East Sussex Local Safeguarding Children Board

Learning and Improvement Framework

November 2013

CONTENTS

1. INTRODUCTION 3

2. SERIOUS CASE REVIEWS (SCRs) 5

A. RATIONALE 5

B. PREPARATION 5

C. PROCESS 6

D. LEARNING 6

3.1. MULTI-AGENCEY REVIEWS (MARs) 6

A. RATIONALE 6

B. PREPARATION 7

C. PROCESS 7

D. LEARNING 7

3.2. PARTNERSHIP REVIEWS (PRs) 7

A. RATIONALE 7

B. PREPARATION 8

C. PROCESS 8

D. LEARNING 9

4. MULTI-AGENCY CASE FILE AUDITS 9

A. RATIONALE 9

B. PREPARATION 9

C. PROCESS 10

D. LEARNING 11

5. SECTION 11 OF THE CHILDREN ACT 2004 – AGENCY SELF-EVALUATION 11

A. RATIONALE 11

B. PREPARATION 11

C. PROCESS 12

D. LEARNING 13

6. CHILD DEATH OVERVIEW PANEL 13

A. RATIONALE 13

B. PREPARATION 13

C. PROCESS 13

D. LEARNING 14

1. INTRODUCTION

The East Sussex Local Safeguarding Children Board (LSCB) is committed to improving outcomes for children. This Learning and Improvement Framework is intended to strengthen and support a learning culture across all agencies in East Sussex who work with children and young people. A culture which is open and able to challenge all partner agencies will be able to identify learning, improve, and then establish effectiveness.

One of the roles of the LSCB is to ensure the effectiveness of safeguarding practice, with the most effective way of improving standards being evidence-based auditing, performance management, and self-analysis. The LSCB ensures that there is continual evaluation of the quality of services being provided, as well as effective communication and joint working between all LSCB partner agencies.

Learning and improvement embraces all activity that contributes to service improvement through satisfying the organisation that agreed standards are being met and outcomes for safeguarding children are being achieved. This is a continual and dynamic process by which we set standards, monitor our achievements against those standards, use the information we have to improve services and undertake ongoing review. Learning and improvement is more than meeting targets and counting activity; it is a coherent and qualitative approach which measures standards and identifies areas that need to be changed. It should be both systematic and themed, cross-agency and single-agency.

The East Sussex LSCB uses a range of performance improvement and quality assurance tools to monitor work within the LSCB. *Working Together 2013* allows LSCBs much greater flexibility in selecting a learning approach which suits the circumstances of the case being reviewed. The learning approaches that can be used include the use of peer reviews, self-evaluation, performance indicators and joint audit. These Review processes are described in this paper, with the purpose of these Reviews being to learn lessons from the way in which local safeguarding agencies worked together, with the Review's recommendations being acted on promptly, and being overseen by the LSCB.

In the final report focusing on national child protection issues by Professor Munro, published in May 2011, she recommends regular review of cases in order to continuously consider the monitoring, learning and adaptation of practice. Professor Munro recommends the use of a "systems approach" for all reviews, focusing on understanding professional practice in context. This focuses on 'why' professionals have acted in the way they have, so the resulting changes are grounded in practice reality. This marks a move from a 'compliance' to a 'learning' culture, with a larger repertoire of learning options to be developed.

"Working Together" 2013 describes the following key learning and improvement principles -

PRINCIPLES FOR LEARNING AND IMPROVEMENT (Working Together 20130)

The following principles should be applied by LSCBs and their partner organisations to all reviews:

- *there should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;*

- *the approach taken to reviews should be* ***proportionate*** *according to the scale and level of complexity of the issues being examined;*
- *reviews of serous case reviews should be led by individuals who are* ***independen****t of the case under review and of the organisations whose actions are being reviewed*
- *professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;*
- *families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process;*
- *final reports of SCRs* ***must be published****, including the LSCB's response to the review findings, in order to achieve transparency. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual reports and will inform inspections; and*
- *improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.*

SCRs and other case reviews should be conducted in a way which:

- *recognises the complex circumstances in which professionals work together to safeguard children*
- *seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;*
- *seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;*
- *is transparent about the way data is collected and analysed; and*
- *makes use of relevant research and case evidence to inform the findings.*

This paper describes the learning and improvement options that the East Sussex LSCB have put in place in order to identify the underlying issues that are influencing local practice in general, so that changes can be made to raise the standards of safeguarding children in East Sussex.

2. SERIOUS CASE REVIEWS (SCRs)

A. RATIONALE

The prime purpose of a Serious Case Review (SCR) is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children.

Working Together 2013 states that a serious case is one where:

- Abuse or neglect of a child is known or suspected; and
- either
- the child has died (including suspected suicide)
- or
- the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.
- Additionally, an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home, or where the child was detained under the Mental Health Act 2005

The purpose of a SCR is to:

- establish whether there are lessons to be learned from the case
- identify how they will be acted on
- improve interagency working, to better safeguard children, and to promote the welfare of children

B. PREPARATION

All agencies represented on the East Sussex Safeguarding Children Board have a duty to cooperate and participate in a Serious Case Review.

Any professional can ask the LSCB to consider a SCR, although there will be three usual sources of referral:

- Cases identified by the Head of Childrens Safeguarding within East Sussex County Council, via the child protection planning processes
- Cases identified in the NHS by the Designated Nurse
- Cases identified by the rapid response or Child Death Overview Panel process when a child or young person dies unexpectedly

The East Sussex SCR sub committee will come to a view about whether a case meets the criteria for a SCR, and make a recommendation to the Independent Chair of East Sussex LSCB. The LSCB Chair may seek peer challenge from another LSCB Chair when considering their decision. Once a decision to conduct a SCR has been taken by the Chair, a SCR Panel will be formed, chaired by an independent person, and including relevant senior managers from each agency who will oversee the process.

From July 2013 there is a national panel of independent experts to advise LSCBs about the initiation and publication of SCRs. The LSCB will inform Ofsted and the national panel of experts of their decision relating to an incident considered by the SCR sub committee.

C. PROCESS

The SCR Panel agrees the scope and key issues of the review, drawing up clear terms of reference, including the time frame. The LSCB will appoint at least one Independent Reviewer who is independent from the LSCB and the organisations involved in the case.

Each agency who were involved with the child and family will be required to be engaged in identifying the appropriate actions to make improvements from reviewing the case. This may involve identifying an Individual Management Review (IMR) author, who will produce a chronology of events, a summary and analysis of involvement, decision making, and adherence to policy and procedures. The IMR reports should also identify good practice, lessons to be learned, and recommendations for action.

However, the SCR Panel may also decide that the most informative method of reviewing the case may not be through the use of IMRs, but could involve an approach that includes direct contributions from front line practitioners who were involved with the child and their family, as well as members of the family if appropriate. The East Sussex LSCB has used such approaches that are described in this paper in the section "Partnership Reviews".

The Independent Overview Author is commissioned to collate the information from the IMR reports, as well as from meetings with front line practitioners, and family members, into a final report, together with an action plan that addresses the recommendations. This report is published in a suitably anonymised manner in order to protect the identity of the children, and other relevant family members.

D. LEARNING

The purpose of under-taking a SCR is to learn lessons for improving both individual agency and inter-agency working, so that it is imperative that lessons are learned and acted upon. The findings are not only important for the professionals involved locally in cases, but the learning from an individual case can also enhance national learning.

The LSCB makes arrangements to provide feedback of the key findings and debriefing to staff who have been closely involved in the SCR. Information is also communicated about the examples of good practice, as well as where changes need to be made. It is important to integrate the learning from individual reviews along side other reviews that have been undertaken, both nationally and locally. Learning from the reviews is incorporated into the LSCB Training Programme. Learning from the SCRs is taken to regular Briefing Sessions that members of the SCR sub committee carry out on an on-going basis for all front line staff and their managers.

3.1 MULTI-AGENCEY REVIEWS (MARs)

A. RATIONALE

The SCR sub committee have carried several reviews of individual children in the past, where the threshold for an SCR has not been met, although the committee has considered that there would be learning from reviewing the case. In these situations a Multi Agency Review is carried out, which reflects the processes of an SCR, but without the external scrutiny or the need to publish a final report.

It is also helpful for the LSCB to under-take a MAR on a regular basis, so that when a SCR is required, which is likely to be on a less frequently, the systems and processes are very much already in place.

B. PREPARATION

The preparation reflects much of the process as described above for a Serious Case Review, but without the higher threshold being met for an SCR, although still with the need for a Review Panel, along with a Chair whose agency was not involved in the case. The source of referral would be similar to that for a SCR

C. PROCESS

The SCR Panel agrees the terms of reference and the time-frame for the MAR, and appoints an Independent Reviewer, who is independent of the LSCB.
Each involved agency under-takes an IMR which includes an analysis of their involvement, as well as a chronology.

Contributions would also be sought from front-line practitioners, as well as family members if appropriate. The Independent Reviewer produces a final report, together with a composite action plan for the recommendations

D. LEARNING

The learning from the MAR is included along with other local and national learning from Reviews, being incorporated into the regular Briefings Sessions held by the LSCB, as well as being taken to individual teams and services to be used as a focus for training.

3.2 PARTNERSHIP REVIEWS (PRs)

A. RATIONALE

Partnership Reviews have been developed by East Sussex LSCB from processes used by LSCBs across the country. Partnership Reviews can be used when a case referred to the SCR sub committee does not meet the threshold for a SCR, and when it is considered that important learning for multi-agency working could be identified by further analysis, as well as a more flexible approach in gaining the learning from the case is most appropriate. Partnership Reviews are not regulated in the same way as SCRs, so that external scrutiny is not required, which gives flexibility in terms of the terms of reference and the time frame.

In October 2013 members of the SCR sub committee all attended training delivered by representatives from the Social Care Institute for Excellence (SCIE) “Learning Together” approach which focused on achieving learning from a case using systems methodology, and achieving a “window on the system”. This thinking has assisted the SCR sub committee in shaping not only the Reviews of serious cases, but also in considering the best ways to audit current individual cases.

The systems approach has ensured that Partnership Reviews allow for evidence to emerge more quickly around learning points, and consequently the opportunity to improve practice in a shorter time-scale. PRs involve the engagement of front-line staff and first line managers in analyzing the case, giving a greater degree of ownership which leads to a greater commitment to learning and dissemination. PRs aim to provide

open and transparent learning from practice to improve inter-agency work with patterns of good practice also high-lighted.

Partnership Reviews only require agencies to submit a chronology and genogram, rather than a full IMR. PRs vastly reduce costs associated with staff time across all agencies.

Partnership Reviews can be used to consider 3 or 4 high profile cases that may have a similar local theme that would provide benefit from deeper analysis, as well as being used for an individual case.

B. PREPARATION

The preparation is reliant on the approach to be taken, and therefore can be very variable.

Usually all involved agencies would provide a chronology of involvement for a specified period, and the SCR Panel would meet to discuss issues identified and areas requiring further questioning/understanding. It may also be helpful for a brief case summary to be prepared for Panel members.

An Independent person would be agreed, who may be an LSCB Board member from an agency who were not involved with the case/s, or it could be an Independent person from outside the LSCB – with the decision on this being appropriate for each case.

Early consideration needs to be given to the involvement of the child and family in the review process.

Frontline staff and their managers are then prepared by their SCR Panel lead for a discussion with the SCR Panel, which could be as a group, or with individual agencies. This preparation is crucial to ensure staff fully understand that the purpose of the review is to gain learning, and not to apportion blame. Staff need to be supported through the process to share their issues/perceptions experienced at the time of working with the family, as well as their later reflections.

C. PROCESS

The SCR Panel, including the Independent person, meet to discuss the issues identified and the areas that require further questioning and understanding from considering the brief case summary and chronology.

The SCR Panel can then decide how best to gain an understanding of the progress of the case, which may be through meeting with individual frontline workers and their managers; meeting with all involved practitioners together; or having a "Learning Event" day which includes both the involved practitioners from the case, as well as key staff from all LSCB agencies who would be able to progress the relevant issues from the case within their services.

SCR Panel members decide, where appropriate, who is best placed to meet with family members to seek their views on how agencies provided support, and how there could be any future improvements to services.

The learning points gained from these discussions are then combined into a brief report and action plan, which is presented to the LSCB Board, as well as all the involved frontline workers involved having direct feedback from their SCR Panel representative.

D. LEARNING

The learning from this approach to reviews is more immediate, as this is a shorter, less time-consuming process, and provides a more systemic understanding of how agencies worked together.

Hearing the voices of frontline workers and their managers can help to reinforce the importance of multi-agency work, and is very powerful in understanding if there needs to be any changes to improve practice, as well as acknowledging good practice. Evaluation forms that are completed by the individual workers who meet with the SCR Panel have been used in some PRs, and this has greatly assisted in understanding the process from the worker's point of view, and so making adjustments in future Reviews.

The learning from Partnership Reviews is then included with the learning from all other review processes in the LSCB training programme, particularly being disseminated to staff through the regular Briefing Sessions.

4. MULTI-AGENCY CASE FILE AUDITS

A. RATIONALE

Multi-agency case file audits form a part of the LSCB's wider role of monitoring and evaluating the effectiveness of the work done by Board partners, both individually and collectively, to safeguard and promote the welfare of children.

In contrast to Reviews which concentrate on a single significant case each time, case file audits enable regular scrutiny of day-to-day frontline practice across several agencies in relation to randomly-selected cases with a variety of outcomes of intervention, eg a child protection plan, child-in-need plan, no further action, etc.

Case file audits have been conducted by members of the East Sussex Quality Assurance (QA) Sub-group since 2009 and have been extremely useful in understanding the current practice of all agencies on the front-line. However, as from 2014 the QA Sub-group will change their process of auditing to ensure a more systemic approach by involving all the front line workers in discussion with the QA Sub-group. This will involve fewer cases at each audit, but it is anticipated that this will give greater insight into current practice.

B. PREPARATION

The QA Sub-group is responsible for multi-agency case file audits. It undertakes up to six such audits annually; at least two of the audits are 'regular case file audits' scrutinising the entire child protection process and the remaining audits are based on one part of the process or a theme, for example an audit of strategy discussions, cases referred for sexual abuse or fabricated or induced illness, or cases relating to privately fostered children.

Given each audit is highly detailed and time-consuming, only eight to 12 cases are selected randomly from a cohort of children meeting specific criteria depending on the audit, eg all children who were subjects of a section 47 investigation during a specific period. An effort is made to ensure the sample of cases selected for each audit is as representative as possible. Usually the sample is stratified by age, investigation

outcome and Children's Services team dealing with the process in order to match, as much as possible, the representation of these criteria in the cohort.

As the audits are multi-agency in focus, agency-specific audit tools have been created to ensure parity of scrutiny. In preparation for the multi-agency audit, QA Sub-group members assess in advance case files held by their agencies for each of the children selected, using their own audit tools. Agencies currently involved in these audits are Children's Social Care, Children's Services Education, East Sussex Healthcare Trust, NHS Sussex and Sussex Police. The Children's Services Education representative also scrutinises school files. In addition, early help professionals are asked to contribute information where relevant.

Once the preparatory work is completed, the auditors come together at a meeting where each case is discussed and recommendations are made. Each case is also graded according to an agreed scheme.

C. PROCESS

Audit criteria are aligned to Ofsted standards to ensure rigour. When grading a case file, the auditors rely on a number of standards and criteria for assessing whether the work is 'good', 'adequate' or 'inadequate'. For a case file to be assessed as 'good' it should provide evidence of:

- Comprehensive and timely screening in response to the referral to establish all relevant facts;
- Comprehensive and timely information sharing between agencies;
- Comprehensive information gathering to inform analysis of risks to the child;
- Appropriate consideration of action to take, if any, for immediate protection of the child;
- Robust assessment of risks to the child and the protection offered by the family;
- Strong evaluation of all appropriate variables when deciding whether or not the intervention threshold has been met;
- Evidence of rigorous outcome-focused planning, with contingency plans if agreed actions cannot be completed within timescales or the family's circumstances change;
- Evidence of sound and timely implementation of plans and systematic review and follow-up of actions; and
- Comprehensive records providing evidence of decision making, interventions and actions.

A case file may be assessed as 'inadequate' if it demonstrates failings in any one of the above standards. The grading is dependent on the contributions of all relevant agencies. While there may be good, or even exceptionally good, interventions by individual agencies and the children have been kept safe, a case may be given an 'inadequate' grading because of specific management or process concerns relating to a particular agency.

Findings and recommendations from each audit are disseminated to each agency immediately following the audit. The QA Sub-group maintains a rolling action log and monitors progress of actions in relation to audit recommendations.

D. LEARNING

Despite the small number of cases selected, each audit is invariably able to identify areas for further development and makes significant recommendations for practice improvement for all agencies whose case files are audited.

When inadequate practice is identified for a particular agency, the relevant LSCB QA Sub-group member communicates audit recommendations immediately to managers and officers asking appropriate action to be taken to improve agency practice. In some cases, QA Sub-group members may take the lead in identifying and initiating actions to improve the effectiveness of multi-disciplinary practice, for example putting in place appropriate multi-agency processes. A recent example is an improved process for recording and sharing information from strategy discussions.

Findings from these audits lead to more focused inter-agency training, including feeding into the LSCB Training Programme, joint-agency training, eg joint workshops for Children's Services and the Police initiated by the relevant QA Sub-group members, and dissemination of local good practice guidance.

5. SECTION 11 OF THE CHILDREN ACT 2004 – AGENCY SELF-EVALUATION

A. RATIONALE

Section 11 of the Children Act 2004 places a duty on key agencies to ensure that they pay due regard to safeguarding and promoting the wellbeing of children when discharging their functions. This duty also applies to any organisation providing services on behalf of these key agencies. The Children Act 2004 (section 14) requires LSCBs to ensure the effectiveness of the work done by agencies for safeguarding and promoting the wellbeing of children.

For these purposes, East Sussex LSCB carries out a self-evaluation audit every two years to assess the implementation of section 11 obligations.

B. PREPARATION

The evaluation involves agencies completing a self-evaluation tool. The design of the tool is a collaborative effort between East Sussex, West Sussex and Brighton and Hove LSCBs.

The self-evaluation tool considers key standards relating to agencies' statutory obligations under section 11. Each key standard usually includes a number of measures for which agencies are required to provide evidence of compliance. Key standards considered are:

- A clear commitment on the part of the agency's senior management to safeguarding and promoting children's wellbeing, demonstrated by a number of ways including a safeguarding lead with clearly defined responsibilities relating to safeguarding children in their job description;
- A clear statement of the agency's responsibilities towards children made explicit in its policies;
- A clear line of accountability and governance within the agency for work on safeguarding and promoting children's wellbeing which is known and understood by all staff;

- A clear commitment to always considering the need to safeguard and promote children's wellbeing and seeking views of children and families when developing or commissioning services;
- A clear commitment to providing the necessary training to all staff, working with or in contact with children, on their obligations for safeguarding and promoting children's wellbeing;
- Strong recruitment and allegation management procedures, including arrangements for appropriate checks and adoption of best practice in safer recruitment of new staff and volunteers;
- Effective inter-agency working to safeguard and promote children's wellbeing, including strategic commitment to the work of the LSCB and appropriate policies for effective inter-agency working in individual cases; and
- Effective information sharing, including strategic and operational guidance and training for successful multi-agency collaboration to safeguard and promote children's wellbeing.

In addition to the self-evaluation tool, guidance is produced as part of the toolkit to assist participants in completing the assessment and to provide a multi-agency benchmark through the use of a common language, with the intention that it will create a more consistent approach to considering safeguarding arrangements at a strategic level when addressing expectations across the three LSCB areas. The guidance provides examples of evidence that may be relevant when considering minimum safeguarding arrangements.

C. PROCESS

Participants are required to provide evidence of compliance, as well as a rating based on the traffic light system, for each standard relating to their statutory obligations.

The traffic light system relates to how an agency assesses itself against achieving the minimum requirements to meet a standard. In this model of self-evaluation, a score of 'green' means that the agency can demonstrate that it is able to meet the minimum requirements. If the agency assesses itself as 'amber' or 'red', it is expected to provide an action plan identifying areas for development and timescales for completing actions.

Section-11 compliance is a mandatory requirement for the following key organisations:
- Local authorities, including county, district and borough councils;
- NHS agencies, including Trusts, Foundation Trusts and Clinical Commissioning Groups (formerly Primary Care Trusts);
- Police (including British Transport Police);
- Probation and Prison Services;
- Youth Offending Teams; and
- Secure training centres.

However, East Sussex LSCB may require all its partners, including those not listed above, to complete the section 11 self-evaluation. Some local Community and Voluntary Organisations who particularly work with children, also complete this audit. In general, about 15 East Sussex agencies take part in the biennial exercise, with some key agencies always being involved every time.

At the end of the self-assessment, action plans from all participants are combined to produce an LSCB action plan which is subject to regular monitoring until the Board is satisfied that all actions have been completed.

In addition, individual agency responses may be audited by other LSCB members in order to provide greater scrutiny through peer review.

D. LEARNING

The section 11 self-evaluation is a useful quality assurance mechanism for recognising strengths and identifying areas for improvement in the way key people and agencies safeguard and promote the wellbeing of children.

- The section 11 self-evaluation is a practical way for the LSCB to gauge whether partners are able to discharge their statutory functions at least to the required minimum standards; it can assist in identifying targets for improvement and strategic goals for the LSCB as a whole.
- Given that the self-evaluation is repeated every two years, it enables agencies to build on recognised strengths and to monitor performance in relation to recognised weaknesses.
- It identifies learning and common training needs that can feed into the LSCB training programme to enable staff to build and strengthen their skills to safeguard and promote children's wellbeing.
- The self-evaluation exercise has the potential to be part of a virtuous quality assurance circle, providing the stimulus for the next exercise by way of improved methodology and new questions to ask.

6. CHILD DEATH OVERVIEW PANEL

A. RATIONALE

The LSCB is responsible for ensuring that a review of each death of a child (aged under 18 years of age), normally resident in the LSCB's area is undertaken by a Child Death Overview Panel (CDOP). This function is set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006. The Panel has a fixed core membership drawn from organisations represented on the LSCB with flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate.

B. PREPARATION

The Chair of the CDOP is not directly involved in providing services to children and families in the area. East Sussex shares a CDOP Panel with Brighton and Hove CDOP, as with a larger population, there is more significance in identifying modifiable factors to any death.
Both East Sussex, and Brighton and Hove, have a Designated Paediatrician, who provides expert advice on each child death, including advice about whether the death was unexpected. Each geographic area also has a CDOP Nurse who particularly provides support to the family following a child's death. East Sussex has a CDOP Co-ordinator who receives all death notifications for both areas, as well as other data relating to any death of a child.

C. PROCESS

The CDOP Co-ordinator establishes which agencies/professionals have been involved with the child and their family prior to, or at the time of the death of the child. The agency report is sent to the lead professional and any other professionals known to have been involved for completion. Family members are consulted about their views on the services provided, and whether they consider that there was anything that could

have been done to prevent the death. All this information is received within 3 weeks of the request, and is collated and anonymised for entry on to the data base. This information is sent to all CDOP members for discussion at a Panel meeting.

The CDOP meeting reviews each case in order to

- classify the cause of death
- identify any modifiable factors which may have contributed to the death
- decide on preventability of the death
- consider whether to make recommendations and to whom they should be addressed
- identify patterns or trends in local data
- where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring the case back to the LSCB Chair for consideration of whether an SCR is required
- consider whether local procedures should be amended for responding to unexpected deaths of children
- co-operate on a national basis with data and local findings

If there are any recommendations from CDOP relating to these reviews, they would be taken to the LSCB for further discussion and action to prevent future such deaths where possible.

D. LEARNING

Any recommendations from CDOP are taken to the LSCB Steering Group on a quarterly basis for further discussion and action.
The CDOP Chair produces an annual report that is presented to the LSCB Board, and is also incorporated into the main annual LSCB Report, which is then put on the LSCB website.
Themes and findings from CDOP are part of the learning that is disseminated by the SCR sub committee in the regular Briefing Sessions.