

## **South-West London Child Death Overview Panel & Child Death Review Process**

**To all South-West London Early Years Settings including childminders, Primary and Secondary Schools, and 6<sup>th</sup> Form Colleges.**

The SW London Child Death Overview Panel (SWL CDOP) is an inter-agency forum for Child Death Reviews comprising the boroughs of Croydon, Kingston Upon Thames, Merton, Richmond upon Thames, Sutton, and Wandsworth. The working arrangements follow the Child Death Review Statutory and Operational Guidance (England) (October 2018). This is the statutory guidance for reviewing child deaths in England. Member agencies include Acute Health (“Hospital”) Services, Children’s Social Care, Safeguarding Children, Police, and Specialist Agencies, such as the London Ambulance and Fire Service and Primary Care (Community Nursing, GP Practices.) When the child is of school age or was in education at the time of death, this also includes Education, comprising primary, secondary schools, and 6<sup>th</sup> form colleges, along with early years settings.

### **What is the purpose of a child death review and what is a CDOP?**

The child death review process is an analysis of deaths of children who die in England from birth up to 18 years of age. Child Death Overview Panels (CDOPs), which undertake a final local overview of child death reviews, are a statutory body and are accountable to their respective Local Authorities and Integrated Care Boards. Every child’s death is a devastating loss that profoundly affects the family involved. In addition to providing support to families and carers, staff involved in the care of the child should also be considered and offered appropriate help. This is grounded in respect of the rights of the child and their family, to prevent child deaths.

Learning lessons from CDOP activity is a priority and will have a positive impact on the safety, health, and wellbeing of children and young people, and ensure the learning is shared widely across the area, as well as regionally and nationally. Child Death reviews are also part of the organizational responses to patient safety incidents and now contribute to the SW London Patient Safety Strategy that is being implemented by the Integrated Care System (ICS) in 2023.

### **How may education and early years settings contribute to the child death review process?**

Deaths of children in the age groups beyond under 1 year of age are relatively rare, so involvement of early years and education settings in child death review processes is likely to be infrequent; However, when a child dies that attends an early years setting, school or college, the death affects not only the child’s family but also the education setting’s community.

At this time the borough’s single point of contact for the child death review process may get in touch with you to request a summary of the child’s education life, the education setting’s interaction with the parents, and the education setting community. This may also include arrangements for bereavement support that may need to be put in place to support the education setting, and any additional concerns, for example, media management, in liaison with the Police

and the Local Authority, including Education and/ or Public Health. Please note that in cases where there is a factor in the child's death that may require health promotion to recent contacts, your setting would be supported by a specialist public health protection team.

As a contributor to the review process, essential information needs to be gathered for all child deaths. This includes demographic data, and information relating to the circumstances of death and a summary of the deceased child's educational life, including any safeguarding concerns if known.

Please note: **Child Death Reviews as a statutory function are outside the remit of GDPR, and consent of living family members is not required.**

### **What we need to know about the child from your education setting**

A summary of the information CDOP needs from the early years setting, Primary, Secondary, or 6<sup>th</sup> form college concerning the child and family section of the reporting form is as follows (a single sentence or two is all that is required in many of these examples below):-

- (a) The date (month/year) the child joined and a summary of the attendance record for one academic year before the death.
- (b) Academic performance of up to one academic year.
- (c) Any known Physical/mental/learning disabilities.
- (d) The child's interaction with her teachers, peers, and the education community.
- (e) Did the child have any special interests (athlete, musician, artist, represented the school in any extra-curricular activities -the list is not exhaustive)
- (f) Any Safeguarding concerns: Domestic violence, alcohol, and substance abuse, neglect, children on a child protection plan, or child in need plan for any reason
- (g) Child/sibling(s) on an Education Health & Care Plan (EHCP) /any stated need plan or a child-in-need plan e.g., children with physical and learning disabilities.
- (h) Child on looked after plan or in a known fostering arrangement.
- (i) Has the education setting sought or been signposted for trauma/bereavement support by another service (e.g., Jigsaw), or if the staff team has been affected by the death, for bereavement support by another service/third sector charity?
- (j) If any of the child's siblings attend the same setting or another education setting has there been communication with the other setting for a joint understanding of the bereavement support offered or support given to the siblings in an education setting?

### **What happens immediately after a child's death?**

A number of decisions need to be made by professionals in the hours immediately following the death of a child. These include:

- how best to support the family, and the education community.
- whether the death meets the criteria for a **Joint Agency Response**.
- whether a Medical Certificate of Cause of Death (MCCD) can be issued, or whether a referral to the coroner is required; and
- whether the death meets the criteria for a NHS serious incident investigation.

Several notifications will also be made to other agencies, including the GP, Police, children's social care, and other professionals; to the Child Health Information System; and the relevant child death review partners and the child death overview panel.

### **What is a Joint Agency Response?**

A Joint Agency Response should be triggered if a child death:-

- is unexpected or could be due to external causes,
  - is sudden and there is no immediately apparent cause (incl. SUDI/C);
  - occurs in custody, or where the child was detained under the Mental Health Act,
  - where the initial circumstances raise any suspicions that the death may not have been natural;
- or
- in the case of a stillbirth where no healthcare professional was in attendance.

This is an important information-gathering process which may include one or more multi-agency meetings that take place within the immediate period following a child's death to establish as much information about the circumstances surrounding the death and consider safeguarding and support for those affected. Effective cross-agency working is key to the investigation of such deaths and to support the family and requires all professionals to keep each other informed, share relevant information between themselves, and work collaboratively. Education settings may be invited to nominate a representative to contribute to this process.

### **How is information gathered?**

The single points of contact (SPOCs) will make contact either by the eCDOP virtual case management system which opens an account for the setting and will send an authentication code to allow you to access a reporting form to be completed for the service or by email where a manual form will be sent to you for completion.

**You are only required to complete what you do know about the child and family using the asterisked\* questions - feel free to choose 'not known' entries which are pre-populated in the response box if you do not know that specific item of information.** Once the asterisked questions are completed you will see a green tick on the left indicating that the section is complete, and you can move to the next section. Once complete, you can upload any letter or document you wish to add to better explain (if required) to complete the report using the icon at the end of the report, and once you click 'save', the document will upload itself and form part of a consolidated reporting form from all services who have contributed information as part of the review.

If you have difficulty accessing the form via the eCDOP system, – an offline copy of the reporting form can be sent via the SPOC who can assist in uploading the report onto the system, which can be returned and sent via email to your local SPOC for upload.

**Contact information.**

For further information to assist completion of your **reporting forms** when requested or more information on the child death process, please do not hesitate to contact the single points of contact (SPOCs) as follows:-

Single Point of Contact	Borough	Email address
SW London CDOP Management email	South-West London CDOP	swl.cdop@swlondon.nhs.uk
Lorraine Beckford	Merton	lorraine.beckford@swlondon.nhs.uk
Sarah Bennett	Kingston & Richmond upon Thames	sarah.bennett@kingrichlscb.org.uk
Kelly Slade	Wandsworth	CDR.team@stgeorges.nhs.uk
Janet Han	Sutton	janet.han@nhs.net
Lauren East	Croydon	CDOPCroydon@croydon.gov.uk

If you wish to notify the South-West London Child Death Overview Panel of a child death, please use this online link to SWL CDOP – this can also connect you to any Child Death Overview Panel across England via SW London.

<https://www.ecdop.co.uk/SWLondon/Live/Public>

For more information on the Child Death Review process please review:-  
Child Death Review Statutory and Operational Guidance (England) (October 2018) These documents provide statutory guidance for reviewing child deaths in England.

<https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england>

**Support for your setting**

The following organisations/resources may be helpful to your setting in enabling support to those affected by a bereavement within your community

<https://www.educationsupport.org.uk/resources/for-individuals/guides/acknowledging-loss-and-bereavement-in-education-settings/>

<https://www.childbereavementuk.org/Listing/Category/schools-further-education>

<https://www.childdeathhelpline.org.uk/>

Please note you may also consider contacting your Local Authority settings lead for additional support for example Educational Psychology Service, Early Years Lead, etc.

