Bexley Local Safeguarding Children Board Procedure for Multi-Agency Response to the Child Death Overview Process

Part 2 – Child Death Overview Panel

This procedure applies to all agencies and voluntary organisations who work with children and young people and their families in Bexley.

(Review date 1 year – May 2009)

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1. Introduction

1.1. This procedure has been agreed by the Local Children Safeguarding Board (LSCB) and is based on the minimum standard tool kit published by the London Safeguarding Children Board (March 2008).

1.2. The procedures are compliant with the requirements for the Child Death Overview Process (CDOP) as outlined in Chapter 7 – *Working Together to Safeguard Children* (DCSF 2006).

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

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

- An overview of all child deaths (birth up to 18th birthday, excluding babies stillborn) in the LSCB area, undertaken by a panel drawn from key organisations represented on the LSCB.

1.4. Part 1 of the procedures applies to the Rapid Response required when a child dies unexpectedly. The procedure enables the capturing of immediate information about unexpected child deaths. In addition it will assist the support to the bereaved family.

1.5. Part 2 of the procedures applies to the Child Death Overview Panel (CDOP) and every LSCB has a responsibility for convening and maintaining a CDOP.

1.6. The CDOP will undertake a review of all child deaths in their area using a standard set of data this can be found at: www.everychildmatters.gov.uk/socialcare/safeguarding/childdeathreveiw/lscbtemplates/

1.7. The CDOP will collect and analyse information about each death with a view to identifying:

- Any case giving rise to the need for a Serious Case Review
- Any matter of concern affecting the safety and welfare of children in the area
- Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area

1.8. The CDOP has a responsibility for reviewing the deaths of all children with priority given to those that are unexpected and unexplained.

2. Membership

The Core Membership of the CDOP in Bexley will be:

- Director of Public Health (Chair)
- Deputy Director Children & Young People's Services (Vice Chair)
- Designated Paediatrician for Unexpected Deaths in Childhood/SUDI Paediatrician
- Coroner or Coroner's Officer
- Children's Social Care
- Police – Public Protection Desk and/or CAIT
- Designated Nurse BCT
- Safeguarding Lead Nurse QMS
- Faith representative (to be confirmed)

The roles and responsibilities of CDOP members can be found in *Appendix 1.*

3. Frequency of meetings

The CDOP should hold meetings on a regular basis at least three times a year. The frequency will be affected by the number of cases that need to be discussed and should enable case discussions in a timely manner.

4. Notifications of Child Deaths

All child deaths should be notified to the Single Point of Contact (SPOC) who will collate all the information for the information templates for discussion at the CDOP meeting.

5. Deaths of children out of the area

5.1. When a child dies in an area that s/he does not reside in the SPOC for the area in which the child dies will inform the SPOC in the area where the child normally resided.

5.2. The CDOP in the area where the death occurred will normally review that death and liaise with the CDOP in the resident area.

5.3. On occasions CDOPs may decide to conduct individual reviews. In this case it is the responsibility of the Chairs of the CDOPs to negotiate the management of the reviews.

6. Process for gathering information on all child deaths

6.1. If a child dies unexpectedly the process in Part 1 of these procedures will be followed. It is the responsibility of Designated Paediatrician for Unexpected Deaths in Childhood to ensure all relevant information is appropriately reflected in the information gathering and evaluation toolkit provided by the DCSF and reports to the CDOP.

6.2. For all other deaths the Notification Form will be sent to the SPOC who will co-ordinate the gathering of information.

6.3. The Agency Report Forms must be completed by each agency that has knowledge of the family or the circumstances of the death. *(Appendix 2).* These will be sent out by the SPOC with agreed timescales for return.

6.4. The overview report for the CDOP will be written by the Designated Paediatrician or person delegated by them. Consideration has to be given in this report as to whether the case meets the criteria for a full case discussion at the CDOP.

6.5 The CDOP Chair is responsible for ensuring the CDOP Analysis Proforma is completed on all child deaths, either by full discussion at a CDOP meeting or through analysis of agency reports to be undertaken by the Designated Doctor/Nurse.

7. Key functions of the CDOP

The key functions of the CDOP are to:

- Receive notification on all child deaths occurring in the local area.
- Collect and collate an agreed national minimum data set.
- Seek information from professionals who had involvement with the child, before and immediately following the death and, where relevant, the child's family members.
- Evaluate the data available and identify lessons to be learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children.
- Assess the cases with regard to the threshold criteria to enable specific cases to be reviewed in depth *(see Threshold Criteria in Appendix 3).*
- Ensure that individual case discussions have taken place regarding unexpected child deaths.
- Monitor the appropriateness of the response of professionals to an unexpected death of a child, reviewing the reports produced by the Rapid Response team on each unexpected death of a child, making a full record of this discussion and providing the professionals with feedback on their work. Where there is an ongoing criminal investigation, the Crown Prosecution Service must be consulted as to what it is appropriate for the CDOP to consider and what actions it might take in order not to prejudice any criminal proceedings.
- Scrutinise the recommendations from the reports compiled by the designated paediatrician for unexpected deaths.
- Identify any common themes from individual cases and consider these in more depth.
- Consider whether the death was avoidable, if so how such deaths might be prevented in the future.

- Identify any patterns or trends in the local data and report these back to the LSCB.
- Consider any report from Children's Social Care that includes an assessment of parenting and environmental factors.
- Alert the Chair of the LSCB about any deaths where, on evaluating the available information, the CDOP considers there may be grounds to undertake further enquiries, investigations or a Serious Case Review and explore why this had not previously been recognised.
- Inform the Chair of the LSCB where specific new information should be passed to the Coroner or other appropriate authorities.
- Provide relevant information to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family.
- Monitor the support and assessment services offered to families of children who have died.
- Monitor and advise the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths.
- Identify any public health issues and consider, with the Director(s) of Public Health, how best to address these and their implications for both the provision of services and for training.
- Co-operate with regional and national initiatives to identify lessons on the prevention of unexpected child deaths e.g. *the London learning from information about child deaths initiative* and the Confidential Enquiry into Maternal and Child Health (CEMACH) see www.cemach.org.uk/
- Ensure each partner agency of the LSCB identifies a senior person with relevant expertise to have responsibility for advising on the implementation of the local procedures on responding to child deaths within their agency.

8. Consent and confidentiality

8.1. Information in CDOP meetings will not be anonymised.

8.2. Parental consent is not required for this information to be passed to the designated paediatrician for unexpected deaths in childhood/the LSCB SPOC. It should only be shared with those who need to know as governed by the *Caldicott Principles* the *Data Protection Act* and *Working Together.*

8.3. Persons with Parental Responsibility *(Children Act 1989)* should be advised that the child's death will be subject to a review in order to learn any lessons that may help prevent future deaths of children. This must be handled sensitively. It should normally be done by the doctor confirming the child's death to the parents, or Coroner's officer and followed up with a letter.

8.4. All LSCB member agencies must be aware of the need to share information on all child deaths to enable the LSCB to carry out its statutory duty.

8.5. Members of the CDOP must sign a confidentiality agreement, including sharing and securely storing information. This agreement will be reviewed at each meeting.

8.6. In no case will any team member disclose any information regarding team discussion within the CDOP outside the meeting, other than pursuant to the mandated agency responsibilities of that individual.

8.7. Public statements about the general purpose of the child death review process may be made, as long as they are not identified with any specific case.

9. Professional and family support

9.1. Before the CDOP meets, the Chair should consider what explanatory information is sent to the child's family (see leaflet in Part 1 *Appendix 4*), based on a report from the Designated Paediatrician for Unexpected Deaths in Childhood, or LSCB Manager/SPOC.

9.2. The CDOP Chair should consider what feedback is given to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family.

9.3. The CDOP Chair should ensure that information is also received and evaluated by the CDOP regarding the services and immediate support offered to all families of children who have died.

10. Learning from child deaths and report to LSCB

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

10.2. The CDOP should identify any public health issues and consider, with the Director(s) of Public Health, how best to address these and their implications for both the provision of services and for training.

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

11. Reporting mechanisms

Each CDOP must submit an annual report to its respective LSCB. The LSCB is responsible for:

- Disseminating the lessons to be learnt to all relevant organisations.

- Ensuring that relevant findings inform the *Children and Young People's Plan.*
- Acting on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.
- Ensuring that data relating to child deaths is submitted to relevant regional and national initiatives to identify lessons on the prevention of unexpected child deaths.

APPENDIX 1

Child Death Overview Panel

Team Membership

The Child Death Overview Panel will have a permanent core membership drawn from the key organisations represented on the BLSCB. Other members may be co-opted to contribute to the discussion of certain types of death when they occur.

Core members

- Director of Public Health - Chair
- Coroner or Coroner's Officer
- Designated Paediatrician /SUDI paediatrician
- Children's Social Care
- Police
- Designated Nurse – BCT
- Representative of Hospital Trust - QMS
- Bereavement Counsellor
- Lay representative/Faith representative

Additional and ad hoc members

e.g. Midwifery
Consideration shall be given to include standing/co-opted members, particularly when specific issues are identified that require more specialist input. These members to be decided.

The role of Core CDR Team Members

1. Public Health:

The public health representative can:
- Provide the team with information on epidemiological and heath surveillance data
- Assist the team in strategies for data collection and analysis
- Assist the team in the evaluating patterns and trends in relation to child deaths and in learning lessons for preventative work
- Inform the team of public health initiatives to support child health
- Advise the team on the development and implementation of public health prevention activities and programmes

2. Coroner or Coroner's Officer

The coroner or coroner's officer can:
- Provide the team with information on the status and outcome of the coroner's investigation into an unexpected child death and explanation of the determined manner and cause of death
- Provide the team with information from the autopsy and other investigations
- Advise the team on the coronial processes, including appropriate governing legislation
- Assist in the development and implementation of strategies to improve the investigation of unexpected childhood deaths

3. Paediatrician:

The paediatrician can:
- Provide the team with information on the health of the child and other family members, including any general health issues, child development, and health services provided to the child or family
- Help the team interpret medical information relating to the child's death, including offering opinions on medical evidence; providing a medical explanation and interpretation of the circumstances surrounding a child's death
- Assist with interpreting the autopsy findings and results of medical investigations
- Advise the team on medical issues including child injuries and causes of child deaths, medical terminology, concepts and practices
- Provide feedback and support to medical practitioners involved in individual case management
- Liaise with other health professionals and agencies

4. Children's Social Care:

The children's social care representative can:
- Provide the team with information on any social care involvement with the child and family, including any child protection procedures
- Provide the team with information on other children in the home and any previous reports of neglect or abuse
- Help the team to evaluate issues relating to the family and social environment and circumstances surrounding the death
- Advise the team on children's rights and welfare, and on appropriate legislation and guidance relating to children
- Identify cases that may require a further child protection investigation, or a Serious Case Review
- Liaise with other Local Authority services
- Provide feedback to social workers and other Local Authority staff involved in individual case management

5. Police:

The police representative can:

- Provide the team with information on the status of any criminal investigation
- Provide the team with information on the criminal histories of family members and suspects
- Identify cases that may require a further police investigation
- Provide the team with expertise on law enforcement practices including investigations, interviews and evidence collection
- Help the team evaluate any issues of public risk arising out of the review of individual deaths
- Liaise with other police departments, and the crown prosecution service
- Feedback to police officers involved in individual case management

6. Designated Nurse:

The child health nurse representative can:

- Provide the team with information on the health of the child and other family members, including primary care services provided to the child and family
- Help the team to evaluate health issues relating to the circumstances of the child's death
- Advise the team on nursing practices that may have had a bearing on the child's health or well-being
- Assist the team in developing appropriate preventive strategies
- Liaise with other nursing and allied health professionals
- Provide feedback and support to nursing colleagues involved in individual case management

7. Hospital Trust Representative – QMS:

The hospital trust representative can:

- Provide the team with information on the circumstances of death in the hospital
- Provide resuscitation and certification processes
- Obtain information from the hospital consultant in respect of a child's pre-existing condition
- Assist the team in developing policy and procedures in relation to links with the hospitals

Agency Report Form

APPENDIX 2

This form to be returned to CDOP Manager at: email

judi.moylan@bexley.gov.uk

Address: Fax:

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.

The first page of this form may be removed for the purposes of anonymisation prior to discussion at the CDOP

A Identifying and Reporting Details

Name **DOB:**
NHS No. **Date of Death**
Gender **Male / Female**

Address	

Agency Report provided by:
Agency **Name**
Address

Tel No **E-Mail address**

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/cessation 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 Department** ☐ **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 B-2
☐ **Drowning**	Complete B-3
☐ **Fire / burns**	Complete B-4
☐ **Poisoning**	Complete B-5
☐**Other accident**	Complete B-6
☐ **Substance misuse**	Complete B-7
☐ **Apparent homicide**	Complete B-8
☐ **Apparent suicide**	Complete B-9
☐ **Sudden unexpected death in infancy**	Complete B-10

Was a post-mortem examination carried out?	**Yes / No**	If yes, complete B-11

* place where the child is believed to have died, or where the event directly leading to death occured. For example, if a child is involved in a road traffic accident, and is resuscitated but subequently dies, the location of death should be recorded as the site of the collision, rather than the hospital where the child's death was confirmed

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 the death
Early family history
Pregnancy and birth
Infancy
Pre-school
School years
Adolescence

C The Child

Birth weight lb oz or kg		**Gestational age at birth (completed weeks):**
Any known medical conditions at the time of death?	**Yes / No**	**If yes, provide details**
Any known developmental impairment or disability at the time of death?	**Yes / No**	**If yes, provide details**
Any medication at the time of death?	**Yes / No**	**If yes, 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 time of death** ☐ **Previously** ☐ **Not at all**	
	Category	☐ **Physical abuse** ☐ **Neglect** ☐ **Emotional abuse** ☐ **Sexual abuse** ☐ **Not known**
Was the child subject to any statutory orders?	☐ **At time of death** ☐ **Previously** ☐ **Not at all** **Category of most recent 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?	☐ **At time of death** ☐ **Previously** ☐ **Not at all**	
Were any siblings subject to a child protection plan?	☐ **At time of death** ☐ **Previously** ☐ **Not at all**	
Were any siblings subject to any statutory orders?	☐ **At 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 deficits.

E Family and Environment

Mother

Age		**Occupation:**
Smoker	**Yes / No**	
Any known:		
Disability, including learning disability?	**Yes / No**	**If yes, provide details**
mental health issues?	**Yes / No**	
substance misuse?	**Yes / No**	
alcohol misuse?	**Yes / No**	
Known to police	**Yes / No**	**Details**

Father

Age		**Occupation:**
Smoker	**Yes / No**	
Any known:		
Disability, including learning disability?	**Yes / No**	**If yes, provide details**
mental health issues?	**Yes / No**	
substance misuse?	**Yes / No**	
alcohol misuse?	**Yes / No**	
Known to police	**Yes / No**	**Details**

Other significant adult (e.g. Mother's partner; significant carer. Add as many as required) Complete details as above for each.		**Relationship to child**
Any known domestic violence in the household?	**Yes / No**	**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 Department			
□ General Practitioner			
□ Health Visitor			
□ School Nurse			
□ CAMHS			
□ Other (please specify)			
□ Police			
□ Children's Services			
□ Education			
□ Connexions			
□ Probation			
□ Other (please specify)			

Factors in relation to service provision:

Include any identified services (both required and provided); any gaps between the child's or family'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 multiagency discussion

Form B2 – Road Traffic Accidents

Date of incident … / … / …

Collision time … : …

Casualty class
- ☐ Driver or rider
- ☐ Pedestrian
- ☐ Vehicle or pillion passenger
- ☐ Not known

If child was driver or passenger or 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 driver or passenger

Type of vehicle 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 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, not on refuge island or central reservation ☐ In carriageway, not crossing ☐ On footway or verge ☐ Not known ☐ Other, specify

If pedal cycle or motor cycle:

Was a helmet worn?	☐ Yes ☐ No ☐ Not known

Form B3 - Drowning

Type of drowning	□ Bath	
	□ Garden pond	
	□ River / lake / canal	
	□ Sea	
	□ Swimming pool	□ Domestic
		□ Private
		□ Municipal
		□ Not known
	□ Not known	
	□Other, 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 / burn	☐ Fire ☐ Electrical ☐ Chemical ☐ Hot liquid ☐ Other ☐ Not known		
If fire:			
Location of fire	☐ Residential accommodation, specify ☐ Main trade or business, specify ☐ Mobile, specify ☐ Other, specify ☐ Not known		
Was a fire / smoke alarm present?	☐ Yes ☐ No ☐ Not known	Was fire / smoke alarm functional?	☐ Yes ☐ No ☐ Not known

Form B5 - Poisoning

Form of substance	☐ Solid ☐ Gas ☐ Liquid ☐ Unspecified
Type of substance	☐ Household products, specify ☐ Prescription medicines, specify ☐ Non-prescription medicines, 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 institution ☐ Public building ☐ Other building ☐ Other, 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 to 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, specify

Form B8 - Apparent homicide

Method	☐ Strangulation, asphyxiation or drowning ☐ Shooting ☐ Sharp instrument ☐ Hitting or kicking ☐ Blunt instrument ☐ Fire ☐ Poisoning, specify type ☐ Other, 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)	□ Self-poisoning	□ Household products, specify □ Prescription medicines, specify □ Non-prescription medicines, specify □ Other, specify □ Not known
	□ 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 vehicle □ Other, specify □ Not known

Form B10 - Sudden unexpected death in infancy

Question	Options	
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 ☐ Cot ☐ Carry cot ☐ Sofa ☐ Moses basket	☐ Car chair ☐ Pram ☐ Not known ☐ Other, specify
Did any of the main carers or household members smoke?	☐ Yes ☐ No ☐ Not known	

Form B11 - Summary of postmortem findings.

Authorisation for Postmortem
- ☐ Coroner
- ☐ Consent of family member

Pathologist conducting postmortem
- ☐ paediatric pathologist
- ☐ general (adult) pathologist
- ☐ forensic pathologist
- ☐ other (specify)

Summary of clinical history from pathologist.

Ancillary investigations carried out
- ☐ Scene/circumstances investigation (specify what, when, by whom and summarise results)
- ☐ Xray skeletal survey (specify by whom & results)
- ☐ Microbiology (specify what, when & results)
- ☐ Virology (specify what, when & results)
- ☐ Toxicology (specify)
- ☐ Metabolic investigations (specify)
- ☐ Cytogenetics (chromosomes)
- ☐ Other investigations (specify)

Summary of Gross (naked eye) pathology findings

Summary of Histopathology findings

Summary of Pathologist's conclusions on cause of death and contributory factors

Cause of Death as given by Pathologist

Ia…………………………………..
Ib…………………………………..
Ic…………………………………..
II…………………………………….

Any other relevant information from Postmortem examination

Name of person completing this form
Designation　　　　Date

APPENDIX 3

Appendix 3: Threshold criteria

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

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

Cause of death may be reviewed briefly to learn key lessons. These are likely to be the substantial number of the deaths for review, and the majority are likely to be neonates. It is suggested that occasionally there should be a more detailed review of a random selection of some of these more 'straightforward' cases to look at them in more depth. The selection could be theme based on the cause of death (e.g. SUDI, cancer, congenital, other, etc).

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

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

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

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

This process requires secure communication systems to share information in a timely way.

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

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

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

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

Type of case	Core papers	Additional papers?	Process and planned outcome
	out in advance of meeting – resource and skills issue.)		recommendations

Level 2			
All alleged murders or violent deaths	Core papers	Any reports on outcomes of the criminal proceedings / coroner's inquest	Full discussion 30 – 45 minutes CDOP summary under agreed headings to be attached to the data to be sent to London-wide data collector / body e.g. – clinical issues, – preventability – clinical lessons – social / cultural lessons – systems lessons
Any death where criminal, coroner or civil proceedings or H&S Executive process are being considered as a result of the death Such cases cannot come to the panel for full discussion until after these proceedings have ended.	Core papers	Any reports on outcomes of the coroner / criminal proceedings / H&S Executive enquiry, NPSA or similar investigations or reviews *Issues disclosability and PII may arise if the panel seeks to discuss the case before the closure of other legal or quasi-legal processes.*	
Any death for which there has been an agency critical incident/ Serious Untoward Incident review	Core	Outcome of the SUI, Serious Untoward Incident Report and Review	
Any death which remains unexplained	Core papers		

<table>
<tr><td>Any death where the ‘parenting’ or lifestyle or pre-death care, behaviour of the parent, carer or key family member is a possible contributing factor in the child’s death</td><td>Core papers</td><td>May require additional reports from adult services, mental health services or substance misuse services

There will be issues of consent and proportionality from the parents or other family members in such information being shared – it may not meet an automatic information sharing threshold.</td><td rowspan="7">– practice lessons (pre and post death)
– recommendations

As above, it will be helpful to have a London wide approach to the outcome summary from the CDOP discussion, to be developed over time under some agreed headings to aid review and data collection

Full discussion
30 – 45 minutes

CDOP summary under agreed headings to be attached to the data to be sent up London-wide
e.g.
– clinical issues,
– preventability
– clinical lessons</td></tr>
<tr><td>Level 2 continued</td><td></td><td></td></tr>
<tr><td>All traffic deaths</td><td>Core papers</td><td>Input to CDOP from traffic specialist – possible information about ‘school travel plan’ for child’s school, if appropriate, etc</td></tr>
<tr><td>All deaths resulting from suicides and self harming behaviours</td><td>Core papers</td><td>Psychiatric review of the papers?</td></tr>
<tr><td>Drowning, death by fire, death by animal</td><td>Core papers</td><td>Other relevant reports – police / HSE? LFB etc</td></tr>
<tr><td>Accidents / unintentional</td><td>Core papers</td><td></td></tr>
<tr><td>Any death where the death although ‘later’ may be directly earlier attributed to an act of violence, assault, lapse of care or self-harming behaviour some time before but which may not have been the immediate cause of</td><td>Core papers</td><td>Relevant incident based reports from police and possibly health</td></tr>
</table>

death at the time of the death			– social/cultural lessons – systems lessons – practice lessons (pre and post death) – recommendations It would be helpful to have a London wide approach to the outcome summary from the CDOP discussion, where possible over time to be developed under some agreed headings
Any death which has attracted public or media interest, subject to the governance panel of LSCB	Core papers	Possibly summary of public / media coverage	
All deaths notified to DCSF / Ofsted under the notification system	Core papers		
Deaths arising from major incidents e.g. terrorism, major accidents	Core papers	Any relevant reports from HSE, other enquiries, investigations etc	
Level 3 (serious case reviews)			
Any SCR into the death of a child after the SCR is complete	Core data set only But no additional agency summaries as this will have been covered in the IMRs for the SCR	SCR overview report Any actions of Management Sub Group or QA sub group if relevant Any outcome from any criminal proceedings if relevant	Note the lessons and outcomes only for aggregation into the CDOP overall work