01 Background

A CDOP is a subgroup of the Local Safeguarding Children Board (LSCB), and has a statutory responsibility to review all infant/child deaths 0-18 years who reside in Cheshire, regardless of where the death took place.

This includes perinatal and neonatal deaths which were registered as a live birth regardless of week's gestation. A planned termination under the abortion Act 1967 will not be reviewed









07 Information & Resource

- 1. Your local LSCB website
- 2. Pan Cheshire CDOP Protocol (2014)
- Pan Cheshire LSCB Guidelines for The management of SUDIC 2015
- 4. Working Together to Safeguard Children 2018, Chapter 5,
- 5. Multi-agency protocol for care and investigation of SUDI 2014 (Kennedy Report)
- 6. Child Death Review Statutory Guidance 2018

06 Questions to Consider

- 1. What is CDOP?
- 2. Do you know who to notify following the unexpected or expected death of an infant or child?
- 3. What is The Child Death Review Process?
- 4. Who is Responsible for undertaking the Child Death Reviews in Cheshire?
- 5. How and to whom do you notify re: an infant or child death?
- 6. Where can you access additional information and resources re CDOP, infant/child death and bereavement?

02 Child Death Reviews

The Pan CDOP was established in July 2013 following the merger of 4 LSCB CDOP's, East Cheshire, Cheshire West/Chester, Warrington and Halton, to enable a more thorough comprehensive data analysis from a wider population and identify any emerging patterns, themes or trends.

CDOP representatives are drawn from key multi-agency organisations. Others may be co-opted to contribute to the discussion if appropriate, i.e. neonatologists, microbiologists etc.



03 The Process

There are two interrelated processes (either of which can trigger a criminal investigation, safeguarding or /and SCR)

- Rapid Response SUDIC (this is when the Sudden Unexpected Death of an Infant/child was not anticipated 24 hours earlier) when the child's death is unexpected
- (Sudden Unexpected Death In Infant or child SUDIC) –
 (The Pan Cheshire LSCB Guidelines for The management of SUDIC 2015) should be followed.
- CDOP A comprehensive review of all Child Deaths
 Expected & Unexpected 0-18yrs and has the ultimate aim
 to prevent potentially avoidable deaths in the future.

05 Aims of CDOP

It is the collection, collation and analysis of information about each death with a view to identifying-

- (i) Where possible establish a cause or causes of death
- (ii) Identify possible contributory factors
- (iii) Any case giving rise to the need for a serious case review
- (iv) Any matters of concern affecting the safety and welfare of children in the area of the authority
- (v) Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area

Recommendations made to the LSCB and other relevant bodies. Information is shared locally and nationally.

04 When an Infant or Child Dies

UNEXPECTED – follow the Pan Cheshire LSCB Guidelines for the Management of SUDIC 2015 This guidance is for all agencies and details their roles and responsibilities. It also contains templates to be completed by the lead clinician.

For ALL DEATHS whether UNEXPECTED OR EXPECTED

Working Together to Safeguard Children 2018, Chapter 5, sets the National Operational Framework for the functions and processes of the CDOP.

Complete the Notification Form – send to appropriate agencies including CDOP administrator *no later than 24 hours*. Deaths of children not normally resident in the Cheshire area and who die here should also be notified; this information will be passed onto the relevant CDOP from their LA who will then coordinate the information

Child Death Review Reporting Form - is used for the collection and collation of information from all the various agencies known to the deceased infant or child. The information is anonymised and presented to the CDOP when all the additional information has been received from Inquests, PM's, Courts, SCR's etc.