Child Death Review Overview Panel

Annual Report 2008-09

FOREWORD

Understanding the causes of deaths in childhood is the first step in being able to take effective action in preventing future deaths. The Child Death Overview Panel was established in Medway in April 2008 to review the deaths of all children in Medway and identify trends and matters of concern. During our first year significant progress has been made in developing processes for the notification of deaths, the Rapid Response and the Child Death Overview Panel. We have reviewed the deaths of 13 children which will allow us to develop a more systematic and detailed understanding of the causes of death and identify priorities for preventative action.

Dr Alison Barnett
Director of Public Health, NHS Medway & Medway Council

Chair, Child Death Review Overview Panel

1. INTRODUCTION

1.1 The publication in 2006 of *Working Together to Safeguard Children* (hereafter *Working Together*) set out new processes in relation to reviewing child deaths. 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.

1.2 This report reviews the first operational year of Child Death Overview Panel in Medway. It will examine the first year's statistical data regarding child deaths and provide an overview of how child death processes have been working during the period.

2. BACKROUND

STATUTORY BASIS OF CHILD DEATH REVIEW ARRANGEMENTS

2.1 The Local Safeguarding Children Board Regulations 2006, Regulation 6, places a requirement on the Medway Safeguarding Children Board (MSCB) 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, in relation to the deaths of children normally resident in Medway:

(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) [*Serious Case Review*];
   (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; 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.

2.2 An unexpected death is defined as one which was not anticipated as a significant possibility 24 hours before the death or where there was similarly unexpected collapse leading to or precipitating the events which lead to the death.

3. Establishment of Child Death Review processes in Medway

3.1 Statutory guidance required the MSCB to have Child Death Review processes in place by 1 April 2008. A multi-agency working group was set up in 2007 to consider how Medway was to meet the challenge. This was chaired by the chair of the MSCB Quality Assurance and Case Review Subgroup, Medway Council's Assistant Director for Children's Care. Members of the working group, some of whom became members of the CDOP were supported by the MSCB to attend regional seminars delivered by the DCSF and CEMACH during the planning period.

3.2 Working Together recommended that Child Death Overview Panels (CDOPs) should be established for a 500,000 minimum population. Initially, it was proposed that Kent and Medway join together to develop such processes (Medway's total population according to the 2001 census is 250,000 with 69,000 children and young people) given that many key stakeholders provide services across both Kent and Medway - eg Kent Police, Kent Probation, South East Coast NHS Ambulance Trust, Medway NHS Foundation Trust and NHS Medway.

3.3 However, this proposal was not endorsed by the Kent Safeguarding Children Board and Medway set up its own processes. The small population has meant significant challenges are posed to identify trends and patterns.

3.4 This working group developed a terms of reference for the CDOP as well as a set of procedures and protocols pertaining to the Rapid Response and the CDOP as well as a set of standard recording templates to support the process based upon those put forward by the DCSF. A secure email address and inbox were set up to facilitate the notification process. These can be found on the MSCB website at www.mscb.org.uk.

3.5 The procedures were ratified by the MSCB in November 2007 and have been subject to review throughout the period, with the agreement that they would be updated to ensure that they were fit for purpose after the had been in place and tested during the first year. The procedures will be redrafted to reflect the lessons that have been learned during the first year of implementation and will be in line with new Statutory Guidance due to be published in December 2009.

3.6 The CDOP is chaired by the Director of Public Health. It was supported by the MSCB Manager and the MSCB Administrator during the period 2008-09 and it is proposed that this will be supplemented in 2009-10 by the appointment of a MSCB Development Officer.

3.7 The CDOP in Medway has been well supported by its constituent partners during this initial period, with positive engagement with the Coronial service and Medway Register Officer.

3.8 The MSCB Quality Assurance and Case Review Subgroup oversees the review of Child Deaths in Medway and reports directly via the subgroup chair to the Medway Safeguarding Children Board Executive on a regular basis. The chair of the CDOP will become an associate member of the MSCB in May 2009.

4. Training

4.1 The CDOP has been supported by the commissioning by the MSCB of a half day workshop delivered by Dr Tracey Ward, Designated Paediatrician for Unexpected Child Deaths from East Sussex, one of the Child Death Pilot sites. Group discussions and presentations have also been facilitated with the working group when the "Why Jason Died" DVD and training materials were used.

4.2 The CDOP has identified a need for further training for its members as well as practitioners who may be involved with Rapid response. These will be rolled out during 2009.

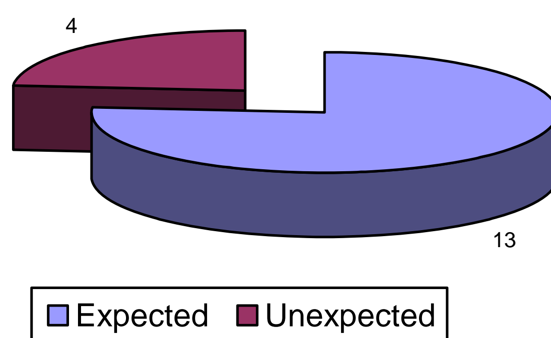
5. Datasets/Summary of Activity

Data Summary	
Total child deaths recorded in Medway	45
No of Medway Children	17
No of Expected deaths (fig 1)	13
No of Unexpected deaths (fig 1)	4
No of children from Medway who died in Medway	13

5.1 At the time of writing, the Medway CDOP has completed reviews of 13 cases – twelve expected and one unexpected death. One unexpected death was referred to the MSCB for consideration by the Serious Case Review Panel and a Serious Case Review is currently underway in accordance with Chapter 8 of Working Together. The Rapid Response for this case has not been completed, but the case will return to the CDOP once the Serious Case Review has been completed in July 2009. The Rapid Response is likely not to be concluded until the Coroners Inquest later in the year.

5.2 Of the remaining two unexpected deaths that have been subject to a rapid response, one is awaiting a post-mortem, the other is awaiting a reconvened rapid response to consider post-mortem results.

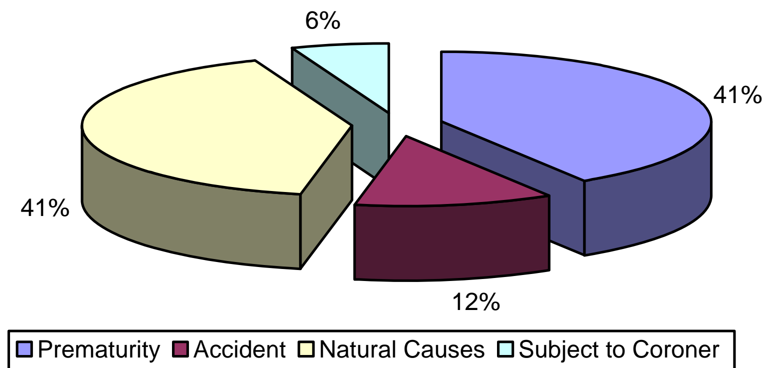
Fig 1: Total Deaths Expected/Unexpected



5.3 The CDOP has worked well during the year and has had a committed membership. The completion of some reviews was delayed pending clarification about the remit of the CDOP to review all child deaths, including neonates and an inquorate CDOP meeting, which was unable to sign off completed reviews. The inquorate meeting was reconvened and 13 cases have now been reviewed.

5.4 The cases reviewed to date show that in the majority of cases, the primary cause of death was due to prematurity or natural causes.

Fig 2: Primary Cause of death



5.5 Twelve child deaths during the review period were deemed by the panel to have been non preventable. In one case the panel, despite guidance from the Government Office and the DCSF, concluded that it did not have adequate information to categorise the death as preventable or non-preventable.

Fig 3: Preventability of Death

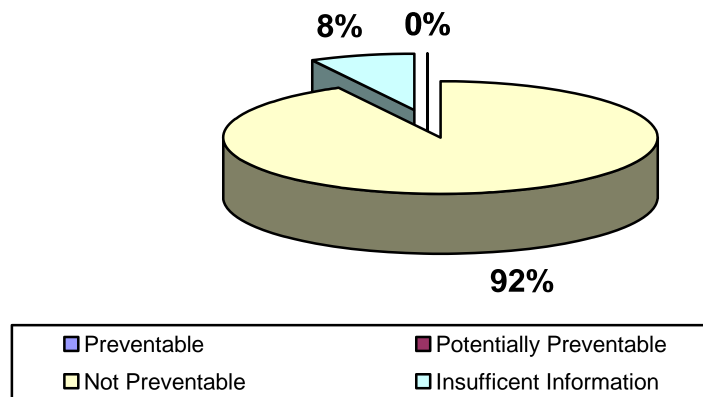


Fig 4: Deaths By Age

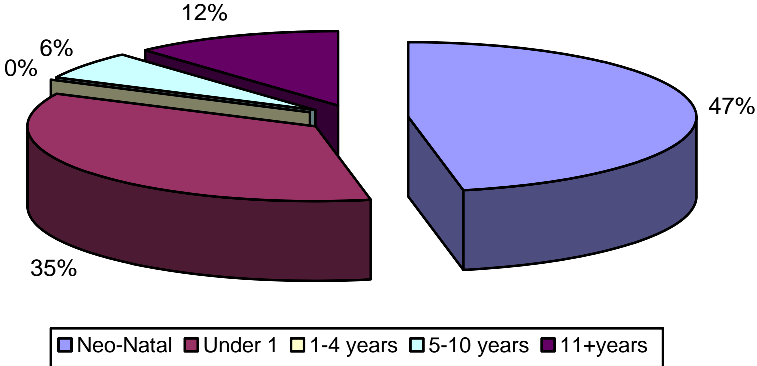


Fig 5: Deaths By Ethnicity

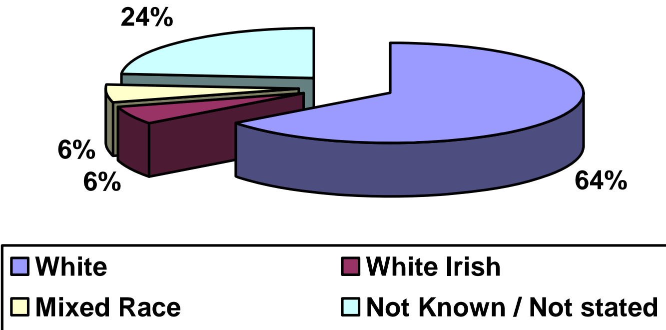
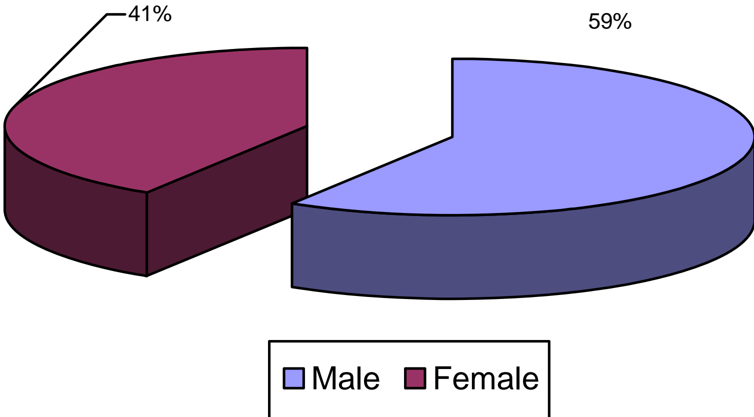


Fig 6: Deaths by Gender



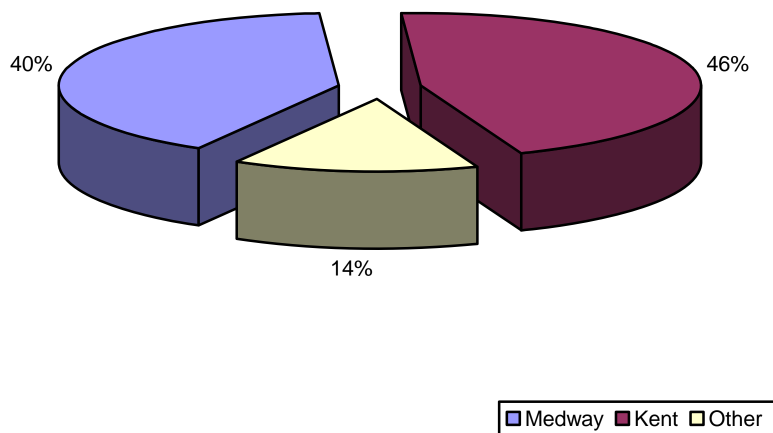
6. Monitoring the effectiveness of the Child Death Review Arrangements

6.1 Please refer to Appendix I, self-assessment return for performance of Medway against PSA 13, Indicator 4: Preventable child deaths as recorded through child death review panel processes.

Notification Process

6.2 The notification process is coordinated by the MSCB Administrator via a secure "Child Death Notification Inbox". This works well. The notification process is clear and positive working relationships have been developed between the MSCB Administrator and those responsible for notifications with in Medway NHS Foundation Trust (where the large majority of deaths are recorded). Verbal notification is made immediately and followed up within 24 hours in written format. Audit systems will be put in place later this year to map the notification although early indications are that this occurs in the majority of cases. There is confidence that notifications of all child deaths in Medway are captured. The notification process is explained via flowcharts which have been made available to partner agencies for display in key areas. Notifications from Medway NHS Foundation Trust are clear and detailed and improving all the time. Notifications made to other Local Safeguarding Children Board's by Medway are done so promptly however, notifications originating from outside Medway are not always received so promptly. The national database of child death notification contacts is not well maintained and often inaccurate, hampering the process.

Fig 7: % of Child Deaths By LA Area



6.3 The notification process when children die outside of the UK requires some improvement, although this is not something that can be influenced by MSCB alone and requires addressing at national level.

The CDOP has reviewed the case of a child who died whilst abroad on holiday. A child who dies abroad is subject to the jurisdiction of the local Coroner only on the return of the child's body to the UK. This makes the instigation of a rapid response difficult. Such issues will be reported to the Government Office by the MSCB.

Rapid Response

6.4 A preliminary audit of the Rapid Response is appended at Appendix I. A Designated Paediatrician for Unexpected Child Deaths is in post and a service level agreement has been signed between NHS Medway and the Medway NHS Foundation Trust. An initial lack of cover arrangements for the Designated Paediatrician resulted in some Rapid Response functions not being covered within the desired timeframe. Cover arrangements for the Designated Paediatrician have now been clarified. Furthermore, arrangements for older children (aged 16 and over) who die in adult wards in hospital have been put in place.

6.5 The Rapid Response process as required by Working Together has built upon the long established processes already in existence between the NHS, Medway Council and Kent Police. The key challenge has been the shift in responsibility for initiating rapid responses away from Medway Council and the Police and Health services in particular where the death occurred outside of Medway. .

Child Death Overview Panel

6.6 The functions of the Child Death Overview Panel are appended at Appendix III. A preliminary audit of the functioning of the CDOP is appended at Appendix I.

6.7 The CDOP has met 5 times during the period and has been well attended by partners. Eleven child deaths were reviewed at a re-convened meeting of the Child Death Overview Panel in May and thirteen reviews have now been completed. This is why there is a disparity between the statistical returns pertaining to preventability that will be submitted to the DCSF (see Appendix II) and the information reported on in the attached monitoring form (Appendix I).

6.8 The Panel has discussed ways in which neo-natal deaths can be recorded for both the purposes of the Foundation Trust and the CDOP to avoid duplication. It is felt that it would be useful for there to be some discussion at a national level of neo-natal and maternal mortality and how this fits in with the work of the Child Death Overview Panel. The Panel has also facilitated some useful discussions about the issues of preventability, which have helped the Panel to develop definitions when providing statutory reports to Government.

6.9 A key challenge to the CDOP during the period has been the small population and consequently the small number of deaths that have

occurred during the period, which the Panel has been able to review. This makes it difficult to identify trends or patterns which may relate to public health matters and/or identify lessons on the prevention of unexpected deaths.

6.10 Work will continue to improve the ways in which the CDOP review and comment on the appropriateness of professional response to unexpected child deaths.

7. Funding and support arrangements

7.1 The Area Based Grant 2008 includes a contribution to support Child Death arrangements and constituted £38,000 which was made available to the MSCB during the financial year. This sum was not ringfenced but was used to support the training needs of the Panel, the costs accrued by the serious case review which (at the time of writing) is being undertaken due to a child's death and also the funding of a part time administrative support assistant (this is estimated to cost in the region of £25,000). NHS Medway has a contract with Medway NHS Foundation Trust for £17,303 for the Designated Paediatrician and administrative support.

8. CDOP membership

Alison Barnett	Director of Public Health, NHS Medway / Medway Council
Caroline Budden	Assistant Director, Children's Care, Medway Council
Rena Merwaha	Designated Paediatrician for Unexpected Death in Childhood, Medway NHS Foundation Trust
Jane Mitchell	Safeguarding Manager, South East Coast NHS Ambulance Trust
Dominic Kilbride	Detective Inspector, Kent Police
Cathy Ross	Designated Safeguarding Nurse, Medway NHS
Clare Wilkes	Operational Safeguarding Lead, Medway Council
Bridget Bygrave-Relf	Joint Service Standards Manager, (Adult Social Care), Medway Council

9. Conclusion

9.1 Significant progress has been made in establishing the arrangements for effective working of the Child Death Overview Panel in its first year and procedures are in place for the prompt review of child deaths in Medway.

9.2 A significant proportion [41%] of childhood deaths in Medway in 2008-09 relate to prematurity [fig 2] and recommendations for 2009-2010 will be to focus on addressing the issue of prematurity. The risk factors associated with premature births are well described as pre- and ante-natal smoking, a lack of antenatal care, conception at a young age and social deprivation.

10. Recommendations

- All agencies to ensure their ongoing engagement and leadership of the Child Death Overview Panel processes.
- In view of the small numbers of deaths in Medway, and that 46% of deaths reported in Medway relate to Kent children [fig 7], the MSCB should investigate the feasibility of closer collaboration and/or merger with the Kent CDOP to allow more meaningful statistical analysis of causes of death.
- As part of its 2009/10 work programme, CDOP to review how agencies engage, provide information and support to bereaved families and gain feedback regarding services.
- CDOP to monitor the support and assessment services offered to families of children who have died.
- CDOP to ensure the promotion and implementation of public health programmes to address risk factors contributing to child mortality rates.
- The CDOP has identified a need for further training for its members as well as practitioners who may be involved with Rapid response. These will be rolled out during 2009.

May 2009

Appendix I

Monitoring the effectiveness of the Child Death Review arrangements

PSA 13, indicator 4: Preventable child deaths as recorded through child death review panel processes

Are Child Death Overview Panels (CDOP) organisational arrangements consistent with WT guidance?

	In place (Green)	Ongoing (Amber)	Not in Place (Red)	Additional Notes
1. Local Safeguarding Children Board (LSCB) has CDR sub-committee accountable to LSCB chair (7.7)	Yes			In place since April 2008 and has met on five occasions in 2008-09
2. The interface between Child death overview panel (CDOP), Local Safeguarding Children Board (LSCB) and Children's Trust in terms of accountability and performance is clearly defined.		Ongoing		Relationship between CDOP and LSCB is clear. Relationship to Children's Trust to be defined as part of review of LSCB Constitution in light of confirmed Government Guidance
3. LSCBs have agreed lines of accountability with CDOP (7.8).	Yes			CDOP feeds into Quality Assurance and Case Review Subgroup and then to the Executive Board.
4. CDOP has drawn up and agreed terms of reference covering its purpose, functions, scope, confidentiality etc	Yes			Responding to Unexpected Deaths in Medway Procedures and Practice Guidance ratified in November 2007
5. CDOP has an effective work plan and an established framework in place to report to the LSCB (7.56)	Yes			CDOP reports to LSCB on a regular basis (currently 6 monthly an Interim and Annual report, given the small numbers of child deaths to report on). Will feed in to QA framework of LSCB
6. LSCBs have locally agreed protocol with coronial service (including arrangements for unexpected deaths) (7.18)	Yes			Information is received appropriately from the Coroners' office but Coroners have decided not to be permanent members of CDOP

Appendix I

7. CDOP has permanent core membership, of appropriate level of seniority, including public health and child health (7.53)	Yes			CDOP core membership is in place, and is chaired by Director of Public Health
8. CDOP is chaired by a member of the LSCB who is not involved in direct service provision. (7.53)	Yes			DPH not a member of the LSCB but does not provide direct service.
9. The Panel chair is a member of the LSCB	Yes			The Chair of the CDOP panel a member of the Board from May 2009.
10. All child deaths are reported to the CDOP (7.51)	Yes			Deaths notified at each meeting.

Appendix I

Are key staff in place and operating effectively?

	In Place	Ongoing	Not in Place	Additional Notes
11. Senior person identified within each partner agency of LSCBs to be responsible for ensuring CD processes are implemented in accordance with local procedures (7.10)	Yes			Senior officers form panel membership. Issues of concern raised at panel when required.
12. PCT has access to a designated paediatrician (7.11)	Yes			Interim designated paediatrician in place and a member of the panel. Service Level agreement between PCT and hospital. Arrangements for permanency currently under discussion
13. Designated paediatrician sits on CDOP	Yes			Yes has attended 4 of 5 meetings.
14. LSCB has decided who is the designated person to whom child death notifications and other data should be sent (7.51)	Yes			Notifications sent to CDOP administrator [available during office hours]
15. Also note from above question:				As above
16. CDOP has permanent core membership, of appropriate level of seniority, including public health and child health (7.53)	Yes			As above
17. CDOP is chaired by a member of the LSCB who is not involved in direct service provision. (7.53)	Yes			As above
18. The Panel chair is a member of the LSCB			No	As above

Appendix I

Is the CDOP functioning effectively?

	In Place	Ongoing	Not in Place	Additional Notes
19. CDOP should have a clear relationship and agreed channels of communication with the local coronial service	Yes			As above
20. LSCB should ensure single and inter-agency training is made available (7.12)		Ongoing		Training has been made available to Panel members, Health and some operational managers. Attendance by key members at regional seminars during 2008. Further training for frontline practitioners being considered e.g. through Practitioners' For a. Arrangements to audit training by single agencies to be implemented in 2009
21. CDOP has effective data management systems in place to record, analyse and monitor childhood deaths and to meet intended purposes and outcomes	yes			Maintained by CDOP Administrator
22. CDOP reports in depth to LSCB all circumstances where abuse has been identified as, or suspected to be, a factor in the death of a child and where appropriate recommends consideration of an SCR	yes			Clear process for reporting cases of concern to LSCB is in place – SCR Panel via MSCB screening panel for case reviews. Has been tested
23. CDOP has agreed arrangements to support the identification of potentially preventable child deaths	Yes			The question of preventability is always considered when a death of a child is reviewed by the panel

Appendix I

24. CDOP makes recommendations relating to lessons to be learned from the review of child deaths	Yes			Has not been tested as so few reviews have been completed. However, CDOP has explicitly considered whether any recommendations are required in child deaths it has reviewed. No recommendations have so far been made as too few reviews have to date been completed.
25. CDOP monitors the appropriateness of the professionals response to each unexpected child death (7.50 + 7.55)	Yes			DCSF approved Agency Report Form used for this purpose and issues of concern will be raised and discussed by the Panel in the future (to date, too few reviews have been completed)
26. CDOP monitors the support and assessment of services offered to families of children who have died		Plan in place		This information is to be evidenced in the notifications submitted to panel.
27. CDOP helps to identify and report on any public health issues that may pose risks to children's health or development		Untested		Any identified public health risk would be reported directly via CDOP chair to the LSCB. None so far. Number of deaths and small population size makes it difficult to track trends
28. CDOP monitors and advises LSCBs on inter-agency resource and training requirements to deliver CDR arrangements effectively (7.55)	Yes			CDOP has identified need for frontline staff who may be required to contribute to rapid response out of hours and training for CDOP members.. Costs will be met from MSCB budget. MSCB training

Appendix I

				programme will include workshops and seminar for RR and CDOP members
29. Mechanisms in place to provide information/data requested for annual returns to DCSF	Yes			

How is the implementation of procedures for responding to the unexpected death of a child monitored?

Rapid Response

	In Place	Ongoing	Not in Place	Additional Notes
30. Unexpected deaths – all trusts follow local procedures for reporting and handling serious patient safety incidents. (7.15)		Ongoing		We have expressed a clear expectation to all providers that child deaths are, when appropriate, reported through the SUI system. We are awaiting assurance from Medway FT that they have amended their Serious Untoward Incident Policy to reflect this.
31. Information is collected and updated in accordance with the national data set (7.18)	Yes			
32. Rapid response procedures identify professional to support family wherever death occurs (7.19 and 7.20)	Yes			
33. Contact is made with other agencies who are involved with or who know the child (7.36)	Yes			Professionals identified at information sharing

Appendix I

				Any agencies not on the Panel identified at initial case discussion are identified and information requested.
34. When a child dies unexpectedly, an information sharing and planning discussion takes place immediately between lead agencies (7.35)	Yes			Planning and information sharing takes place immediately. Some delay to initial case discussion in a minority of cases due to unavailability of key staff.
35. All relevant medical educational and social information is submitted to the coroner within 28 days of the death (7.40)		Ongoing		Medical records are sent to Coroner, Discussions to be held at CDOP regarding social and educational information
All case discussions:				
36. Include all relevant professionals	Yes			Core membership of the group well established.
37. Share information and identify cause of death or contributory factors (7.43 + 7.45)	Yes			
38. Explicitly consider possibility of abuse or neglect (7.46)	Yes			At time of first meeting
39. Identify possible lessons learned	Yes			Process in place
40. Agree how information will be shared with parents, and who will support them (7.47)	Yes			
41. Are recorded	Yes			

Appendix I

Overview Panel

	In Place	Ongoing	Not in Place	Additional Notes
42. All deaths are subject to systematic review (7.50)	Yes			The process for monitoring all deaths is in place and will be evaluated in May 2009
43. Uses a framework to consider whether the death of a child was preventable.(7.50)	Yes			National Form C used in meetings, explicitly states question of preventability. Advice sought from GO where decision could not be reached on one particular case
44. Data analysis is used intelligently to recognise local risks/issues (7.50)	Yes			Although population is small, trends and patterns difficult to identify
45. Relevant findings from child death reviews inform the C&YP plan (7.57)				Too small a sample.
46. The relationship and lines of accountability between CDOP and LSCB are robust and support the challenging of local practice/arrangements where there are lessons to be learned from the death of a child	Yes			Recommendations from CDOP would be presented to the LSCB via QACR subgroup but untested as this has not yet arisen

Appendix II

Department for Children, Schools and Families

Form LSCB1

2008/09

Local Safeguarding Children Board (LSCB) Preventable Child Death Data Collection

This collection covers reviews of child deaths by your Local Safeguarding Children Board which took place between 01 April 2008 and 31 March 2009.

Submit completed forms by 29 May 2009

Please note if only one Local Authority is a member of your LSCB, please record information about this LA only in item number 2, 7, 12 and 17 and leave items 3-6, 8-11, 13-16 and 18-21 blank.
If your LSCB is the only member of your Child Death Overview Panel please leave items 22-26 blank.

Numbers of children

Data for the year to 31 March 2009

	Value			Item
Title of the Local Safeguarding Children Board:	MSCB			1
Name of Local Authorities which are members of your LSCB:				
Local Authority name 1	Medway			2
Local Authority name 2				3
Local Authority name 3				4
Local Authority name 4				5
Local Authority name 5				6
Local Authorities codes which are members of your LSCB:				
Local Authority Code 1 :	887			7
Local Authority Code 2 :				8
Local Authority Code 3 :				9
Local Authority Code 4 :				10
Local Authority Code 5 :				11
The number of child deaths which have been reviewed by your Child Death Overview Panel for your LSCB between 01 April 2008 and 31 March 2009, for each of the LAs which are members of your LSCB:				
Local Authority 1	2			12
Local Authority 2				13
Local Authority 3				14
Local Authority 4				15
Local Authority 5				16
Of these reviewed deaths, the number the panel assessed as being preventable (In accordance with the definition of preventable child deaths as described in PSA 13: Improving the safety of children and young people (2007)), for each of the LAs which are members of your LSCB:				
Local Authority 1	0			17
Local Authority 2				18
Local Authority 3				19
Local Authority 4				20
Local Authority 5				21
Is the Child Death Overview Panel which reviews the child deaths within your LSCB responsible for reviewing the deaths of children from any other LSCB area(s)? (If so please list the name(s) of the LSCBs below)				
LSCB 1	N/A			22
LSCB 2				23
LSCB 3				24
LSCB 4				25
LSCB 5				26

Appendix III

Functions of the Medway Child Death Overview Panel
(taken from Working Together to safeguard Children 2006, Chapter 7)

- implementing, in consultation with the local Coroner, local procedures and protocols that are in line with this guidance on enquiring into unexpected deaths, and evaluating these together with information about all deaths in childhood
- collecting and collating an agreed minimum data set and, where relevant, seeking information from professionals and family members
- meeting frequently to evaluate the routinely collected data (see paragraph 7.50) 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
- having a mechanism to evaluate specific cases in depth, where necessary, at subsequent meetings
- monitoring 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 Panel to consider and what actions it might take in order not to prejudice any criminal proceedings
- referring to the Chair of the LSCB any deaths where, on evaluating the available information, the Panel considers there may be grounds to undertake further enquiries, investigations or a Serious Case Review and explore why this had not previously been recognised
- informing the Chair of the LSCB where specific new information should be passed to the Coroner or other appropriate authorities
- providing 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
- monitoring the support and assessment services offered to families of children who have died
- monitoring and advising the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths
- organising and monitoring the collection of data for the nationally agreed minimum data set, and making recommendations (to be approved by LSCBs) for any additional data to be collected locally
- identifying any public health issues and considering, with the Director(s) of Public Health, how best to address these and their implications for both the provision of services and for training; and
- co-operating with regional and national initiatives – e.g. the Confidential Enquiry into Maternal and Child Health (CEMACH) (found at:www.cemach.org.uk/) – to identify lessons on the prevention of unexpected child deaths.