Multi-Agency Procedures in the case of Child Deaths in Jersey

January 2016

DOCUMENT PROFILE	
Document Status	Procedures document
Short Title	Multi – Agency Child Death Procedures
Document Purpose	To set out procedures to be followed for review of child deaths, including Rapid Response when a child dies unexpectedly.
Target Audience	Staff in statutory departments and non-government agencies who work with children in Jersey.
Author	States of Jersey Police and CDOP
Publication Date	January 2016
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Approval Route	CDOP, Core Business Group, Safeguarding Partnership Board
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Contents

1. Background to the Child Death Overview Panel

1.1 Introduction

The following document sets out processes to be followed when a child dies in Jersey.

Each death of a child is a tragedy and enquiries must keep an appropriate balance between forensic and medical requirements and supporting the family at a difficult time. Professionals supporting parents and family members must assure them that the objective of the child death review process is not to allocate blame, but to learn lessons. The purpose of the child death review is to help prevent further such child deaths.

The Safeguarding Partnership Board (SPB) is not a statutory body and these procedures are not legally enforceable. However they are based on best practice guidance from England and provide a framework which should be read in conjunction with Chapter of 5 of Working Together to Safeguard Children 2015[1]. Partnership arrangements locally are set out in a Memorandum of Understanding (MOU), which clarifies expectations on organisations with regard to safeguarding and working with the SPB.

1.2 Child Death Overview Panel (CDOP)

The SPB is responsible for ensuring that a review of each death of a child normally resident in Jersey is undertaken by a CDOP. To this end, a **CDOP** has been established between the Islands Child Protection Committee (ICPC), Guernsey and Alderney and the Safeguarding Children Partnership Board (SPB), Jersey. This panel will consider all child deaths under 18, excluding still births and planned terminations.

The role of the panel is advisory; it will consider the circumstances of individual cases, contributory factors and preventability. The responsibility for determining the cause of death rests with the Deputy Viscount (as coroner) or the doctor who signs the medical certificate of the fact and cause of death.

CDOP will make recommendations for action to ICPC & SPB to prevent future similar deaths; identify patterns and trends; make SCR referrals as required; agree local procedures and provide an annual report to the SPB.

2. Child Death Overview Panel - role and function

2.1 A **Joint Child Death Overview Panel (CDOP)** has been established between the Islands Child Protection Committee (ICPC), Guernsey and Alderney and the

[1] Working Together 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

Safeguarding Partnership Board (SPB), Jersey. The agreed Terms of reference of the Panel are attached at Appendix 2.

2.2 The role of the panel is advisory; it will consider the circumstances of individual cases, contributory factors and preventability. CDOP will make recommendations for action to ICPC & SPB to prevent future similar deaths; identify patterns and trends; make SCR referrals as required; agree local procedures and provide an annual report to the SPB.

2.3 The Responsibilities of CDOP are as follows:

- reviewing all child deaths up to the age of 18, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
- collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
- discussing each child's case and providing relevant information, or any specific actions, related to individual families to the professionals directly involved – so they can then convey this to the family in a sensitive manner;
- determining whether the death was deemed preventable (i.e. those deaths in which modifiable factors may have contributed to the death) and decide what, if any, actions could be taken to prevent future such deaths;
- making recommendations to ICPC/SPB Chairs in a timely fashion, so that action can be taken locally to prevent future such deaths where possible;
- identifying patterns or trends in local data and reporting these to the ICPC/SPB;
- where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring back to the ICPC/SPB Chair, as appropriate, for consideration of whether a SCR is required, and
- agreeing local procedures for responding to unexpected deaths of children.

2.4 The CDOP Chair will be appointed by agreement between the ICPC and SPB Chairs for a period of two years; the appointment of Chair and Vice-Chair will alternate between the islands. The Panel anticipates meeting twice per year to consider cases from both Jersey and Guernsey.

2.5 CDOP will include a standing membership, representing both islands, from agencies/ services which include:

- Police (Guernsey or Jersey)
- Children's services (Guernsey or Jersey)
- Public Health (Guernsey or Jersey)
- Board mangers – ICPC(Guernsey) and SPB(Jersey)
- Consultant Paediatrician (Guernsey or Jersey)
- Designated nurse (Guernsey or Jersey)

Agency representatives on CDOP will liaise with their island counterpart.

2.6 CDOP may co-opt, as appropriate, additional members on a temporary basis in order to access specialist skills and knowledge which will assist the work of the group. CDOP Members of the panel may name substitutes to attend in their place, who will have similar responsibilities; substitutes should be representatives from the same Island in order to avoid an imbalance of Island representation on the panel.

2.7 Members will keep up to date with any emerging procedural issues in their agency, and within the field of Child Safeguarding generally and will develop and contribute to joint working protocols. They will exercise their responsibility to be a conduit of information between the Board and agencies/services.

3. Referral process to CDOP

3.1 All cases of child deaths in Jersey must be notified to the Safeguarding Board Manager, who is the Designated person in the SPB responsible for collating child death information; notifications may come from any professional involved with the case. All forms and templates to be used for reporting child deaths can be found on the SPB website – Child Death Review forms [2]. Initial referral information is provided using Form A; in the case of informal referral, professionals will be asked to complete this form and return it to SPB.

3.2 The Designated person, on identification of involved agencies from information provided in the referral, will circulate Form B for completion. This will provide background information and supplementary information about the specific cause of death. A collated and anonymised version of this information is provided to the panel members considering each case.

3.3 The Panel will review each case individually and

- Classify the cause of death
- Identify any modifiable factors
- Decide on the preventability of the death
- Consider whether to make recommendations and to whom they should be made.

3.4 Thus the CDOP function is reach a decision as to whether the death was preventable[3] or not and to make recommendations for learning and improvements to services. CDOP will collate information about any matters of concern affecting the safety and welfare of children in the Island and will identify any wider public health or safety concerns arising from a particular death or from a pattern of deaths.

3.5 Recommendations from CDOP will be referred to the Independent Chairs of ICPC and SPB and an annual report will be provided to the Board and on to Ministers, via the Children and Vulnerable Adults Policy group (CAVA). Recommendations from CDOP will be monitored through the agreed processes of the SPB and using the Recommendations Actions Tracker to ensure that there is an appropriate response to any findings.

3.6 The CDOP process is summarised at Appendix 3.

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[2] www.safeguarding.je/cdop

[3] Definition of preventable child deaths: those in which modifiable factors may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced. *WT 2015*

4. Rapid response service for unexpected child deaths

4.1 Definition of an unexpected death of a child

4.1.1 An unexpected death is defined as 'the death of a child not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death'.

4.1.2 The on-call paediatrician should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt, the processes for unexpected child deaths should be followed until the available evidence enables a different decision to be made.

4.1.3 A child is defined as 'any person under the age of 18 years'.

4.2 Action by professionals when a child dies unexpectedly - Rapid response remit

4.2.1 The services response to an unexpected child death should be safe, consistent and sensitive to those concerned including bereaved parents and siblings.

4.2.2 Professionals should be aware that, in certain circumstances, separate investigative processes may be taking place alongside those described in this procedure (e.g. criminal investigations, coroner investigations). Professionals and agencies should liaise across processes to avoid duplication.

4.2.3 The purpose of a rapid response service is to ensure that the appropriate agencies are engaged and work together to:

- Ensure support for the bereaved family members, as the death of a child will always be a traumatic loss - the more so if the death was unexpected;
- Identify and safeguard any other children in the household or affected by the death;
- Respond quickly to the unexpected death of a child;
- Make immediate enquiries into and evaluate the reasons for and circumstances of the death, in agreement with the Deputy Viscount (as Coroner);
- Enquire into and constructively enquire as to how each organisation discharged their responsibilities when a child has died unexpectedly (liaising with those who have ongoing responsibilities for other family members), and whether there are any lessons to be learnt;
- Co-operate appropriately post death, maintaining contact at regular intervals with family members and other professionals who have ongoing responsibilities to the family, to ensure that they are appropriately informed

(unless such sharing of information would place other children at risk of harm or jeopardise police investigations);

- Consider media issues and the need to alert and liaise with the appropriate agencies;
- Provide bereavement support as needed, for any other children, family members or members of staff who may be affected by the child's death.

4.2.4 Rapid response begins at the point of death and ends when the final meeting has been convened and chaired by the on call paediatrician. Any records of the meeting (meeting notes) should be forwarded to the chair of the SPB at the time of the review.

4.2.5 Where notified of a death abroad, the professionals responsible for the child death in the Health and Social Services Department where the child is normally resident must consider implementing this procedure as far as is practically possible and fully record any decisions made.

4.3 Rapid response time

4.3.1 The paediatrician is responsible for ensuring all actions relating to the rapid response process are completed. The rapid response timeline involves three phases:

- **Phase one (usually 0-5 days):**The management of information sharing from the point at which the child's death becomes known to any agency until the initial results of the post-mortem have been completed;
- **Phase two (usually 5-7 days):** the management of information sharing once the initial post mortem results are available; and
- **Phase three (usually 8-12 days)**: the management of information sharing through the case discussion meeting when the final post-mortem report is available.

4.3.2 The rapid response process involves all agencies and the information flow may vary dependent on agencies involved and at the same time all should understand that there may be a number of different processes that run concurrently.

4.3.3 Phase I: usually 0-5 days – Immediate response

i. Children who die unexpectedly in the community should be taken to an accident and emergency department (ED) rather than a mortuary, and resuscitation should always be initiated unless clearly inappropriate.

ii. As with children who die in hospital, their parent/s should be allocated a member of hospital staff to support them throughout the process.

iii. A child should not be taken to ED in situations where:

- The circumstances of the death require the child's body to remain at the scene for forensic examination (police will be involved in these cases and decisions will be made after consideration by the police Senior Investigating Officer and liaison with the Deputy Viscount) ; or
- The death was expected in the context of the child's life limiting condition and they were receiving palliative care.

iv. Where a child is not taken immediately to ED, the professional confirming the death should inform the Deputy Viscount, and the on call paediatrician at the earliest opportunity. This death will be subject to local procedures if the doctor is unable to issue a Medical Certificate of the Fact and Cause of Death.

v. The families of children who are not taken to hospital should receive support throughout the process from a professional in the rapid response team whose role is to provide such support.

4.3.4 On arrival at hospital

i. As soon as practicable (i.e. as a response to an emergency) after arrival at a hospital, the child should be examined by the consultant paediatrician or delegated senior paediatric clinician on call. In some cases, this examination might be undertaken jointly with a consultant in emergency medicine, or for some children over 16 years of age, the consultant in emergency medicine may be more appropriate than a paediatrician. A detailed and careful history of events leading up to and following the discovery of the child's collapse should be taken from the parents / carers.

ii. Where the causes of death or factors contributing to it are uncertain, investigative samples should be taken immediately on arrival and after the death is confirmed and with the authorisation of the Deputy Viscount. Consideration should always be given to undertaking a full skeletal survey and may include a CT/MRI scan prior to autopsy.

iii. In seeking to clarify the cause of death and the factors which contributed to it, the paediatrician should document:

- A full account of any resuscitation and any interventions or investigations carried out;
- An account by the carer, including narrative, of the events leading to the death; and
- A body chart documenting the examination findings and any post-mortem changes.

iv. When the child is pronounced dead, the medical paediatric or ED consultant or delegated senior clinician should inform the parents, having first reviewed all the available information. S/he should explain future police and Deputy Viscount's (as Coroner) involvement, including the Deputy

Viscount's authority to order a post-mortem examination. This may involve taking particular tissue blocks and slides to ascertain the cause of death. The medical consultant must seek consent from those with parental responsibility for the child if the tissue is to be retained beyond the period required by the Deputy Viscount. All of this is covered in the Post Mortem Guide. A copy of this should be passed to the family and the family taken through the guide by the appointed Family Liaison Officer (FLO) or other professional involved.

v. The parents should normally be given the opportunity to hold and spend time with their child in a quiet designated area. The allocated member of staff should maintain a discrete presence throughout.

vi. A debrief for all staff, police, paramedics, doctors, etc. should take place a couple of days after the attempted resuscitation.

vii. The medical consultant who saw the child must inform the on call paediatrician immediately after the Deputy Viscount is informed. The Deputy Viscount (as Coroner) must investigate violent or unnatural death, or death of no known cause and all deaths where a person is in custody at the time of the death, or living in a children's home or mental health establishment. The Deputy Viscount has jurisdiction over the child's body at all times (including any tissue samples organs) until such time as he or she releases the body for the funeral.

viii. The same processes will apply to a child who is admitted to a hospital ward and subsequently dies unexpectedly in hospital.

ix. Professionals should be aware that, in certain circumstances, separate processes may be taking place alongside those described in this procedure (i.e. criminal investigations).

4.3.5 Immediate notification and information sharing.

i. The paediatrician is responsible for co-ordination of the multi-agency response, and must ensure that the following have been notified:

- The Deputy Viscount;
- The police; and
- Other agencies as appropriate (e.g. children's service)
- and, in a timely manner, will notify the Chair of the SPB and CDOP coordinator (SPB office).

ii. The paediatrician must ensure that information is shared and initiate a planning discussion between relevant agencies such as the police, health and children's service (and others, including the Viscount's Department) in a timely manner to decide next steps. This may or may not involve a meeting.

iii. Where the death occurred in a hospital, the plan should also address the actions required by the hospitals serious incidents protocol. Where the

death occurred in a custodial setting, the plan should ensure appropriate liaison with the investigator from the Prison's Ombudsman.

iv. Before leaving the hospital, or if the child died at home, before the professionals leave the home, the parents have the contact details for the lead professionals (consultant paediatrician, senior investigating police officer or Deputy Viscount), and the details of who they should contact for information on the progress of any investigation or if they wish to visit the hospital to see their child. This function will generally be fulfilled by a Police Family Liaison officer.

v. For each unexpected death of a child (including those not seen in ED) urgent contact should be made with any other agencies who know or are involved with the child (including CAMHS, school or early years) to inform them of the child's death and to obtain information on the history of the child, the family and other members of the household. The enquiries should be made in conjunction with the Deputy Viscount.

4.3.6 Police investigation

The police will begin an investigation into the unexpected death of a child on behalf of the Deputy Viscount.

4.3.7 Potential visit to the place where the child died

When a child dies unexpectedly in a non-hospital setting the senior investigation police officer and paediatrician should make a decision about whether a visit to the place where the child died should be undertaken and who should attend. Where appropriate a Lead and Designated Nurse may jointly visit to provide support to the family. This should almost always take place for cases of sudden infant death (Working together) (SUDI) - *[Sudden Unexpected Death in Infancy: a multi-agency protocol for care and investigation. The report of a working party convened by the Royal Colleges of Pathologists and the Royal College of Paediatrics and Child Health (2004). London: RCPath] [See paragraph 5.1 in the Kennedy Report]*

4.3.8 Phase II; within 5-7 days

A case discussion should take place within one week of the child's death, in order to:

- Ensure the right support is available for the family;
- Ensure all agencies are aware of their roles and responsibilities;
- Review the preliminary cause of death (if available);
- Identify any safeguarding concerns around surviving children, and refer accordingly to the police child protection team and children's service;
- Ensure all relevant agencies are involved in the process;
- Identify what further investigations or enquiries are required, agree which agency will undertake each task and agree timescales (which may not exceed those set out in this procedure) for doing so. If abuse or neglect

appear to be possible causes of death, children's service and the police should be informed and serious case review procedures considered.

Prior to this meeting, the paediatrician should discuss the case with the pathologist (when a post-mortem has taken place and consent obtained from the Deputy Viscount) and the police senior investigating officer, where appropriate.

4.3.9 Involvement of the Deputy Viscount (as coroner) and pathologist

i. The Deputy Viscount (as Coroner) must investigate violent or unnatural death, or death of no known cause and all deaths where a person is in custody at the time of the death, or living in a children's home or mental health establishment. The Deputy Viscount has jurisdiction over the child's body at all times (including any tissue samples organs) until such time as he or she releases the body for the funeral.

ii. Assuming that a doctor is not able to issue a Medical Certificate of the Fact and Cause of Death and if the Deputy Viscount deems it necessary (and in almost all cases of an unexpected child death it will be), the Deputy Viscount will order a post-mortem examination to be carried out as soon as possible by the most appropriate pathologist available (this may be a paediatric pathologist, forensic pathologist or both) who will perform the examination according to the guidelines and protocols laid down by The Royal College of Pathologists. The paediatrician should collate information collected by those involved in responding to the child's death and share it with the pathologist conducting the post mortem examination in order to inform this process. Where the death may be unnatural, or the cause of death has not been determined (and in certain other circumstances), the Deputy Viscount will in due course hold an inquest.

iii. All information collected relating to the circumstances of the death - including a review of all relevant medical, social and educational records - must be included in a report for the Deputy Viscount prepared by the Police. Evidence and information obtained should be provided to the Deputy Viscount as soon as it is available and as soon as possible. In the usual way, an initial Police Sudden Death Report should be made available to the Deputy Viscount as soon as possible. Other reports from professional agencies should be delivered to the Deputy Viscount within 28 days of the death, unless some of the crucial information is not yet available.

iv. The results of the post mortem examination belong to the Deputy Viscount. In most cases it is possible for these to be discussed by the paediatrician and pathologist, together with the senior investigating police officer, as soon as possible, and the Deputy Viscount should be informed immediately of the initial results

v. If the initial post-mortem findings or findings from the child's history suggest evidence of abuse or neglect as a possible cause of death, the police and children's service should be informed immediately, and the serious case review processes in **Serious Case Reviews Procedure** should be followed. If there are concerns about surviving children living in the household, professionals should follow the procedures set out in **Child protection enquiry** below.

vi. In all cases the paediatrician should convene a further multi-agency discussion very shortly after the initial post-mortem results are available. This discussion usually takes place five to seven days after the death and should involve the pathologist, police, children's services and the paediatrician, plus any other relevant healthcare professionals, to review any further information that has come to light and that may raise additional concerns about safeguarding issues.

4.3.10 Phase III: usually within 8 – 12 days

i. Further case discussion meeting should be convened and chaired by the paediatrician following the final results of the post-mortem examination becoming available. This should involve those who knew the child and family and those involved in investigating the death - the GP, health visitors, school nurse, paediatrician/s, pathologist or pathologist report, police senior investigating officers and, where relevant, social workers.

ii. The purpose of the meeting is to share information to identify those factors that may have contributed to the death and then to plan the future care for the family. Potential lessons to be learned may also be identified at this stage. The outcome of this meeting should inform the inquest, if there is one.

iii. The meeting should explicitly address the possibility of abuse or neglect as causes or contributory factors in the death, and the outcomes of this should be recorded.

iv. The paediatrician must ensure that the results of the post-mortem examination are shared with parents, provided this is consistent with the requirements of the Deputy Viscount and the police.

v. Where other investigations are ongoing, the meeting should conclude with a record of the current situation.

vi. An agreed record of the case discussion meeting and all reports should be sent to the Deputy Viscount, to take into consideration in the conduct of the inquest.

5. Other related processes

5.1 If, during the enquiries, concerns are expressed in relation to the needs of surviving children in the family, discussions should take place with Children's Services. It may be decided that it is appropriate to initiate an initial assessment. If concerns are raised at any stage about the possibility of surviving children in the household being abused or neglected, the multi-agency guidelines should be followed. Children's Services have lead responsibility for safeguarding and promoting the welfare of children. The police will be the lead agency for any

criminal investigation. The police must be informed immediately that there is a suspicion of a crime, to ensure that the evidence is properly secured and that any further interviews with family members are conducted if appropriate.

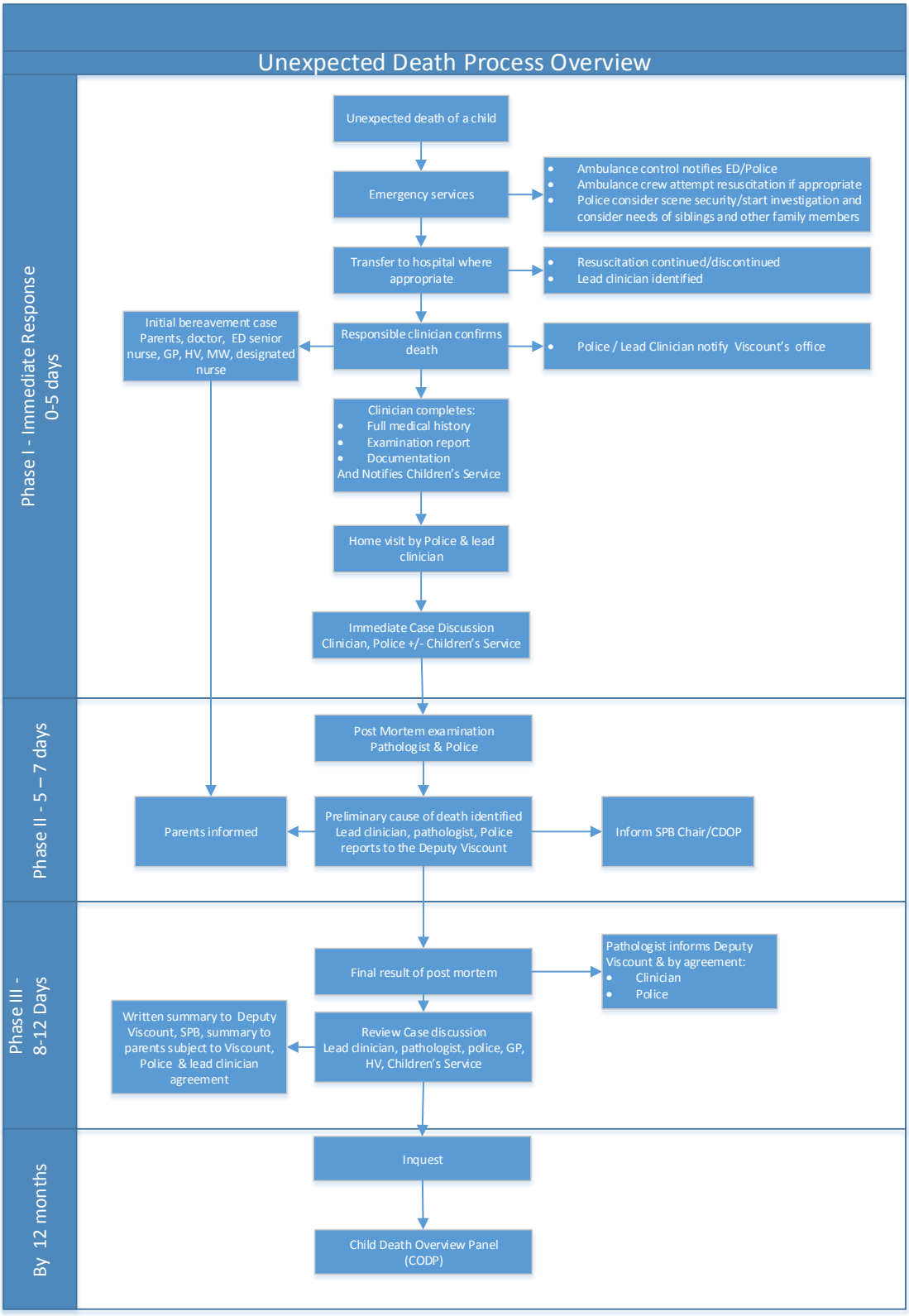
5.2 If it is thought, at any time, that the criteria for a serious case review might apply, the Chair of the SPB should be contacted and the serious case review procedures should be followed.

5.3 Where there is an ongoing criminal investigation, the Senior Investigating Officer and the Law Officers' Department must be consulted as to what it is appropriate for the professionals involved in reviewing a child's death to be doing, and what actions to take in order not to prejudice any criminal proceedings. In certain circumstances a second post-mortem examination may be required by a defendant in criminal proceedings or at the insistence of the family of the deceased child. Again, this would be subject to authorisation by the Deputy Viscount.

5.4 All agencies previously engaged with the family including GP's, health visitors, support workers, routinely used marketing agencies etc. should be notified so as to stop contacting the family and adding to their grief.

5.5 A follow up bereavement appointment should be offered to the parents two-three months following the death.

6. Appendix 1 – Unexpected Death Process



7. Appendix 2 – CDOP agreed Terms of Reference

Safeguarding Partnership Board Children

Islands Child Protection Committee

Working Together for the Children of Guernsey and Alderney

Terms of Reference - Child Death Overview Panel

1. Introduction

A **Joint Child Death Overview Panel (CDOP)** has been established between the Islands Child Protection Committee (ICPC), Guernsey and Alderney and the Safeguarding Partnership Board (SPB), Jersey.

This panel will consider all child deaths under 18, excluding still births and planned terminations. The role of the panel is advisory; it will consider the circumstances of individual cases, contributory factors and preventability. CDOP will make recommendations for action to ICPC & SPB to prevent future similar deaths; identify patterns and trends; make SCR referrals as required; agree local procedures.

2. Responsibilities of CDOP

The responsibilities of CDOP are as follows:

- reviewing all child deaths up to the age of 18, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
- collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
- discussing each child's case and providing relevant information, or any specific actions, related to individual families to the professionals directly involved – so they can then convey this to the family in a sensitive manner;
- determining whether the death was deemed preventable (i.e. those deaths in which modifiable factors may have contributed to the death) and decide what, if any, actions could be taken to prevent future such deaths;

- making recommendations to ICPC/SPB Chairs in a timely fashion, so that action can be taken locally to prevent future such deaths where possible;
- identifying patterns or trends in local data and reporting these to the ICPC/SPB;
- where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring back to the ICPC/SPB Chair, as appropriate, for consideration of whether a SCR is required, and
- agreeing local procedures for responding to unexpected deaths of children.

3. Value Base

CDOP members will ensure that policies and procedures reflect a consistent value base in regard to the following principles:

- safeguarding is **everyone's responsibility**: for services to be effective each professional and organisation should play their full part (Working Together 2013) **and**
- a **child-centred approach**: for services to be effective they should be based on a clear understanding of the needs and views of children. (Working Together 2013)
- **anti-discriminatory and anti-oppressive practice** demonstrated through mutual respect and sensitivity to the diversity of children and adults circumstance and backgrounds in respect to age, gender, physical or mental ability, culture, religion, language, sexual orientation or socio-economic status
- **confidentiality, data protection and information sharing** - CDOP will use anonymised case data; a confidentiality statement will be signed by attendees at each meeting (Appendix A)

  'Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children' **(Working together 2013)**

4. Membership

4.1 The CDOP Chair will be appointed by agreement between the ICPC and SPB Chairs for a period of two years; the appointment of Chair and Vice-Chair will alternate between the islands.

4.2 CDOP will include a standing membership, representing both islands, from agencies/ services which include:

- Police (Guernsey or Jersey)
- Children's services (Guernsey or Jersey)
- Public Health (Guernsey or Jersey)
- Board mangers – ICPC(Guernsey) and SPB(Jersey)
- Consultant Paediatrician (Guernsey or Jersey)
- Designated nurse (Guernsey or Jersey)

Agency representatives on CDOP will liaise with their island counterpart.

4.3 CDOP may co-opt, as appropriate, additional members on a temporary basis in order to access specialist skills and knowledge which will assist the work of the group.

4.4 CDOP Members of the panel may name substitutes to attend in their place, who will have similar responsibilities; substitutes should be representatives from the same Island in order to avoid an imbalance of Island representation on the panel.

4.5 Member responsibility

- Members will keep up to date with any emerging procedural issues in their agency, and within the field of Child Safeguarding generally.
- Members will develop and contribute to joint working protocols.
- Members will exercise their responsibility to be a conduit of information between the Board and agencies/services

5. Decision Making and Accountability

5.1 To be quorate, attendance must include as a minimum:

- the Chair or Vice Chair
- and at least four other members or their substitutes representing Paediatrician/Named Nurse/Police/Social Services.

5.2 CDOP will conduct business on a consensual basis.

5.3 Members of CDOP are accountable to each other and ICPC/SPB respectively for completion of actions as required.

5.4 The recommendations from CDOP will be communicated by formal letter to the Chairs of ICPC and SPB, including recommendations for consideration of cases by Serious Case Review sub groups of the Boards.

6. Administration

The Chair will ensure, with the support of the ICPC/SPB Officers, that:

- CDOP meets annually on dates to be agreed in advance or at such other intervals as may be agreed by members.
- Meetings will alternate venue between Guernsey and Jersey; the respective Boards will cover costs of hosting the meeting alternately, and Boards will cover travel costs for their own attendees.
- Extraordinary meetings may be called by the Chair as required.
- The agenda is circulated prior to the meetings and meeting notes are taken, circulated to members with copies being retained and stored by the Chair.; the hosting Island will provide administrative support.
- Meeting notes are agreed as a permanent record at the following meeting.
- An annual report will be prepared by the CDOP chair for submission to ICPC and SPB.

Appendix A - CONFIDENTIALITY STATEMENT TO BE SIGNED BY MEMBERS OF THE CHILD DEATH OVERVIEW PANEL (CDOP)

As part of my membership of the Child Death Overview Panel (CDOP), I agree to the following:

I. As a member of CDOP, I understand that will receive anonymised reports forwarded by information coordinators on behalf of ICPC (Guernsey) and SPB (Jersey) in the case of all child deaths under 18, excluding still births and planned terminations..

II. I agree to the following:

   a. As a member of CDOP, I am clear about the circumstances under which serious cases are conducted and discussed at CDOP meetings, and about the STRICTLY CONFIDENTIAL nature of this process.

   b. Minutes of any CDOP meetings will remain confidential to the Panel as convened, and documents will be marked 'CONFIDENTIAL – NOT TO BE DISCLOSED'.

   c. CDOP Reports written by my agency (ICPC Guernsey or SPB Jersey), in hard copy or electronic format, will not be shared with people outside my agency without the consent of the Chief Executive or equivalent of my department or agency and the Chair of the ICPC or SPB.

   d. As agreed by CDOP, electronic copies of the whole or parts of specified reports or documents are to be removed from the electronic records.

   e. I will take responsibility for ensuring the confidentiality of CDOP reports and any other related material forwarded to me and undertake to store it securely.

As a member of Child Death Overview Panel, I agree to abide by this statement.

Name: (Please print) _____

Signed: _____

Date: / /

To be signed at each meeting of the Child Death Overview Panel

8. Appendix 3 – Referral process to CDOP