Medway Safeguarding Children Board

Management and review arrangements for all Child Deaths in Medway

Terms of reference:

The Rapid Response Team

The Child Death and Serious Case Review Screening Panel

The Child Death Overview Panel

2011

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Introduction

The Local Safeguarding Children Boards Regulations 2006 sets out the functions of the LSCB. LSCBs have the following functions in relation to the deaths of children normally resident in their area;

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

- (i) any case giving rise to the need for a Serious Case Review
- (ii) any matters of concern affecting the safety and welfare of children in Medway; and
- (iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in Medway; and

(b) putting in place procedures for ensuring that there is a co-ordinated response by the authority, their board partners and other relevant persons to an unexpected death.

This document details the management and review arrangements for all child deaths in Medway in support of this LSCB function.

Operational Functions

1. The Rapid Response Team

1.1 The Rapid Response Team is a group of key (multi agency) professionals who will come together to enquire into and evaluate each unexpected death of a child (i.e. the death was not expected as a significant possibility 24 hours before[1].)

1.2 The majority of child deaths will not raise any concerns for professionals, as they will have been due to natural causes, however there are some sudden deaths that do occur as the result of non-accidental injury, abuse or neglect. It is these deaths that will need further investigation with the first step being through the multi agency rapid response team.

1.3 The work of the team will be co-ordinated by the designated paediatrician responsible for unexpected child deaths who will be identified by the Medway NHS Foundation Trust.

1.4 The MSCB has published a procedure and practice guidance titled "Responding to the Unexpected Death of a Child" to accompany this document.

1.2 Membership

[1] Paragraphs 7.21 and 7.22, *Working Together to Safeguard Children*, 2010

1.2.1 The Rapid Response Team will be made up of those who are or will be involved with the child before/after his or her death:

- Paediatricians, A&E staff, Police, GP, Health Visitor, Social Workers/Children's social care and Nurses.
- If the child is new born then the midwife may be involved similarly the professionals who deal with parental issues such as mental health or substance abuse may also be part of the team.
- Where the child is older, more agencies may have relevant information such as teachers, other education professionals, and Youth Offending Team staff.

1.2.2 The majority of child deaths occur in the home at night, or in the early hours of the morning, with the ambulance service being first on the scene leading to the child being brought to the Accident and Emergency (A&E) Department. It is therefore within A&E that a Rapid Response Team is likely to function. This will involve the professionals who are on call and so some agencies listed above will not be available until the next working day if that agency has no on call rota for responding to unexpected deaths. Therefore it is vital that a process is in place to ensure all professionals who can contribute information are made aware as soon as possible.

1.3 Roles and responsibilities

1.3.1 The Rapid Response Team work together to;

- Respond quickly to the unexpected death of a child
- Make immediate enquires into and evaluating the reasons for the circumstances of the death, in agreement with the coroner
- Undertaking the types of enquiries/investigations that relate to the current responsibilities of their respective organisations when a child dies unexpectedly.
- Monitor the support and assessment services offered to families of children who have died, and where appropriate referring on to specialist bereavement services
- Collect information in a standard manner
- Ensure that all investigations around the death are carried out sensitively and to a high standard.
- Follow the death through and maintain contact at regular intervals with family members and other professionals who have ongoing responsibilities for other family members, to ensure they are informed and kept up to date with information about the child's death.

- Submit information by report (form b) to the Child Death Overview Panel covering factors relevant to the death, particularly any preventable factors.

1.4 Immediate Response (Please refer to chapter 7 of Working Together to Safeguard Children)

1.4.1 A baby or child who dies suddenly or unexpectedly at home should be taken to Medway Hospital's A&E Department.

1.4.2 It is important that professionals such as the Police, and where possible a member of the Child Abuse Investigation Unit, arrive at the hospital as soon as possible to liaise with the clinician for the child in order to start to find out what has happened. Even when the death is not at all suspicious the Police will be gathering information on behalf of the coroner.

1.4.3 Other members of the team such as the social worker, GP midwife or health visitor will attend but if time is of the essence may have to provide essential background information over the phone.

1.5 Unexpected deaths that are suspicious

1.5.1 The results of the initial medical/ police enquiries may mean that Kent and Medway Safeguarding Procedures will come into play and that a strategy meeting will be held to decide the next steps.

1.5.2 The Rapid Response Team would contribute to the strategy meeting and then the Lead Person would ensure that the Serious Case Review screening panel has the relevant details in order to decide if the circumstances around the child's death constitute a Serious Case or Lessons Learned Review.

Strategic Functions

There are two distinct core functions which are inter-related:

The Serious Case Review Screening Panel
Child Death Overview Panel (CDOP)

2. The Serious Case Review Screening Panel (SCRSP)

2.1 Purpose

2.1.1 The Serious Case Review Screening Panel acts as a sub-committee of the MSCB to consider cases where children have died or been seriously injured and identify (in line with requirements set out in Working

Together chapter 8) any case giving rise to the need for a Serious Case Review (SCR). The process for making referrals to the SCR screening panel can be found in the MSCB practice guidance on Serious Case Reviews.

2.1.2 To consider whether to conduct a SCR whenever a child has been seriously harmed in the following situations:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect, or
- a child has been seriously harmed as a result of being subjected to sexual abuse, or
- a parent has been murdered and a domestic homicide review is being initiated, or
- a child has been seriously harmed following a violent assault perpetrated by another child or an adult.

And the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter agency and/or inter disciplinary working.

2.1.3 The multi agency SCRSP will establish whether or not the criteria for an SCR has been met, and make a recommendation to the MSCB chair accordingly.

2.1.4 Questions that may help in deciding whether a case should be the subject of a SCR are in Working Together to safeguard children 2010, 8.12.

2.1.5 The decision to undertake a serious case review ultimately rest with the MSCB chair.

2.1.6 Where the threshold for undertaking a serious case review is not met, but where an incident has occurred and there are concerns about multi-agency working to safeguard children and promote their welfare, then the screening panel will consider the need for a lessons learned review or single agency review. For example, where a child has died of natural causes, but multi-agency working has been found to be a cause for concern.

2.2 Scope

2.2.1 The SCRSP will consider any referral about all deaths and serious incidents of all children and young people from birth (excluding those babies who are stillborn) up to the age of 18 years who are normally resident in Medway. This will include neonatal deaths, expected and unexpected deaths in infants and in older children.

2.2.2 The Panel will consider all cases presented relating to any concerns that may have been identified and make decisions about whether a Serious Case Review, Lessons Learned Review or some other form of single or inter-agency review is required.

2.2.3 If it is agreed that further review is required, the SCRSP will identify the composition of a Review panel and agree a Terms of Reference.

2.3 Frequency of Meetings

2.3.1 The SCRSP will be called to meet as soon as possible whenever a referral is received.

2.4 Panel Membership

2.4.1 The core membership of the SCRSP will be made up of representatives of MSCB member agencies. These representatives should:

- Be able to represent their organisation's views, policies and practice appropriately, and have been explicitly given the mandate to do so.
- Have sufficient experience and knowledge of the field to inform the debate and the matters under consideration.
- Be an individual of sufficient seniority to ensure that recommendations arising from the Serious Case Review Panel are appropriately addressed within individual agencies.

2.4.2 The membership as a minimum should consist of

Social Care (Adult and Children's Services)
Designated Doctor
Designated Nurse
Probation
Police – PPU
Education Safeguarding
GP Representative

2.4.3 Other members may be co-opted to contribute to the discussion of certain types of cases when they occur.

2.4.4 The SCRSP will be administered by the MSCB Administrator or the Child Death Review coordinator.

2.5 Chairing Arrangements

2.5.1 The Assistant Director of Children's Care at Medway Council will chair the SCRSP.

2.6 Confidentiality and Information Sharing

2.6.1 Information discussed at the Panel meetings will not be anonymised prior to the meeting; it is therefore essential that all members adhere to strict guidelines on confidentiality and information sharing. Information is being shared in the public interest for the purposes set out in Working Together and is bound by legislation on data protection.

2.6.2 Panel members will all be required to sign a confidentiality agreement before participating in the Panel process. Any ad-hoc or co-opted members and observers will also be required to sign the confidentiality agreement. At each meeting of the Panel, all participants will be required to sign an attendance sheet, confirming that they have understood and signed the confidentiality agreement.

2.7 Accountability and Reporting arrangements

2.7.1 The Panel will be accountable to the chair of the Medway Safeguarding Children Board.

The Child Death Overview Panel (CDOP)

The Child Death Overview Panel (CDOP)

2.8 Purpose

2.8.1 Through a comprehensive and multidisciplinary review of child deaths, the Medway Child Death Overview Panel (CDOP) aims to better understand how and why children in Medway die and use our findings to take action to prevent other deaths and improve the health and safety of our children.

2.8.2 In carrying out activities to pursue this purpose, the CDOP will meet the functions set out in paragraph 7.36 of *Working Together to Safeguard Children 2010* in relation to the deaths of any children normally resident in Medway.

2.9 Functions

- To review the available information on all child deaths of children aged up to 18 years to determine whether the death was preventable.

- Make recommendations to the MSCB or other relevant bodies as soon as these have been decided in order that prompt action can be taken to prevent future such deaths where possible.
- Implement, in consultation with the local Coroner, local procedures and protocols that are in line with the guidance in Chapter 7 of *Working Together* on enquiring into unexpected deaths, and evaluating these as part of the information set held on all deaths in childhood.
- Collect and collate an agreed minimum data set of information on each child death in Medway and, where relevant, to seek additional information from professionals and family members.
- Evaluate data on the deaths of all children normally resident in Medway, thereby identifying lessons to be learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children.
- Identify any patterns or trends in the local data and report these to the MSCB. This includes identifying significant risk factors and trends in individual child deaths and in the overall patterns of deaths in Medway, including relevant environmental, social, health and cultural aspects of each death, and any systemic or structural factors affecting children's well-being to ensure a thorough consideration of how such deaths might be prevented in the future.
- Meet frequently to review and evaluate the routinely collected data on the deaths of all children, and thereby identifying lessons to be learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children.
- Have a mechanism to evaluate specific cases in depth, where necessary, at subsequent meetings. This may involve revisiting child deaths after the outcome of other types of investigations is known.
- Monitor the appropriateness of the response of professionals to an unexpected death of a child; reviewing the reports produced by the rapid response team in each unexpected death of a child.
- Review the appropriateness of the professionals' responses to each death of a child, their involvement before and at the time of the death, and relevant environmental, social, health and cultural aspects of each death, to ensure a thorough consideration of how such deaths might be prevented in the future.
- Refer to the chair of the MSCB any deaths where, on evaluating the available information, the panel considers there may be grounds to undertake further enquiries, investigations or a SCR and explore why this had not previously been recognised.
- Inform the MSCB chair 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.

- Advising and monitoring the MSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths.
- Organise and monitor the collection of data for the nationally agreed data set, and making recommendations for any additional data to be collected locally.
- Identify any public health issues and consider how best to address these and their implications for both the provision of services and for training.
- Cooperate with regional and national initiatives to identify lessons on the prevention of child deaths.
- Increase public awareness and advocacy for the issues that affect the health and safety of children
- Identify and advocate for needed changes in legislation, policy and practices to promote child health and safety and to prevent child deaths.

2.10 Scope

2.10.1 The CDOP will gather and assess data on the deaths of all children and young people from birth (excluding those babies who are stillborn) up to the age of 18 years who are normally resident in Medway, irrespective of where they die. This will include neonatal deaths, expected and unexpected deaths in infants and in older children.

2.10.2 Where a child normally resident in another area dies within Medway, that death shall be notified to the CDOP in the child's area of residence. Similarly, when a child normally resident Medway dies outside Medway the Medway CDOP should be notified via the Child Death Review Coordinator. In both cases an agreement should be made as to which CDO P (normally that of the child's area of residence) will review the child's death and how they will report to the other.

2.11 Panel Membership

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

2.11.2 Membership for 2011-2012

Director of Public Health, NHS Medway/Medway Council
Assistant Director, Children's Care, Medway Council
Operational Safeguarding Lead, Children's Care, Medway Council
Designated Doctor for Child Death (Neonatal), Medway NHS Foundation Trust (FT)

Designated Paediatrician for Unexpected Death in Childhood, Medway NHS FT
Designated Nurse Medway, Safeguarding Children, NHS Kent and Medway
Named Midwife, Child protection, Medway NHS FT
Detective Inspector, Kent Police
Safeguarding Manager, South East Coast NHS Ambulance Trust
Service Manager, Adults services, Medway Council
Child Death Review coordinator, MSCB

2.11.3 Examples of co-opted members are CAHMS, Coroner, CAFCASS, Probation, Education, Kent Fire and Rescue service; according to the contribution needed.

2.11.4 The Medway CDOP is scheduled to meet monthly, subject to need.

2.12 Chairing Arrangements

2.12.1 The Director of Public Health, a member of the MSCB, will chair the Child Death Overview Panel.

2.12.2 The chair is responsible for;

- Charing CDOP meetings, encouraging all members to participate appropriately;
- Ensuring all statutory requirements are met;
- Maintaining a focus on preventative work;
- Facilitating resolution of agency disputes;
- Ensuring that this process operates effectively;
- To lead the panel to agree on the category for cause of death;
- To lead the panel's discussion and identification of any factors which, may have contributed to the death of the child that could be modified to reduce the risk of future child deaths.
- Approve all decisions where a death was deemed preventable.

2.13 Administrative arrangements

2.13.1 The MSCB Child Death database is owned by the chair of the MSCB and managed by the MSCB Child Death Review coordinator. The database will be operated in accordance with the data protection, audit and information security policies of the host agency for the MSCB Child Death Review coordinator and database.

2.13.2 Complaints received regarding the actions of an individual professional or agency will be directed to the relevant agency and dealt with under that agency's complaints procedure. Any other complaints regarding the application of these procedures by the

CDOP or a professional operating on their behalf will be referred to the chair of the MSCB.

2.13.3 The Medway Council Press Office, on behalf of the MSCB, will deal with all media issues relating to the work of the Child Death Review Panel and Child Death review process in Medway.

2.13.4 The MSCB Child Death Review coordinator will, in conjunction with the MSCB Manager, ensure that an up to date and accessible directory of relevant legislation, guidance and information sources is maintained by the MSCB for use by professionals and members of the public, and accessible via the MSCB website.

2.14 Confidentiality and Information Sharing

2.14.1 In accordance with Working Together 2010 panel members will receive anonymised Form As and collated Form Bs prior to the CDOP meeting. Panel members will be provided with any additional papers as required at meetings.

2.14.2 Any reports, minutes and recommendation arising from a CDOP meeting will be fully anonymised and steps taken to ensure that no personal information can be identified.

2.15 Accountability and Reporting arrangements

2.15.1 The CDOP will be accountable to the chair of the Medway Safeguarding Children Board.

2.15.2 The Child Death Overview Panel is responsible for developing its work plan, which should be approved by the MSCB. It will prepare an annual report for the MSCB, which is responsible for publishing relevant, anonymised information.

2.15.3 The MSCB takes responsibility for disseminating the lessons to be learnt to all relevant organisations, ensures that relevant findings inform the Children and Young People's Plan and acts on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.

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

2.16 Professional and family support

2.16.1 Professionals that are involved in the Child Death response and review processes should ensure that they have adequate professional support for their role.

2.16.2 CDOP have produced an information leaflet for parents to explain the process of review for their child's death and invites them to contribute. The leaflet gives details of some bereavement support organisations. However, bereavement support should be offered in the first instance from health services.

2.17 Data collection and storage

2.17.1 Copies of physical datasets will be stored securely at Gun Wharf, and accessible to the Child Death Review coordinator and the MSCB administrator in the coordinators absence. Information from the datasets will also be transferred to a child death database, owned by the MSCB and managed by the MSCB CDR coordinator. The data protection and information security policies of Medway Council as the host agency for the CDR coordinator and the MSCB administrator will be applied to the management of information held.

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