 3 months, depending on the size of the population covered and other demographic factors.

8. **Clear operational procedures will support the smooth running of the child death review processes; it will be important that their implementation and output is routinely monitored.** The key elements of the procedures identified in the study are outlined below:

a. **Notification**. A single point of notification should be established whereby professionals and members of the public can notify the panel of any child's death (paragraph 7.51, *Working Together*). This will enable rapid 24 hour notification as soon as the child's death is known about and should enable joint notification of both the CDOP and the Primary Care Trust, and of the Coroner for all unexpected deaths, those that are violent, unnatural or of unknown cause. Rapid notification may also serve as a trigger for the rapid response process where appropriate. The professional confirming the child's death should notify the panel of that death, as should any other professional becoming aware of a child's death. One professional should take responsibility for informing the parents that they are doing so, and provide them with information about the review process. A simple notification form has been developed (Appendix 10) providing identifying information on the child and family, basic information on the circumstances of death, and information on any professionals and agencies involved. This notification form also serves as a means of monitoring any action taken in response to the child's death, and the progress of the child death review processes.

b. **Information gathering**. Information has to be gathered from all professionals who have been involved with the child or family, either before or in response to the death. This information needs to be sufficient to inform the process of local child death review, as well as providing core data for regional and national collation and analysis. An agency report form has been developed (Appendix 11). This form is intended to enable individual professionals to submit information they hold about the child and family and their agency's involvement. It is equally important that parents are given an opportunity, through the involved professionals or directly, to contribute any information they wish to the process. Information gathered from different professionals will then be collated either by a local case discussion (see below) or by the panel co-ordinator in consultation with those professionals involved, to provide a case record for consideration by the CDOP. It is envisaged that this form will constitute the core data set to be collated nationally.

c. **Individual case discussions / data review.** All information gathered from different professionals can be collated on the data collection form, and any gaps or discrepancies in information identified. This will ideally be done through an individual case discussion held after all investigations are complete, typically 3-4 months after the child's death. These individual case discussions should always take place following an unexpected child's death (paragraph 7.43 of *Working Together*) and are of value following any child's death. The discussion should involve all those professionals directly involved with the child and family. The outcomes of these discussions should be fed back to the families concerned, and consideration should be given at the discussions as to how best to do so (paragraph 7.47 of *Working Together*).

d. **Analysis of the information.** The Child Death Overview Panel should receive notification of and core information on all child deaths in their area (paragraph 7.51 of *Working Together*). The panel should review the information provided to them and analyse it with a view to establishing the following (paragraph 7.55 of *Working Together*):

    - Whether any case requires further enquiries, investigations or a Serious Case Review;
    - The degree to which the death could be considered preventable, taking account of potentially modifiable factors in relation to the child themselves, the parenting capacity, the wider family and environment, and service provision or need;
    - Whether there are lessons to be learnt, or actions to be taken to safeguard and promote the welfare of children or prevent future child deaths.

The study findings strongly suggest that the panel uses the information provided through the information gathering process rather than going back to original records or individual practitioners. A proforma has been developed to assist panels in reviewing individual deaths (Appendix 12). This proforma may be completed in draft at the individual case discussion, or by the co-ordinator prior to a panel meeting, and then added to or ratified by the panel. The outcomes of the panel discussion, in an anonymised form will be collected nationally to inform the prevention of child deaths indicator for the PSA 13: *Improve Children and Young People's Safety* (HM Government, 2007).

e. **Overviews.** In addition to reviewing each individual death, the panel will review overall patterns of child death and contributory factors. The degree or depth to which the panel reviews each death will be determined by the panel members, taking account of the outcome of any local case discussion, along with any identified priorities, agreed with the LSCB and constituent members. Panels may approach this in different ways, for example, taking a random sample of all deaths for in-depth review; or selecting particular categories or groups of deaths (such as road traffic collisions, neonatal deaths, SUDI, or expected deaths) to review at a panel meeting; or focusing on particular population groups, such as children from ethnic minorities, or adolescents.

f. **Outcomes.** Following each panel meeting, any identified lessons to be learnt or preventive actions to be taken should be reported to the LSCB and its constituent agencies, with recommendations for action. The LSCB will carry responsibility for endorsing any appropriate recommendations and for monitoring their implementation by constituent agencies. Recommendations should be kept to a minimum and focused on specific actions that could make a difference for children. Each panel will prepare an annual report summarising the activity and findings of the panel during the previous year. This report should be submitted to the LSCB and will be a public document. In addition, the panel may decide to present interim reports on a quarterly basis or following each panel meeting, as determined by the LSCB.

9. **Establishing systems for safe storage and use of data gathered for the child death overview processes.** Sharing of information for these purposes is covered by the government's *Information Sharing Practice Guidance* (HM Government, 2006b). Consideration should be given to establishing information sharing agreements between members of the CDOP where this is not already covered by existing LSCB agreements. Any identifiable information has to be handled with care and respect, and a system established for tracking any copies of documents. Any outputs from the panel that enter the public domain must be fully anonymised.

10. **Training is necessary for all members of the CDOP, including co-opted members.** Training materials have been commissioned by DCSF and made available to LSCBs for this purpose. Any new members will need to receive appropriate induction. Consideration should also be given to the ongoing professional development of the panel.

11. **Monitoring the function and outcomes of its CDOP and any related processes.** Suggested audit tools for monitoring the rapid response and child death overview processes are provided at Appendices 13 and 14.

Implications for further research

12. **There is a need for further systematic research into the outcomes of child death reviews, both in this country and internationally.** In the first instance, a systematic review of the literature, using a structured framework to analyse any reported outcomes is recommended.

13. **As the child death review processes are established in this country, they should be properly evaluated.** Researchers could draw on both quantitative and qualitative methods to determine the efficiency and effectiveness of the process, particularly in relation to outcomes for children; to ascertain the experience of professionals involved in the process; and to explore perceptions of the processes amongst families and the wider community.

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Appendices

Appendix 1: Questionnaire for LSCB chairs

1	Does your LSCB currently have, or are you developing a joint agency protocol for the management of unexpected childhood deaths?	Have ☐ Developing ☐ Do not have ☐	If no, please go to Q2
	1a If so, does this extend to all unexpected deaths in children, or just to sudden unexpected deaths in infancy? Please specify the age range covered:	All children ☐ Infants only ☐ …….. to …….	
	1b When was the protocol implemented? (expected date for protocols in development)	…………………..	
2	Does your LSCB have a lead paediatrician for Sudden Unexpected Deaths in Infancy (SUDI paediatrician)	Yes ☐ No ☐	
3	Does your LSCB currently have, or are you developing a child death review team?	Have ☐ Developing ☐ Do not have ☐	If no please go to Q4
	3a If so, does this team review all childhood deaths or just unexpected deaths?	All deaths ☐ Unexpected deaths only ☐ Other ☐	
	3b When was the team implemented? (expected date for team in development)	………………….	
	3c Would you be willing to participate in the pilot evaluation of the child death review processes? If so, please provide your name and contact details ……………………………………………………………………… ……………………………………………………………………… ………………………………………………………………………	Yes ☐ No ☐	
4	Have members of your LSCB had any formal training in the management of Unexpected Childhood Death?	Yes ☐ No ☐	

We welcome any further comments you may have on the development / implementation of child death review processes.

Appendix 2: Research site audit tool

1. Name of LSCB
2. Define the geographic area that the Child Death Overview Panel will cover (particularly in relation to Local Authority, PCT and police boundaries):
   a. Local Authority/ies:
   b. Primary Care Trust(s):
   c. Police Force(s):
   d. Strategic Health Authority/ies:
   e. Hospitals:
3. Define the population of your Child Death Overview Panel area:
   a. What is the total population in your identified community?
   b. How many children are under age 18?
   c. How many children are under age 5?
   d. Annual birth rate?
4. What is the racial and ethnic makeup of your community? Please give percentages where available:

a.	White UK	%
b.	White other	%
c.	Asian / Asian British	%
d.	Black / Black British	%
e.	Chinese	%
f.	Other	%

5. Please provide deprivation indices for your area:
6. Urban / Rural mix indicate which of these best describes your area; if a mixture, please estimate what proportion fits each: (Please check appropriate boxes and provide proportion estimates where applicable).
   a. London built up area ☐
   b. Other metropolitan area ☐
   c. Other urban ☐
   d. Rural ☐

7. How many children, ages 0 - 18 died in the past calendar year of all causes? Please indicate if collected data or an estimate. (Please select tick box).

	Age	Number	Collect.	Est.
a.	< 28 days (excluding stillbirths)		☐	☐
b.	28 days to < 1 year		☐	☐
c.	1 - 4		☐	☐
d.	5 - 9		☐	☐
e.	10 - 14		☐	☐
f.	15 - 18		☐	☐

8. What information (if any) do you currently have about causes of child death in your area?

9. What agencies currently collect data on child deaths? How is the information accessed?

Agency	Type of Data Held	How could a Child Death Overview Panel access this data?
Public Health		
PCT (Child Health Computer)		
Hospital Records Department		
Registrar of Births, Deaths & Marriages		
Coroner		
Police		
Social Services		
Other (please list):		

10. What procedures are currently in place for responding to unexpected childhood deaths?

Is there a local protocol?

Which professionals / agencies are involved?

Which deaths are covered? (consider age range and causes)

What information is generated and what happens with this?

If you have an agreed protocol for responding to unexpected childhood deaths, please could you send a copy, when returning this completed questionnaire.

11. Do any of the following types of reviews currently take place in your area?

    a. Local case discussion for SUDI

    b. Local case discussion for other SUDC

    c. Infant Mortality Review

    d. CEMACH regional pilot

    e. Hospital mortality review

    f. Domestic Violence

12. What structures or processes are in place for serious case reviews? (e.g. is there a standing sub-committee or is a panel convened ad-hoc; are there terms of reference - is so please supply).

13. Which individuals / agencies have been involved in developing your Child Death Overview Panel?

Agency	Involved in Planning?	Committed to Child Death Review process?
Public Health		
Child Health		
Hospital medical & nursing staff		
Midwifery		
Primary Care		
Children's Social Work Services		
Police Child Protection Team		
Other police representatives		
Community representatives		
Parent representatives		
Coroner		
Registrar		
Education		
Ambulance / Paramedic Services		
Pathologists		
CAMHS		
Adult Mental Health		

14. Can you identify any specific factors which have been instrumental in helping to establish Child Death Review processes in your LSCB?

15. Can you identify any barriers to implementation that you have encountered? If so, how have you managed to address these barriers?

Appendix 3: Structured Observation Tool

Name of CDOP

Date and time of meeting

Venue

Observers present

Time meeting started **Time meeting ended**

Persons and agencies present
(list initials, profession and agency)

Who chaired the meeting?

Who took minutes?

Was there an agenda?
If so, attach / note points from agenda

What paperwork had been provided in advance?

What paperwork / records were provided at the meeting?

What deaths were reviewed?
Overall number of deaths reviewed
For each, note identifier (e.g. case number **-** do not record any names); date of death and age at death; gender; cause / mode / category of death; what information was available to enable review of the death; how did the team review the death; length of time spent reviewing each death; what conclusions were reached

What were the outcomes/recommendations of the team meeting?

Other notes
e.g. process of the meeting, team interaction, what worked well and what didn't work well, issues raised not covered above

Appendix 4: Interview Proforma

Date
Interviewer
Interviewee
Name of Child Death Overview Panel

Background knowledge and skills of the Chair

1. Tell us first about your experience of chairing the CDRT so far?
    a. What has worked well?
    b. What has been difficult?
2. What aspects of background knowledge do you think are important for the CDRT chair? (e.g. medical knowledge; knowledge of child protection policy and procedures; knowledge of national legislation…)
3. What skills do you think are important for the CDRT chair?
4. Are you also undertaking any other roles currently? If yes, is there any conflict between the two roles? How do you manage these conflicts?

Administration and Management

1. What resource needs have you identified for the CDRT? (human, financial, other)
2. What resources have you been able to access and from where?
3. What about accountability in the group? Who is accountable to you and who you are accountable to? Has accountability ever been an issue in the group?
4. What is the administrative structure of your CDRT? Do you have a manager? An administrator? If so what background, grade and hours and how are they financed?
5. If you don't have a regular administrative staff, what alternative strategy do you have for managing the administrative work?
6. At present, which agencies/professionals are represented on your CDRT? Are there plans to include more members? What are the constraints involved?
7. How do you determine conditions for membership?
8. How have you gone about engaging different professionals or agencies in the CDRT? What has worked? What have been the major constraints and how have you dealt with them?
9. How do you organise your CDRT meetings? (frequency, timing, agenda, preparation, minute taking)
10. How are you/will you address issues of confidentiality and information sharing?.

Mapping the Work

1. Which kind of deaths are covered by your CDRT? (age range, geography, types of death)
2. Have you already defined the purpose/remit of the CDRT? If so how was this established?
3. How have you defined the population and geographic boundaries? Have you considered collaborating with neighbouring LSCBs?
4. If collaborating with neighbouring LSCBs, what issues has this raised? How have you agreed different responsibilities?
5. How do you deal with cross-boundary issues in relation to notification, data collection and review of the deaths?
6. What sort of arrangements are in place for
    a. Notification of deaths
    b. Data collection
    c. Data storage
    d. Presenting cases to the CDRT
    e. Screening or filtering information on all deaths
    f. Analysing the deaths/identifying preventable factors?
7. What have been the outputs so far? In what form are these outputs put together - an annual report or other such publications? How are these outputs disseminated to members of the CDRT, the LSCB and other bodies?
8. What mechanisms do you have for ensuring that recommendations lead to practical implementation?
9. What procedures do you have/are you considering for quality assurance / audit of the CDRT?
10. What mechanisms do you have in place for serious case reviews? How do these relate to the CDRT?
11. What mechanisms do you have in place for responding to unexpected childhood deaths? How do these relate to the CDRT?
12. What training or development needs have you identified for CDRT members? How do you plan to meet these needs?

Appendix 5: Research site details

Local Authority	Government Office Region	Police Force	In CEMACH?	Population (April 2001)	Population density	Ethnicity	%	Deprivation Indices Rank (/354) (Decile)
Birmingham	W Mids	W Mids	Yes	977,087	36.49	White	70.35	15 (1st)
						Mixed	2.86	
						Asian	19.52	
						Black	6.12	
						Chinese/Other	1.15	
Bristol	SW	Avon & Somerset	Yes	380,615	34.77	White	91.83	67 (2nd)
						Mixed	2.08	
						Asian	2.85	
						Black	2.32	
						Chinese/Other	0.91	
East Sussex	SE		No	92,177 + ?	3.16	White	97.92	243 (7th)
						Mixed	0.72	
						Asian	0.59	
						Black	0.22	
						Chinese/Other	0.54	
Halton	NW		No	118,208	14.95	White	98.79	21 (1st)
						Mixed	0.60	
						Asian	0.23	
						Black	0.11	
						Chinese/Other	0.27	
Harrow	London	Met	No	206,814	40.98	White	58.77	232 (7th)
						Mixed	2.82	
						Asian	29.65	
						Black	6.14	
						Chinese/Other	2.62	

Local Authority	Government Office Region	Police Force	In CEMACH?	Population (April 2001)	Population density	Ethnicity	%	Deprivation Indices Rank (/354) (Decile)
Oxfordshire	SE	Thames Valley	No	128,188 + 95,640	1.89	White	97.92	332 (10th)
						Mixed	0.72	
						Asian	0.57	
						Black	0.35	
						Chinese/Other	0.44	
Salford	NW	GMP	No	216,103	22.23	White	96.13	12 (1st)
						Mixed	0.99	
						Asian	1.38	
						Black	0.58	
						Chinese/Other	0.91	
Southwark	London	Met	No	244,866	84.86	White	63.02	17 (1st)
						Mixed	3.74	
						Asian	4.06	
						Black	25.90	
						Chinese/Other	3.28	
Wakefield	Yorks & Humberside	W Yorks	No	315,172	9.31	White	97.74	54 (2nd)
						Mixed	0.46	
						Asian	1.41	
						Black	0.14	
						Chinese/Other	0.26	

Appendix 6: Audit Results

Study Site	**Population (Under 18) (Under 5) Birth rate**	**Ethnic Grouping** A White UK B White other C Asian/Asian British D Black/Black British E Chinese F Other	**Measures of Deprivation**	**Urban / Rural mix**	**Child deaths known about (Collected / Estimated)** A <28 days (excluding stillbirths) B 28 days - < 1 year C 1-4 D 5-9 E 10-14 F 15-18
Birmingham	977,087 69,959 (<5) 14,792 p.a.	A 70.35% B 2.86% (mixed) C 19.52% D 6.12% E 1.15%	Deprivation indices rank = 15/354	Other metropolitan	A 19 B 25 C 13 D 9 E 8 F 18 **Total 172** (based on ONS data)
Bristol	400,000 90,000 (<18) 25,000 (<5)	A B C D 9.8% E	Not given	Other metropolitan	A 20 (E) B 8 (E) C 6 (E) D 7 (E) E 3 (E) F 6 (E) Total (50)
East Sussex	492,324 104,672 (<18) 26,511 (<5) 9.7 per 1000	A 97.7% B 2.3% C 0.6% D 0.3% E 0.6%	13/327 SOAs included in the 10% most deprived E Sussex = 11th most deprived of 34 shire counties >55,000 (10%) on benefits	2/3 other urban 1/3 rural	A 12 (C) B 7 (C) C 4 (C) D 2 (C) E 1 (C) F 1 (C) **Total 27**

Study Site	Population	Ethnic Grouping	Measures of Deprivation	Urban / Rural mix	Child deaths known about (Collected / Estimated)
Halton	118,752 27,915 (<18) 7,296 (<5) 1,562 pa	A 98.79% B 0.60% C 0.23% D 0.11% E 0.27%	ONS data lists deprivation indices rank (/254) as 21 (1st decile) Mainly concentrated on Runcorn side	Other urban	A 0 B 1 (C) C 1 (C) D 0 E 0 F 3 (C) **Total 5**
Harrow	206,814 53,000 (<18) 12,360 (<5) 2,860 p.a.	A 58.8% B C 29.6% D 6.1% E 2.6% F 2.8%	232/354 on deprivation indices; 5th most affluent borough in London	London built up area	A 12 B 8 C 3 D 2 E 2 F 0 **Total 27 (C)**
Oxfordshire	617,168 133,037 (<18) 35,943 (<5) 12.2 (annually)	A 89.9% B 5.2% C 1.7% D 0.8% E 0.6% F 0.5%	Source: IMD 2004 (data not given)	Not given	A 24 B 32 C 1 D 3 E 5 F 3 **Total 68**
Salford	216,103 49,700 (<18) 12,529 (<5) 2,500 p.a. approx	A 92.71% B 3.42% C 1.39% D 0.58% E 0.55% F 0.36%	38.19%, 12th in league	Other metropolitan	A 10 B 7 C 3 D 2 E 0 F 1 **Total 23**

Study Site	**Population**	**Ethnic Grouping**	**Measures of Deprivation**	**Urban / Rural mix**	**Child deaths known about (Collected / Estimated)**
Southwark	253,800 62,000 (<19) 17,355 (<5)	A 62% B C 5% D 24% E 2% F 7%	68% children in socially rented accommodation 50% in overcrowded accommodation Majority of electoral wards in 10% most deprived	London built up area	Data not available
Wakefield	320,000 71,000 (<18) 18,115 (<5)	A 97.7% B C 1.41% D E	Not given	Other metropolitan/ other urban City, five towns, ex-mining semi-rural villages	A 14-15 (E) B 6 (C) C 5 (C) D/E 5 (C) F 4 **Total 34 -35** (E)

Appendix 7: ONS Mortality Data

Local Authority			0 - 19	<28 days	>28 days < 1year	1 - 4	5 - 9	10 - 14	15 - 19	Causes (>28 days)
Birmingham	2004	M	112	55	19	9	4	6	19	Neoplasms: 7
		F	86	44	16	12	4	3	7	Perinatal & Congenital: 36
										Other Medical Causes: 83
	2005	M	107	63	13	8	4	4	15	External: 34
		F	65	36	12	5	5	4	3	Not elsewhere classified: 12
	Total	M	219	118	32	17	8	10	34	
		F	151	80	28	17	9	7	10	
		All	**370**	**198**	**60**	**34**	**17**	**17**	**44**	
Bristol	2004	M	22	9	4	2	1	1	5	Neoplasms: 5
		F	23	5	10	3	1	1	3	Perinatal & Congenital: 17
										Other Medical Causes: 17
	2005	M	19	9	6	0	1	1	2	External: 6
		F	19	10	2	3	1	2	1	Not elsewhere classified: 5
	Total	M	41	18	10	2	2	2	7	
		F	42	15	12	6	2	3	4	
		All	**83**	**33**	**22**	**8**	**4**	**5**	**11**	
East Sussex	2004	M	28	7	8	1	1	6	5	Neoplasms: 7
		F	17	6	2	3	1	0	5	Perinatal & Congenital: 8
										Other Medical Causes: 17
	2005	M	28	7	3	3	2	2	11	External: 28
		F	12	2	1	3	2	1	3	Not elsewhere classified: 3
	Total	M	56	14	11	4	3	8	16	
		F	29	8	3	6	3	1	8	
		All	**85**	**22**	**14**	**10**	**6**	**9**	**24**	

Local Authority			**0 - 19**	**<28 days**	**>28 days < 1year**	**1 - 4**	**5 - 9**	**10 - 14**	**15 - 19**	**Causes (>28 days)**
Halton	2004	M	12	4	3	0	2	0	3	Neoplasms: 2
		F	5	3	1	0	0	0	1	Perinatal & Congenital: 2
										Other Medical Causes: 9
	2005	M	12	6	2	1	1	1	1	External: 5
		F	5	1	1	0	1	0	2	Not elsewhere classified: 2
	Total	M	24	10	5	1	3	1	4	
		F	10	4	2	0	1	0	3	
		All	**34**	**14**	**7**	**1**	**4**	**1**	**7**	
Harrow Data not available										
Oxfordshire	2004	M	35	8	7	4	2	4	10	Neoplasms: 5
		F	28	11	7	2	1	3	4	Perinatal & Congenital: 17
										Other Medical Causes: 21
	2005	M	29	14	6	0	1	4	4	External: 20
		F	19	10	2	1	2	1	3	Not elsewhere classified: 5
	Total	M	64	22	13	4	3	8	14	
		F	47	21	9	3	3	4	7	
		All	**111**	**43**	**22**	**7**	**6**	**12**	**21**	
Salford	2004	M	17	8	2	1	0	1	5	Neoplasms: 2
		F	7	2	3	1	0	0	1	Perinatal & Congenital: 3
										Other Medical Causes: 13
	2005	M	10	5	3	0	0	1	1	External: 7
		F	14	3	4	2	0	4	1	Not elsewhere classified: 5
	Total	M	27	13	5	1	0	2	6	
		F	21	5	7	3	0	4	2	
		All	**48**	**18**	**12**	**4**	**0**	**6**	**8**	

Local Authority			**0 - 19**	**<28 days**	**>28 days < 1year**	**1 - 4**	**5 - 9**	**10 - 14**	**15 - 19**	**Causes (>28 days)**
Southwark	2004	M	23	12	6	0	1	2	2	Neoplasms: 2
		F	19	11	4	0	1	1	2	Perinatal & Congenital: 7
										Other Medical Causes: 12
	2005	M	14	6	0	1	0	3	4	External: 12
		F	20	11	2	3	0	1	3	Not elsewhere classified: 3
	Total	M	37	18	6	1	1	5	6	
		F	39	22	6	3	1	2	5	
		All	**76**	**40**	**12**	**4**	**2**	**7**	**11**	
Wakefield	2004	M	14	2	5	1	0	2	4	Neoplasms: 5
		F	22	12	4	2	0	0	4	Perinatal & Congenital: 8
										Other Medical Causes: 11
	2005	M	25	10	0	4	4	2	5	External: 17
		F	16	9	2	2	0	2	1	Not elsewhere classified: 3
	Total	M	39	12	5	5	4	4	9	
		F	38	21	6	4	0	2	5	
		All	77	**33**	**11**	**9**	**4**	**6**	**14**	

Appendix 8: Terms of Reference for a Child Death Overview Panel

These terms of reference apply to the Child Death Overview Panel of **ENTER LSCB NAME HERE** LSCB(s) and [its / their] constituent agencies. The Child Death Overview Panel is a sub-committee of the LSCB, established in accordance with the LSCB Regulations (SI No 2006/90) and following the processes set out in *Working Together to Safeguard Children* (2006).

Date: dd/mm/yy

Purpose

The purposes of the Child Death Overview Panel are to:

(a) collect and analyse information about each child's death with a view to identifying

- *(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);*
- *(ii) any matters of concern affecting the safety and welfare of children in the area of the authority; and*
- *(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area.*

(b) put in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

The Panel will review deaths of all children aged 0-18 (excluding stillbirths) normally resident in the Local Authority area. Where the Panel is made aware of the death of a child in their area who would normally be resident in another Local Authority area, or the death of a child in another area who would normally be resident in their area, the Panel manager will liaise with his / her opposite number in the other Local Authority area to ensure both Panels are notified of the death, and to determine which Panel is best placed to carry out a review of that child's death.

Functions

The Child Death Overview Panel will:

- Meet regularly to complete a multi-agency evaluation of all child deaths in their area;
- Where appropriate undertake a detailed and in-depth evaluation into specific cases, including all unexpected deaths, assessing all relevant social, environmental, health and cultural aspects, or systemic or structural factors of the death, along with the appropriateness of the professionals' responses to the death and involvement before the death, in order to complete a thorough consideration of whether and how such deaths might be prevented in future;
- Collect and collate information using the templates (DCSF, 2008) and where relevant seek further information from professionals and family members;
- Identify local lessons and issues of concern, requiring effective inter-agency working;
- Identify and report any local Public Health issues and consider, with the Director(s) of Public Health and other provider services how best to address these and their implications for both the provision of services and for training;

- identify and advocate for needed changes in legislation, policy and practices, or public awareness, to promote child health and safety and to prevent child deaths
- Ensure concerns of a criminal or child protection nature are shared with the police, children's social care and the Coroner;
- Ensure any case identified as meeting criteria for a Serious Case Review are referred to the chair of the LSCB;
- Provide information to professionals involved with families so that this can be passed on in a sensitive and timely manner;
- Implement, review and monitor the local procedures for rapid response arrangements in line with *Working Together 2006*;
- Monitor the quality of information, support and assessment services to families of children who have died
- co-operate with any regional and national initiatives in order to identify lessons on the prevention of child deaths.

Accountability

The Child Death Overview Panel will be responsible, through its chair, to the chair of the Local Safeguarding Children Board. The Panel will provide to the LSCB and all constituent agencies, an annual report (in which all information should be aggregated and anonymised) which shall be a public document. In addition, the Panel will report to the LSCB any matters of concern arising from the course of its work as set out above.

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

The LSCB will supply data regularly on every child death, as required by the Department for Children, Schools and Families, to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of these deaths.

Administration

The Panel will be chaired by the Chair of the LSCB or his/her representative. The work of the Panel will be co-ordinated by the panel manager, supported by a clerical assistant.

Membership

The Panel will have

- a fixed core membership drawn from key organisations within the LSCB;
- will have the flexibility to co-opt other professionals to become panel members on a case by case basis.

Core members:

LIST CORE MEMBERS HERE

Appendix 9: Sample Brochure and Letter to Parents

Child Death Review Processes
Information for Parents and Carers

What are the Child Death Review Processes?

From April 2008 the law requires that all children's deaths must be reviewed by the Local Safeguarding Children Board Child Death Overview Panel. (*Working Together To Safeguard Children 2006, Ch 7, www.ecm.gov.uk/workingtogether*)

What is the purpose of the Panel?

The aim of holding Child Death Reviews is to collect information about the deaths of all children in the area, so that the Panel can:

- identify whether there are any patterns or trends emerging locally,
- identify any lessons that can be learned about the patterns of child deaths locally, and
- based on that knowledge take action to improve the safety and welfare of children in the area
- to ensure that, where possible further deaths of children can be prevented.

Will parents need to be involved?

No. The Panel will only need to consider information provided by agencies that had been in contact with the child. However, if you have information or questions that you would like to be considered by the panel, we would like to know what they are so that we can address them.
See below for contact details.

How will the reviews happen?

The Child Death Overview Panel will meet regularly several times a year. All the information presented to the Panel will be *strictly confidential* and will be treated with sensitivity and respect.

Who will be on the Panel?

The Panel will be chaired by the Chair of the Local Safeguarding Children Board, or representative, and will have representatives from

- Public Health
- Local Authority Children's Services
- Child Health Services (paediatrics, nursing and midwifery)
- The Police

Other professionals may be invited to give specialist advice where needed.

How will the Panel report on its findings?

The Child Death Review Panel will provide an annual report to the Local Safeguarding Children Board. This will be a publicly available document, which will be published on the Local Safeguarding Children Board website.
All reports prepared by the Panel will be based on aggregated information, and no personal case information will be included in them.

If you have any further questions about these processes please contact
……………… Child Death Overview Panel Manager, on ………

Letter for Parents

Dear

I am writing to you as <the chair> of < > 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 (www.ecm.gov.uk/workingtogether). 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.

I will get in touch with you in the next 2 weeks to see whether you would like to contribute anything to the review and if so how. This could be through myself or another person visiting you at home; through a telephone discussion; or you could talk to your GP or another professional known to you. If you prefer, you could put your questions or comments in writing. If you have any questions or comments, or would like any further information, please contact me by phone or at the address given above.

Yours sincerely

Appendix 10: Form A - Notification Of Child Death

Notification to be reported to CDOP Manager at: e-mail
Tel
Fax

If there are a number of agencies involved, liaison should take place to agree which agency will submit the Notification.

Date of referral	/ /
Name of referrer	
Agency	
Address	
Postcode	
Tel Number	
E-mail	

Full Name of Child					DOB / /
Sex	☐	Male	☐	Female	NHS No.
Address					
Postcode					
Ethnic group	☐	White	☐	Black or Black British	
	☐	Mixed	☐	Asian or Asian British	
	☐	Chinese or other ethnic group	☐ ☐	If other, please specify Not known	
School/nursery etc					

Date & time of death	/ / Time			
Place of death				
Death certificate issued?	☐	Yes	☐	No
Any known cause of death as specified on the death certificate?	Ia Ib Ic II			

Notification Details:

Please outline circumstances leading to notification. Also include if any other review is being undertaken e.g. internal agency review; any action being taken as a result of this death.

Other Significant Family & Household Members

Full Name	DOB	Relationship	Full Address
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		

Details of Agency Contacts

Please note that is the notifying agency’s responsibility to clarify these details.

Agency	**Name, Address & Tel No.**	**Agency Report**	
		Requested (date)	**Received (date)**
GP		/ /	/ /
Midwife / Health Visitor / School nurse		/ /	/ /
Paediatrician		/ /	/ /
Police		/ /	/ /
Children’s Social Care		/ /	/ /
School / Nursery etc		/ /	/ /
Others (list all agencies known to be involved)		/ /	/ /
		/ /	/ /
		/ /	/ /

Management

Death expected or unexpected?		☐	Expected	☐	Unexpected
Reported to	Coroner	☐	Yes	Date: / /	
		☐	No	Name:	
Reported to	Registrar	☐	Yes	Date: / /	
		☐	No	Name:	
Post mortem examination:		☐	Yes	Date: / /	
		☐	No	Venue:	
Level of review		☐	Notification only		
		☐	General review		
		☐	In depth review		
		☐	Serious Case Review		
		☐	Other		
Date of local case discussion		/ /			
Date discussed at panel		/ /			

Appendix 11: Form B - Agency Report Form

Please fax / e-mail to CDOP Manager at
The security of any system for transferring the information on these forms must be clarified and agreed with the Caldicott guardian.

Each agency representative to complete this form to summarise information available within their agency. Each representative should complete only those sections for which they have information. The CDOP manager will collate the information from the different agency reports to provide an overall case record. This collation will be agreed at the local case review or by the individual agency representatives in consultation with the CDOP manager.

The form consists of six domains, A to F, along with supplementary forms B2 - B11 to be completed according to the type of death.

A - Identifying and Reporting Details

Name		DOB	/ /
NHS No.		Date of death	/ /

Agency Report Provided by

Agency			
Name			
Address			
Postcode			
Tel No		Email	

B - Summary of Case and Circumstances leading to the death

What was the mode of death?	☐	Expected death: planned palliative care
	☐	Found dead / collapsed
	☐	Witnessed event
	☐	Active withdrawal of treatment
	☐	Brain stem death

Was there any attempted resuscitation?	☐	Yes
	☐	No
	☐	Not known

Where is the child believed to have died?	☐	Acute Hospital	☐ ☐ ☐ ☐ ☐	Emergency Dept Paediatric Ward Neonatal Unit Intensive Care Unit Other
	☐	Home of normal residence		
	☐	Other private residence		
	☐	Foster Home		
	☐	Residential Care		
	☐	Public place		
	☐	School		
	☐	Hospice		
	☐	Mental health inpatient unit		
	☐	Abroad		
	☐	Other (specify)		
	☐	Not known		

Were any of the following events known to have occurred?		
☐	Road traffic accident	Complete B2
☐	Drowning	Complete B3
☐	Fire / burns	Complete B4
☐	Poisoning	Complete B5
☐	Other accident	Complete B6
☐	Substance misuse	Complete B7
☐	Apparent homicide	Complete B8
☐	Apparent suicide	Complete B9
☐	Sudden unexpected death in infancy	Complete B10

Was a post mortem examination carried out?	☐	Yes If yes, complete B11
	☐	No

Provide a narrative account of the circumstances leading to the death. This should include a chronology of significant events (e.g. contact with service; changes in family circumstances) in the background history, and details of any important issues identified.

Consider:	Events leading to death	Pre-school
	Early family history	School years
	Pregnancy and birth	Adolescence
	Infancy	

C - The Child

Gender	Male	☐	**Age at death** (yy / mm / dd)	/ /	
	Female	☐	**Indicate if estimated**	Age confirmed	☐
				Age estimated	☐
Birth weight (lb oz or kg**)**	lbs oz kgs		**Gestational age at birth** (completed weeks)		

Ethnic group	☐	White	☐	Black or Black British
	☐	Mixed	☐	Asian or Asian British
	☐	Chinese or other ethnic group	☐	Not known

Any known medical conditions at the time of death?	Yes	☐	No	☐
If yes, please provide details				

Any known developmental impairment of disability at the time of death?	Yes	☐	No	☐
If yes, please provide details				

Any medication at the time of death?	Yes	☐	No	☐
If yes, please provide details				

Education / Occupation	☐	Nursery		
	☐	School		
	☐	College		
	☐	Not in education		
	☐	Left education	☐	Employed
			☐	Unemployed

Factors in the child:
Provide a narrative description of any relevant factors within the child. Include any known health needs; factors influencing health; development / educational issues; behavioural issues; social relationships; identity and independence; any identified factors in the child that may have contributed to the death.

D - Parenting Capacity

At the time of death was the child living with:	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Mother Father Step parent Other relatives Foster carers Private fostering Residential unit Other

Was the child subject to a child protection plan?	☐ ☐ ☐	At the time of death Previously Not at all
Category of most recent child protection plan:	☐ ☐ ☐ ☐ ☐	Physical abuse Neglect Emotional abuse Sexual abuse Not known

Was the child subject to any statutory orders?	☐ ☐ ☐	At the time of death Previously Not at all
Category of most recent statutory order:	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Police Powers of Protection Emergency Protection Order Interim Care Order Care Order Supervision Order Residence Order Section 20 (Children Act 1989) Antisocial behaviour order Other court order, please specify:

Had the child been assessed as a child in need under section 17 of the Children Act 1989?	☐ ☐ ☐	At the time of death Previously Not at all
Were any siblings subject to a child protection plan?	☐ ☐ ☐	At the time of death Previously Not at all
Were any siblings subject to any statutory orders?	☐ ☐ ☐	At the time of death Previously Not at all

Factors in the parenting capacity:
Provide a narrative description of the parenting capacity. Include issues around provision of basic care; health care (including antenatal care where relevant); safety; emotional warmth; stimulation; guidance and boundaries; stability. Include strengths as well as difficulties.

E - Family and Environment

Mother

Age **Occupation**

Smoker Yes ☐ No ☐

Any known:

Disability including learning disability?	Yes ☐	No ☐	If yes please provide details.
Mental health issues	Yes ☐	No ☐	If yes please provide details.
Substance misuse?	Yes ☐	No ☐	If yes please provide details.
Alcohol misuse?	Yes ☐	No ☐	If yes please provide details.
Known to police?	Yes ☐	No ☐	Please provide details.

Father

Age **Occupation**

Smoker Yes ☐ No ☐

Any known:

Disability including learning disability?	Yes ☐	No ☐	If yes please provide details.
Mental health issues	Yes ☐	No ☐	If yes please provide details.

Substance misuse?	Yes	☐	No	☐	If yes please provide details.
Alcohol misuse?	Yes	☐	No	☐	If yes please provide details.
Known to police?	Yes	☐	No	☐	Please provide details.

Other significant adults (e.g. mother's partner; significant carer). Add as many as required, please complete details as above for each.

Relationship to child					
Age					**Occupation**
Smoker	Yes	☐	No	☐	
Any known:					
Disability including learning disability?	Yes	☐	No	☐	If yes please provide details.
Mental health issues	Yes	☐	No	☐	If yes please provide details.
Substance misuse?	Yes	☐	No	☐	If yes please provide details.
Alcohol misuse?	Yes	☐	No	☐	If yes please provide details.
Known to police?	Yes	☐	No	☐	Please provide details.

Relationship to child

Age **Occupation**

Smoker Yes ☐ No ☐

Any known:

Disability including learning disability? Yes ☐ No ☐ If yes please provide details.

Mental health issues	Yes ☐	No ☐	If yes please provide details.
Substance misuse?	Yes ☐	No ☐	If yes please provide details.
Alcohol misuse?	Yes ☐	No ☐	If yes please provide details.
Known to police?	Yes ☐	No ☐	Please provide details.

Any known domestic violence in the household?	Yes ☐	No ☐	If yes please provide details.
Was the child an asylum seeker?	Yes ☐	No ☐	

Factors in the family and environment:
Include family structure and functioning; wider family relationships; housing; employment and income; social integration and support; community resources; include strengths and difficulties.

F - Service Provision

Details of agency involvement
Include dates of first and most recent contact with family; services offered / provided.

Agency / professional	Date of first contact	Date of most recent contact	Details of services offered / provided.
Health:	/ /	/ /	
Hospital in-patient	/ /	/ /	
Hospital out-patient	/ /	/ /	
Emergency Dept	/ /	/ /	
GP	/ /	/ /	
Health Visitor	/ /	/ /	
School Nurse	/ /	/ /	

Agency / professional	**Date of first contact**	**Date of most recent contact**	**Details of services offered / provided.**
CAMHS	/ /	/ /	
Other Health (Please specify)			
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
Police	/ /	/ /	
Children’s Social Care	/ /	/ /	
School / nursery etc	/ /	/ /	

Agency / professional	**Date of first contact**	**Date of most recent contact**	**Details of services offered / provided.**
Connexions	/ /	/ /	
Probation	/ /	/ /	
Other (Please specify)			
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

Factors in relation to service provision
Include any identified services both required and provided; any gaps between child's or family member's needs and service provision; any issues in relation to service provision or uptake

Issues for discussion

Include any action or learning to be taken as a result of the child’s death; issues that require broader multi-agency discussion

Form B2 - Road Traffic Accident

Date of incident / /	**Collision time** :

Casualty class

☐ Driver or rider
☐ Pedestrian
☐ Vehicle or pillion passenger
☐ Not known

If child was the driver or passenger or a pedestrian. Type of vehicle that hit the child

☐ Pedal cycle
☐ Motorcycle ≤ 50 cc
☐ Motorcycle > 50 cc and ≤ 125 cc
☐ Motorcycle > 125 cc and ≤ 500 cc
☐ Motorcycle > 500 cc
☐ Taxi / private hire car
☐ Car
☐ Minibus (8 - 16 passenger seats)
☐ Bus or coach (17 or more passenger seats)
☐ Other motor vehicle
☐ Other non-motor vehicle
☐ Ridden horse
☐ Agricultural vehicle (include diggers etc)
☐ Tram / light rail
☐ Goods vehicle ≤ 3.5 tonnes mgw
☐ Goods vehicle > 3.5 tonnes mgw and < 7.5 tonnes mgw
☐ Goods vehicle > 7.5 tonnes mgw
☐ Not known

Age of driver of vehicle that hit the child

Breath test of driver of vehicle that hit the child

☐ Not applicable
☐ Positive
☐ Negative
☐ Not requested
☐ Refused to provide
☐ Driver not contacted at time of accident
☐ Not provided (medical reasons)
☐ Not known

If child was the driver or passenger. Type of vehicle the child was in

☐ Pedal cycle
☐ Motorcycle ≤ 50 cc
☐ Motorcycle > 50 cc and ≤ 125 cc
☐ Motorcycle > 125 cc and ≤ 500 cc
☐ Motorcycle > 500 cc
☐ Taxi / private hire car
☐ Car
☐ Minibus (8 - 16 passenger seats)
☐ Bus or coach (17 or more passenger seats)
☐ Other motor vehicle
☐ Other non-motor vehicle
☐ Ridden horse
☐ Agricultural vehicle (include diggers etc)
☐ Tram / light rail
☐ Goods vehicle ≤ 3.5 tonnes mgw
☐ Goods vehicle > 3.5 tonnes mgw and < 7.5 tonnes mgw
☐ Goods vehicle > 7.5 tonnes mgw
☐ Not known

Breath test of driver of vehicle that child was in

☐ Not applicable
☐ Positive
☐ Negative
☐ Not requested
☐ Refused to provide
☐ Driver not contacted at time of accident
☐ Not provided (medical reasons)
☐ Not known

Did vehicle have restraints?	☐ Yes ☐ No ☐ Not known	Were restraints used?	☐ Yes ☐ No ☐ Not known
Did vehicle have air bags?	☐ Yes ☐ No ☐ Not known	Did airbags deploy?	☐ Yes ☐ No ☐ Not known
Was airbag switched on?	☐ Yes ☐ No ☐ Not known		

If child was passenger

Age of driver of vehicle that child was in

Passenger position ☐ Front seat passenger ☐ Rear seat passenger
☐ Other

If child was pedestrian (pedestrian location)

☐ In carriageway, crossing on pedestrian crossing facility.
☐ In carriageway, crossing within zig-zag lines at crossing approach
☐ In carriageway, crossing within zig-zag lines at crossing exit
☐ In carriageway, crossing elsewhere
☐ On central refuge island or central reservation
☐ In centre of carriageway, no on refuge island or central reservation
☐ In carriageway, not crossing
☐ On footway or verge
☐ Not known
☐ Other (please specify):

If pedal cycle of motor cycle, was a helmet worn?

☐ Yes
☐ No
☐ Not known

Form B3 - Drowning

Type of drowning:	☐ Bath ☐ Garden pond ☐ River / lake / canal	
	☐ Swimming pool	☐ Domestic ☐ Private ☐ Municipal ☐ Not known
	☐ Not known ☐ Other (please specify)	
For garden pond / pool drowning:		
Was the garden pond or swimming pool secured (fenced)?		☐ Yes ☐ No ☐ Not known

Form B4 - Fire / burns

Type of fire / burns:	☐ Fire ☐ Electrical ☐ Chemical ☐ Hot Liquid ☐ Not known ☐ Other (please specify)	
If fire: Location of fire:	☐ Residential accommodation, please specify ☐ Main trade or business, please specify ☐ Mobile, specify ☐ Other, specify ☐ Not known	
Was a fire / smoke alarm present?		☐ Yes ☐ No ☐ Not known
Was a fire / smoke alarm functional?		☐ Yes ☐ No ☐ Not known

Form B5 - Poisoning

Form of substance:	☐ ☐ ☐ ☐	Solid Gas Liquid Unspecified
Type of substance:	☐ ☐ ☐ ☐	Household products, please specify Prescription medicines, please specify Non-prescription medicines, please specify Not known
Location of poisoning:		

Form B6 - Other non-intentional injury

Specify nature of non-intentional injury (e.g. fall, collision not involving a motor vehicle, sports injury, suffocation, bite, sting, electric shock etc).	
Brief account of events:	
Location of incident:	☐ Home or garden of usual residence ☐ Other home or garden ☐ Public place (e.g. park) ☐ School or other educational institutional ☐ Public building ☐ Other building ☐ Other, please specify ☐ Not known
If fall	
Type of fall:	☐ Fall on same level ☐ Fall from building or structure ☐ Fall on or from stairs ☐ Other fall from one level in another ☐ Fall on or from ladder or stepladder ☐ Unspecified fall
Approximate height of fall:	

Form B7 - Substance Misuse

Was the child known to substance misuse services?

☐ Yes
☐ No
☐ Not known

Was the child known to be currently using:

- ☐ Heroin
- ☐ Methadone
- ☐ Other Opiates
- ☐ Solvents
- ☐ Benzodiazepines
- ☐ Barbiturates
- ☐ Alcohol
- ☐ Hallucinogens
- ☐ Not known
- ☐ Ecstasy
- ☐ Cannabis
- ☐ Amphetamines (excluding Ecstasy)
- ☐ Major tranquilisers
- ☐ Cocaine (excluding Crack)
- ☐ Anti-depressants
- ☐ Crack
- ☐ Other, please specify

Form B8 - Apparent Homicide

Method	☐ Strangulation, asphyxiation or drowning ☐ Shooting ☐ Sharp instrument ☐ Hitting or kicking ☐ Blunt instrument ☐ Fire ☐ Poisoning, specify type ☐ Other, please specify ☐ Not known
Relationship of perpetrator	☐ Mother ☐ Father ☐ Other family member ☐ Unrelated, known to child ☐ Stranger ☐ Not known

Form B9 - Apparent Suicide

Method (If more than one, give direct cause	☐ Carbon monoxide poisoning ☐ Suffocation ☐ Hanging / strangulation ☐ Burning ☐ Drowning ☐ Electrocution ☐ Firearms ☐ Cutting or stabbing ☐ Jumping from a height ☐ Jumping / lying before a train ☐ Jumping / lying before a road ☐ Other, please specify ☐ Not known
☐ Self-poisoning	☐ Household products, please specify ☐ Prescription medicines, please specify ☐ Non-prescription medicines, please specify ☐ Other, please specify ☐ Not known

Form B10 - Sudden unexpected death in infancy

In what position was the child put to sleep?	☐ Back ☐ Front ☐ Side ☐ Not known	
Was the child sleeping with another person at the time of death?		☐ Yes ☐ No ☐ Not known
Where was the child put to sleep?	☐ Bed ☐ Cost ☐ Carry cot ☐ Sofa ☐ Other, please specify	☐ Moses basket ☐ Car chair ☐ Pram ☐ Not known
Did any of the main carers of household members smoke?		☐ Yes ☐ No ☐ Not known

Form B11 - Summary of post-mortem findings

Authorisation for post-mortem?	☐ Coroner ☐ Consent of family member
Pathologist conducting post-mortem	☐ Paediatric pathologist ☐ General (adult) pathologist ☐ Forensic pathologist ☐ Other, please specify
Summary of clinical history from pathologist	
Ancillary investigations carried out ☐ Scene / circumstances investigation (specify what, when, by whom and summarise results	
☐ X-ray skeletal survey (specify by whom and results)	

☐ Microbiology (specify what, when and results)

☐ Virology (specify what, when and results)

☐ Toxicology (specify)

☐ Metabolic investigations (specify)

☐ Cytogenetics (chromosomes)

☐ Other investigations (specify)

Summary of gross (naked eye) pathology findings
Summary of histopathology findings
Summary of pathologists conclusions on cause of death and contributory factors
Cause of death as given by pathologist ☐ Ia ☐ Ib ☐ Ic ☐ II
Any other relevant information from post-mortem examination

Name of person completing this form ________________

Designation ________________

Date / /

Appendix 12: Analysis proforma

Analysis Proforma

This proforma can be used as the basis for a local case discussion following the death of a child, and for the case review by the Child Death Overview Panel.

Name		Date of death	/ /
Date of Birth	/ /	Date of review	/ /
Professionals Present			
Apologies			

List of documents available for discussion

Cause of death as presently understood

Case Summary

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

The Local Case Discussion panel should analyse any relevant environmental, extrinsic, medical or personal factors that may have contributed to the child's death under the headings below.

For each of the four domains below, determine different levels of influence for any identified factors:

0 - Information not available

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

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

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

Domain	Relevance
Factors intrinsic to the child Include any known health needs; factors influencing health; development / educational issues; behavioural issues; social relationships; identity and independence; abuse of drugs or alcohol; note strengths and difficulties	

Domain	Relevance
Factors in the parenting capacity Include issues around provision of basic care; health care (including antenatal care where relevant); safety; emotional warmth; stimulation; guidance and boundaries; stability; note strengths and difficulties	

Domain	Relevance
Factors in the family and environment Include family structure and functioning, including parental abuse of drugs or alcohol; wider family relationships; housing; employment and income; social integration and support; community resources; note strengths and difficulties	

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

The Local Case Discussion panel should categorise the death using the following scheme.

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

Category	Name & description of category	Tick box below
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.	☐
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.	☐
3	**Trauma and other external factors** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. **Excludes** Deliberately inflected injury (category 1).	☐
4	**Malignancy** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.	☐
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.	☐
6	**Chronic medical condition** For example, Crohn's disease, liver disease, neurodegenerative disease, immune deficiencies, cystic fibrosis, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.	☐
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, and other congenital anomalies including cardiac.	☐
8	**Perinatal / neo-natal event** Death ultimately related to perinatal events, eg sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).	☐

9	**Infection** Any primary infection (i.e. not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.	☐
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either ‘SIDS’ or ‘unascertained’, at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).	☐

The panel should categorise the ‘preventability’ of the death - tick one box.

Preventable	Identifiable failures in the child’s direct care by any agency, including parents; latent, organisational, systemic or other indirect failure(s) within one or more agency	☐
Potentially preventable	Potentially modifiable factors extrinsic to the child	☐
Not preventable	Death caused by intrinsic or extrinsic factors, with no identified modifiable factors	☐
	Inadequate information upon which to make a judgement. *NB this category should be used very rarely indeed.*	☐

Issues identified in the review

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

Learning Points

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

Recommendations

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

Follow up plans for the family, where relevant

Possible Actions

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

☐ Yes ☐ No ☐ Already done

If yes please specify

Appendix 13: Audit tool for Rapid Response

To be completed for each unexpected child death

1. **Date of Death:** / /

Age of Child: y m d Age Not known ☐

2. **Who notified the rapid response team of the death?** (Please tick all that apply)

Ambulance Control ☐ Hospital Emergency Dept ☐

Not notified ☐ Not known ☐

Other (please specify)

3. **How soon after discovery of the death was the child notified to the team?**

Within 2 hours ☐ Within 24 hours ☐

Next working day ☐ Not known ☐

Later (please specify)

4. **Was an initial history taken in hospital, if so by whom?** (tick all that apply)

Paediatrician ☐ Emergency Dept Doctor ☐

Police Officer ☐ No history taken ☐

Not known ☐

Other (please specify)

5. **Was the child examined in hospital, if so by whom?** (tick all that apply)

Paediatrician ☐ Child not examined ☐

Emergency Dept Doctor ☐ Not known ☐

Police Officer ☐

Other (please specify)

6. **Were appropriate laboratory investigations carried out?**

All investigations according to local protocol ☐ Not appropriate ☐

Some investigations ☐ Not known ☐

No investigations ☐

If any difficulties in carrying out investigations, what were the reasons for this?

7. **Were the parents offered the following care and support?** (tick all that apply)

Allowed to hold their child ☐
Offered photographs and mementos ☐
Offered bereavement counselling or religious support ☐
Given information about the rapid response process ☐
Not known ☐

Offered written information ☐
Given contact numbers ☐
Informed about the post mortem ☐
Not appropriate ☐

8. **Was an early multi-agency information sharing and planning meeting held, if so when was this held?** (tick all that apply)

Yes - telephone discussions ☐
Yes - sit down meeting ☐
No ☐

Same day ☐
Later (please specify) ____________
Not known ☐

9. **Did a joint agency home visit take place?**

Yes ☐
No ☐

Not appropriate ☐
Not known ☐

If so, when did this take place?

Same day ☐
Next working day ☐

Later (please specify) ____________
Not known ☐

Who took part in the home visit? (tick all that apply)

General paediatrician ☐
SUDI paediatrician ☐
Police officer (Child Abuse Investigation Unit) ☐
Police officer (other) ☐
Scenes of crime / forensic officer ☐

General practitioner ☐
Health visitor / midwife ☐
Bereavement support worker ☐
Social worker ☐
Not known ☐

Other (please specify) ____________________________

If a joint agency home visit did not take place, please specify why.

____

10. Was an autopsy carried out? If so by whom? (tick all that apply)

Yes ☐
General hospital pathologist ☐
Forensic pathologist ☐

No ☐
Paediatric pathologist ☐
Not known ☐

Other (please specify) ____________________

If so, when did this take place?

Same day ☐
Next working day ☐

Later (please specify) ________
Not known ☐

11. Was there a final case discussion?

Yes ☐
No ☐

Not yet, but planned ☐
Not known ☐

How long after the death did this take place?

Within 2 months ☐
2 – 4 months ☐

Later (please specify) ________
Not known ☐

If an inquest was held / planned, did the final case discussion precede or follow the inquest?

Preceded the inquest ☐
No inquest held ☐

Followed the inquest ☐
Not known ☐

Who attended the final case discussion? (tick all that apply)

General paediatrician ☐
SUDI paediatrician ☐
Police officer (Child Abuse Investigation Unit) ☐
Police officer (other) ☐
Scenes of crime / forensic officer ☐

General practitioner ☐
Health visitor / midwife ☐
Bereavement support worker ☐
Social worker ☐
Not known ☐

Other (please specify) ____________________

Were the family informed of the outcome of the final case discussion?

Yes - through a home visit ☐
Yes - by telephone ☐
No ☐

Yes – by letter ☐
Yes - other ☐
Not known ☐

12. What was the final cause of death?

Death from natural causes ☐
Accident ☐
Suicide ☐
Not known ☐
SIDS ☐
Homicide ☐
Cause of death not established ☐

Other (please specify) ____________________

13. Were any concerns of a child protection nature identified?

Yes ☐
Not known ☐
No ☐

14. Was the case referred on to the CPS?

Yes ☐
Not known ☐
No ☐

Appendix 14: Audit tool for Child Death Overview Panels

1. **How many child deaths have occurred of children normally resident in your local authority area during the past 6 months?**

Not known ☐

2. **How many were notified to your panel?**

Not known ☐

3. **How many deaths of children not normally resident in your local authority area have been notified to your panel in the past 6 months?**

Not known ☐

How many of these has your panel been actively involved in reviewing?

Not known ☐

4. **How many times has your panel met during the last 6 months?**

Not known ☐

For each meeting of your panel within the past 6 months, please complete the following information.

5. **Which agencies / professionals were represented at the meeting?** (tick all that apply)

Police ☐
Hospital paediatrician ☐
Nursing ☐
Public health ☐
Education / school ☐
Bereavement support ☐
Not known ☐

Children's Social Care ☐
Community paediatrician ☐
Midwifery ☐
Primary Care ☐
Coroner's office ☐
Lay member ☐

Other (please specify)

How many panel members were present?

Not known ☐

6. **How many cases were discussed at the panel meeting?**

Not known ☐

How many cases of each category of death were discussed at the meeting?

Expected death from natural causes		Homicide	
Unexpected death from natural causes		Suicide	
SIDS		Cause of death not established	
Accident		‘Near misses’	
Not known	☐		

How many deaths were discussed in each of these age groups?

Neonatal deaths (< 4 weeks)		Infant deaths (4 – 52 weeks)	
1 - 4 years		5 - 9 years	
10 - 14 years		15 - 18 years	
Not known	☐		

How many deaths were considered to be preventable?

Preventable		Potentially preventable	
Not preventable		Inadequate information to make judgement	☐

7. Were any cases referred on for further investigation? If so, please list how many under each category?

No deaths referred on	☐	Coroner	
Police / CPS		Social Services for s47 enquiry (siblings / other children	
LSCB for Serious Case Review		Not known	☐

Other (please specify) ____________________

7. **Did the panel make recommendations in any of the following areas?** (tick all that apply)

Recommendations specific to the management of an individual case ☐

Training commissioners / providers ☐

Changing local organisational structures and practices ☐

Changing regional policies or practices ☐

Influencing legislation or national policy ☐

Not known ☐

Community education / awareness ☐

National education / awareness ☐

Advocacy and health promotion ☐

Mobilising local communities ☐

No recommendations ☐

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