

On the Professionals' page open the Safeguarding Procedures and read Part 6. Also "Working Together to Safeguard Children - 2006" chapter 7 gives more detail on Child Death Overview Panels is also available on the professionals' page.

If you have any queries or want further information please contact:

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Designated Nurse - Safeguarding Children	01925 251514
Designated Doctor - Safeguarding Children	01925 405712
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For further information visit our website
www.safeguardingwarringtonchildren.org.uk

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Warrington Safeguarding Children Board



CHILD DEATH OVERVIEW PANEL

A guide for professionals

Child Death Overview Panel

What is a child death overview panel and why does Warrington require one?

From April 2008 Central Government requires all Local Authorities to establish a Child Death Overview Panel. The purpose of the Panel is to determine whether any lessons can be learned from the death of a child or children and prevent further deaths in future.

This will include reviewing the appropriateness of the response from each professional and their agency involvement with the child before and after their death.

The Director of Public Health will chair the Child Death Overview Panel in Warrington, and the membership will include professionals employed by agencies such as the PCT, Hospital Trust, Children's Social Care, the Coroner, Registrar and Police. Other members will be asked to join when appropriate, for example the fire service.

All information that is made available to panel members is confidential and the names of children and their families will remain anonymous.

It is not the intention of the Panel to add to any distress the family may be experiencing but work towards preventing future deaths if possible.

What information will the Panel receive and what will they do with it?

It is the sole aim of the Panel to prevent, wherever possible, further deaths of a child or children.

All details of any child that dies from birth to 18 years of age will be notified in writing to the Manager of the Child Death Overview Panel. The information will be received from all relevant agencies such as the PCT, the Hospital, Social Care, Police and GPs.

The information relating to a child's death will include place, time and cause of death. It will also include information relating to the support the family are receiving and identify any gaps in provision.

How often will the Child Death Overview Panel meet?

The Panel will meet every 3 months initially but can be varied. The panel will

- Implement in conjunction with the local Coroner, local procedures and protocols on enquiring into unexpected deaths, and evaluate these together with information about all deaths in childhood.
- Collect and collate the agreed information about each child death, seeking information from professionals and family members;
- Meet regularly to evaluate the information collected on the deaths of children, and identify issues of concern or lessons to be learnt in relation to inter agency collaboration to safeguard children;
- Ensure that mechanisms are in place to make enquiries in relation to specific cases of unexpected deaths in childhood;
- Monitor the appropriateness of the response of professionals to an unexpected death of a child;
- Provide relevant information to those professionals involved with the child's family, in order that this information be shared with family members;
- Monitor the support and assessment services offered to families of children who have died;
- Monitor and advise the WSCB on the resources and training required locally to ensure an effective inter agency response to child deaths;

- Co-operate with regional and national initiatives to identify lessons on the prevention of unexpected child deaths

Will the Child Death Overview Panel produce a report and recommendations?

Yes. The panel will produce a report, including statistics, once a year for the Chair of WSCB. All information relating to individual children will remain anonymous. Recommendations will be made, if necessary, on what actions agencies, individuals within agencies or communities need to take to prevent further deaths. This information will be made available to the public via the WSCB web site and will be communicated to all agencies involved in safeguarding children.

What will the recommendations be?

The Panel will look at various aspects such as:

- Could the death of this individual child have been prevented?
 - How can we prevent such deaths in the future?
 - Did all agencies offer appropriate support to the child?
 - Has the family received the appropriate support after the death?
- * Is there a training need for professionals that should be addressed?

Where can I find further information about the Child Death Overview Panel?

An explanation on the legal requirements of the Child Death Overview Panel can be found on the following web site:

www.safeguardingwarringtonchildren.org.uk