4. Merseyside Child Death Overview Panel (CDOP)

Introduction: Regulation

4.1 Regulation 6 of the Local Safeguarding Children Board Regulations 2006 places a statutory duty on LSCBs in relation to the deaths of any children normally resident in their area. Guidance regarding the process is provided in Chapter 5 of Working Together to Safeguard Children 2013. This function became a statutory requirement from 1st April 2008. This chapter will set out the principles relating to when a child dies in Liverpool Safeguarding Children Board area.

4.2 The guidance in this chapter relates to the deaths of all children and young people from birth (excluding those babies who are stillborn or planned terminations that are within the law but including children with life limiting conditions) up to the age of 18 years.

4.3 From April 2008 each of the Merseyside LSCBs, Knowsley, Liverpool, Sefton, St Helens, and Wirral operated CDOPs independent of each other. In April 2011 four of the Merseyside LSCBs merged, Knowsley remained independent until April 2014 but is now part of Merseyside CDOP, hence these procedures apply all LSCB areas in Merseyside.

4.4 There are two interrelated processes for reviewing child deaths:

a) A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child;

b) An overview of child deaths in Liverpool LSCB area undertaken by the Merseyside Child Death Overview Panel.

4.5 Regulation 6 (LSCB Regulations 2006) requires the collection and analysis of information about each child death known to agencies in their area with a view to identifying:

i. Any case giving rise to the need for a Serious Case Review

ii. Any matters of concern affecting the safety and welfare of children in the area of the authority;

iii. Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area,

And

4.6 Putting in place procedures for ensuring that there is a coordinated response by the authority, their LSCB partners and other relevant persons to an unexpected death.

Overall Principles

4.7 The death of a child is traumatic for family members, hence subsequent enquiries/investigations should keep an appropriate balance between forensic and medical requirements and the family’s need for support. Children with a known
disability or a medical condition should be responded to in the same manner as any other children. A minority of unexpected deaths are the consequence of abuse or neglect, or are found to have abuse or neglect as an associated factor. In all cases enquiries should seek to understand the reasons for the child’s death, address the possible needs of other children in the household, the needs of all family members and also consider any lessons to be learnt about how best to safeguard and promote children’s welfare in the future. This should be done without compromising any potential investigation if one is being pursued.

4.8 At the same time families should be treated with sensitivity, discretion and respect and professionals should approach their enquiries with an open mind.

4.9 For all child deaths from 0-18 years, irrespective of age, a review by CDOP is progressed.

Process

4.10 Following a child death paediatric liaison staff in hospitals, or identified staff in other health resources, complete an initial notification death (Form A) informing the Merseyside CDOP Manager and Administrator that a child death has occurred.

4.11 On receipt of an initial notification requests are sent to agencies to check their records. If the child or family members are known or have been known in the past agencies are required to complete an agency report with the information they hold and return to the CDOP team. All agency reports are merged into a single multi-agency report that is anonymised for panel members to receive. Multi-agency reports are disseminated in advance of the CDOP meeting to enable panel members to prepare for the meeting, and returned after the meeting to be destroyed. Merseyside CDOP holds copies of reports in relation to child deaths in a secure environment.

4.12 Each child’s death is considered in relation to the circumstances of the death, any factors pertinent to the child, family, or services provided and the analysis concludes with the categorisation of death and whether any modifiable factors are identified. If there are modifiable factors evident recommendations can be made to aim to prevent a death of a similar nature in the future. CDOP may identify issues that cannot be linked to the death but are nevertheless concerning and these, along with learning points and recommendations for change are referred to the respective agency and LSCB. Further information relating to the CDOP process can be found in the Merseyside CDOP Protocol (June 2014).

4.13 In circumstances where the death is unexpected and unexplained it will be necessary to pursue enquiries/investigations involving LSCB partner agencies, Police, Health and Social Care as a minimum but others as appropriate. In these circumstances agencies are required to follow the Merseyside Sudden Unexpected Death in Infancy (SUDI) Protocol (0-2 years) or the Sudden Unexpected Death in Childhood (SUDC) Protocol (2+18 years) It is important that an appropriate balance is achieved between forensic and medical requirements for investigation and the family’s need for support.
Definition of an Unexpected Death

4.14 An unexpected death is defined as “the death of a child that was not anticipated as a significant possibility, for example 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events that led to the death”.

4.15 The Designated Paediatrician should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt these procedures should be followed until the available evidence enables a different decision to be made, and always with the consent of the Coroner.

4.16 When a child dies unexpectedly, several investigative processes may be instigated, particularly when abuse or neglect is a factor. In following the SUDI or SUDC protocols the guidance will ensure that the relevant professionals and organisations work together in a co-coordinated way, in order to minimise duplication and ensure that the lessons learnt contribute to safeguarding and protecting the welfare of children in the future. Where there is an ongoing criminal investigation, the Crown Prosecution Service must be consulted as to what is appropriate for the professionals to be doing, and what actions to take in order not to prejudice any criminal proceedings.

Coroner

4.17 The Coroner is notified of all sudden unexpected deaths immediately after they occur and there is regular consultation with the Coroner for the duration of any investigation and subsequent proceedings as per the SUDI and SUDC protocols. Not all child deaths are notified to the Coroner if the cause of the child’s death is known and there are no concerning circumstances.

Involving Parents, Families and Carers

4.18 Merseyside CDOP has produced a leaflet entitled ‘What we have to do when a child dies’ that is distributed by Merseyside Registrars on behalf of CDOP. This occurs when the child’s death is registered. If an inquest is being held the leaflet is given as part of the Inquest pack as registration of the cause of death will not occur until the Inquest has concluded.

4.19 Parents, families and carers can participate in the CDOP process through conveying written or verbal information to the CDOP Manager or a panel member. They cannot attend the meeting, but can meet the CDOP Manager or a panel member should they wish.

4.20 The Department for Education produced a leaflet entitled ‘The Child Death Review’ that describes a number of processes associated with a child’s death, including the Inquest and post mortem, in addition to the review by a Child Death Overview Panel.