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1. Introduction

1.1 This Procedure sets a minimum standard for a Child Death Overview Panel (CDOP) as outlined in chapter 5 of the Government guidance Working Together to Safeguard Children 2015.

1.2 As described in Working Together and the Local Safeguarding Children Board Guidance (DCSF, 2006), there are two inter-related processes for reviewing child deaths. Either process can trigger a serious case review.

1.3 The processes are:

- A rapid response by a team of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child, this is detailed in the Rapid Response Procedure (March 2017).

- An overview of the deaths of all children (birth up to 18th birthday excluding babies who are stillborn or lawful terminations) normally resident in the LSCB area/s, undertaken by a panel drawn from key organisations represented on the LSCB – this Procedure applies.

1.4 Each Local Safeguarding Children Board (LSCB) has a responsibility for convening and maintaining a CDOP.

Interface with local, national and regional processes

1.5 The LSCB baseline procedure has been expanded on to relate to local needs.

1.6 A number of templates have been developed at a national level, for LSCBs to use to assist collecting information about child deaths:

- Form A for initial notification;
- Form B for agency reports; and
- Form C for analysis at the panel meeting.

1.7 LSCB Chairs in London have agreed that London will use the Fo-rms B and C from Dept. for Education. However, for initial notification London will use the initial notification form available at www.londonscb.gov.uk/child death. (Form A)

2. Context

2.1 When a child dies within the area in which s/he normally resides, the LSCB must collect and analyse information about each death with a view to identifying:

- any case giving rise to the need for a review mentioned in Regulation 5(1) (e) of the Local Safeguarding Children Board Regulations 2006;
any matters of concern affecting the safety and welfare of the children in the area of the authority; and

any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area;

2.2 When a child dies outside of the area in which s/he normally resides, the statutory responsibility for conducting the review lies with the LSCB where the child normally resides. To avoid unnecessary additional burden on professionals and the child’s family, it is not recommended that the two CDOPs conduct individual reviews. However, the two CDOP Chairs should negotiate and agree how learning from the review/s will be shared across both areas.

3 Core purpose

3.1 The CDOP will undertake an overview of all child deaths within the locality this is based on information available from those who were involved in the care of the child, both before, at the time and immediately after death, and other sources such as:

- Case summaries from health records;
- Case information from police, LA Children’s Social Care and Education;
- Post Mortem reports.

3.2 The CDOP has a responsibility for reviewing the deaths of all children, with priority given to those deaths that are both unexpected and unexplained.

3.3 Where necessary, the CDOP has the authority to recommend that a serious case review should be undertaken by the LSCB. If there is to be a serious case review, it will be undertaken by the LSCB where the child normally resides, with the final decision taken by the LSCB Chair.

4 Membership

4.1 There will be a fixed core membership on the CDOP, which is drawn from the key organisations represented on the LSCB, as per Appendix 2.

4.2 Other members will be co-opted as and when appropriate, e.g. London Fire Brigade, adult mental health services, education/early years, bereavement services etc.

4.3 The CDOP Chair should be accountable to the LSCB, but should not be involved in providing direct services to children and families in the LSCB area. The Ealing CDOP is chaired by Jackie Chin, Director of Public Health, Ealing CCG.
5 Frequency of meetings

5.1 The CDOP should hold meetings on a regular basis to enable the circumstances of each child death to be discussed in a timely manner. The Ealing CDOP meets 3-4 times per year.

5.2 The CDOP should ensure that all other processes have concluded before reviewing a child death, although data collection should continue in the meantime.

6 Notification of child deaths

6.1 All deaths of children normally resident /or occurring in Ealing should be notified to the CDOP Borough single point of contact (SPOC) who will inform the designated paediatrician for child death. See Appendix A for contact details.

7 Deaths of children occurring outside Ealing

7.1 When a child dies in an area s/he is not normally resident in, the SPOC for the area in which the child died will inform the SPOC in the area the child normally lived.

7.2 The CDOP in the area where the child was normally resident will review the death and liaise with the area where the child died, where appropriate. For children not normally resident in London, the CDOP Chair for the area where the child died should also write to the CDOP conducting the review to ensure that any lessons are shared. The CDOP Chair for the area where the child was normally resident is responsible for ensuring that this process operates effectively. To avoid unnecessary additional burden on professionals and the child’s family, it is not recommended that two LSCBs conduct individual reviews.

7.3 If it is unclear in which CDOP area the child normally resided (such as in cases of shared care arrangements in different boroughs), the relevant CDOP Chairs should negotiate and agree who will lead the review. If no agreement can be reached, the CDOP chairs involved should escalate the issue to their respective LSCBs, for agreement to be reached by the LSCBs Chairs. Timescales should not be allowed to slip, therefore until any dispute is resolved, the case must be treated as the responsibility of the disputing LSCB in whose area the child was last known to have been alive.

7.4 Information sharing between two CDOPs when a child dies out of his/her normal residency area is in addition to informing the coroner within 1 working day and immediate notification of the designated paediatrician for unexpected deaths in childhood, if the death was unexpected (see the Rapid Response Procedure (2017)).
7.5 Children who die in hospital will be reviewed by the CDOP for the area in which they were normally resident.

7.6 The CDOP must review the circumstances of children who are normally resident in the area but who die abroad.

8 Key functions

8.1 The key functions of the CDOP are to:

a) Receive notification on all child deaths occurring in the local area.

b) Collect and collate an agreed national minimum data set.

c) Seek information from professionals who had involvement with the child before and immediately following the death and, where relevant, the child’s family members.

d) Evaluate the data available and identify 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.

e) Assess the cases with regard to the threshold criteria to enable specific cases to be reviewed in depth (see Threshold criteria in appendix 2).

f) Ensure that individual case discussions have taken place regarding unexpected child deaths.

g) Monitor 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 CDOP to consider and what actions it might take in order not to prejudice any criminal proceedings.

h) Identify any common themes from individual cases and consider these in more depth.

i) Consider whether the death was preventable, if so how such deaths might be prevented in the future.

j) Identify any patterns or trends in the local data and report these back to the LSCB.
k) Consider the Framework for the Assessment of Children in Need and their Families (Department of Health et al, 2000) to assess any child, parent, social or environmental factors which could contribute to developing an understanding of the individual child’s death (Sidebotham and Fleming, 2007; p20-24).

l) Alert the Chair of the LSCB about any deaths where, on evaluating the available information, the CDOP considers there may be grounds to undertake further enquiries, investigations or a serious case review and explore why this had not previously been recognised.

m) Inform the Chair of the CDOP where specific new information should be passed to the coroner or other appropriate authorities

n) Provide 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.

o) Monitor the support and assessment services offered to families of children who have died.

p) Monitor and advise the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths.

q) Identify any public health issues and consider, with the Director /s of Public Health, how best to address these and their implications for both the provision of services and for training;

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

s) Ensure each partner agency of the LSCB identifies a senior person with relevant expertise to have responsibility for advising on the implementation of the local procedures on responding to child deaths within their agency.

9 Consent and confidentiality

9.1 Information in CDOP meetings will not be anonymised.

9.2 It is best practice to seek consent before processing information about any individual, but it is legitimate to share information with the designated paediatrician for unexpected deaths in childhood / the CDOP SPOC and CDOP Manager without seeking parental consent. It should only be shared with those who need to know as governed by the Caldicott Principles, the Data Protection Act and Working Together.
9.3 CDOPs have arrangements in place for parents and carers to be advised that the child’s death will be subject to a review in order to learn any lessons that may help to prevent future deaths of children. *(See attached letters in Appendix 4)*

9.4 All LSCB member agencies must be aware of the need to share information on all child deaths to enable the LSCB to carry out its statutory duty.

9.5 Members of the CDOP must sign a confidentiality agreement, including sharing and securely storing information (see *model confidentiality statement in appendix 2*) when they join the CDOP. This agreement will be reviewed at each meeting.

9.6 In no case will any CDOP member disclose any information pertaining to any individual case which has been dealt with by the CDOP outside the meeting, other than pursuant to the mandated agency responsibilities of that individual or for the purpose of joint investigations. Public statements about the general purpose of the child death review process may be in line with the LSCB process for managing media interest (see the *Rapid Response Procedure (2017)*, as long as they are not identified with any specific case.

10 Professional and family support

10.1 The CDOP Chair should consider what information is given 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.

10.2 The CDOP Chair should ensure that information is also received and evaluated by the CDOP regarding the services and immediate support offered to families of children who have died (see information around the care of the bereaved family in Rapid Response Procedure (2017)).

11 Learning from child deaths

11.1 The CDOP will monitor and advise the LSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths.

11.2 The CDOP will identify any strategic issues (such as public health, Community safety, health and safety etc) and consider how best to address these and their implications for both the provision of services and for training.
11.3 The CDOP will contribute to regional and national initiatives to identify lessons in prevention of unexpected child deaths.

12 Reporting mechanisms

a. The CDOP must submit an annual report to the LSCB

b. The LSCB is responsible for:

- Disseminating the lessons to be learnt to all relevant organisations;

- Ensuring that relevant findings inform the *Children and Young People’s Plan*;

- Acting on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children; and

- Ensuring that data relating to child deaths is submitted to relevant regional and national initiatives to identify lessons on the prevention of unexpected child deaths.
APPENDIX 1

CDOP Contact List

CDOP Co-ordinator

Steve Bourne
Ealing Safeguarding Children Board Manager,
Perceval House,
Ealing,
London W5 2HL
Tel: 0208 825 9618
E-mail: Steve.Bourne@nhs.net

Rapid Response Administrator Ealing

Lesley Tilson
Paediatric Unit 10th Floor
Ealing Hospital
Uxbridge Road
Southall
Middlesex
UB1 3HW
Tel; 0208 967 5276 or 0208 967 5000 bleep 110
Secure fax; 0208 967 5254
Email; Lesley.tilson@nhs.net

Designated Paediatrician, CDOP

Dr Ramnik Mathur
Consultant Paediatrician
Ealing Hospital
Tel: 0208 967 5000 Ext 3313
Secure fax: 0208 967 5254
APPENDIX 2

Members of CDOP Panel and Organisations

Organisation

Chair - Director Public Health, Ealing
Consultant Paediatrician Ealing Hospital
CDOP Manager/Coordinator
Safeguarding Manager, Ealing Children’s Social Care
Designated Nurse Safeguarding Children, NHS Ealing CCG
Metropolitan Police, Ealing Borough
Metropolitan Police, CAIT Northwood
APPENDIX 3

Confidentiality Statement

CHILD DEATH OVERVIEW PANEL

CONFIDENTIALITY STATEMENT

The purpose of the Child Death Overview Panel is to conduct a review of all preventable child deaths in Ealing in order to better understand how and why children die and to take action to prevent other deaths.

In order to assure a co-ordinated response that fully addresses all systematic concerns surrounding child deaths, all relevant data should be shared and reviewed by the team, as permitted within the stipulations of the Data Protection Act, including historical information concerning the deceased child, his or her family, and the circumstances surrounding the death. Much of this information is protected from public disclosure.

The London Procedures for Rapid Response and for Child Death Overview Panels and the Ealing LSCBs protocols for child death reviews stipulate that in no case will any team member disclose any information pertaining to any individual case outside the meeting other than pursuant to the mandated agency responsibilities of that individual.

Any information obtained or recommendations or decisions made by the CDOP shall be treated as confidential by the undersigned. Public statements about the general purpose of the child death review process may be made in line with the London LSCB process for managing media interest (see Rapid Response Procedure 2017), as long as they are not identified with any specific case.

The undersigned agrees to abide by the terms of this confidentiality policy.

Name | Agency | Signature | Date
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APPENDIX 4: Threshold criteria

There are three levels or types of child death cases for the members of the Child Death Overview Panel (the CDOP) to consider.

Level 1 – Scope: where the child’s death is ‘anticipated / not unexpected’ and likely to be more ‘straightforward’, with no additional complicating factors.

Cause of death may be reviewed briefly to learn key lessons. These are likely to be the substantial number of the deaths for review, and the majority are likely to be neonates. It is suggested that occasionally there should be a more detailed review of a random selection of some of these more ‘straightforward cases to look at them in more depth. The selection could be theme based on the cause of death (e.g. SUDI, cancer, congenital, other, etc).

Level 2 – Scope: where there additional factors in relation to the child’s death. The CDOP will require papers additional to the core papers. The range of types of deaths meeting level 2 are listed below (this is not exhaustive).

Level 3 (serious case review) – Scope: Lessons, recommendations and action plans from any serious case review need to be incorporated into the overall planning and strategy (including policy and staff development) arising from all child deaths. The serious case reviews should also be included in the annual report of the CDOP.

The decision to undertake a serious case review is made by the Chair of the Local Safeguarding Children Board.

Process – All CDOP members contract to read the CDOP case papers in advance of the meeting to avoid delay in scheduled meeting time. Any glaring questions or omissions should be communicated to the CDOP Chair in advance of the meeting and if they cannot be dealt with before the meeting, the case is withdrawn and deferred to a subsequent panel with the required information / documents provided.

All panel members must use secure communication systems to transfer such information in a timely way e.g. nhs.net or met.pnn.police.co.uk

Local data collection and analysis / London learning – All the agreed child and family specific data in relation to the death, preventability scoring and summary outcomes and recommendations must be recorded as per the Department for Education Guidelines

This information should input into a simple local electronic database (Access or Excel) which is consistent across London and allows the collation of all London child death data by the London Safeguarding Children Board for annual strategic analysis and recommendations.

Reporting – Local data, lessons and recommendations to be reported to the Local Safeguarding Children Board at least annually or more frequently, as agreed.
## APPENDIX 4 – Threshold Criteria (cont’d.)

<table>
<thead>
<tr>
<th>Type of case</th>
<th>Core papers</th>
<th>Additional papers?</th>
<th>Process and planned outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Straightforward deaths</td>
<td>Notes from the rapid response meeting, if a meeting was held.</td>
<td>Only those which exist already and will be deemed – by Chair and CDOP Co-ordinator – to assist the CDOP. To be kept to minimum and should have been summarised in the <em>Analysis Form C</em></td>
<td>All CDOP members under contract to read the CDOP papers in advance of the meeting to avoid CDOP meeting being delayed by reading time.</td>
</tr>
<tr>
<td>Natural</td>
<td></td>
<td></td>
<td>Any significant questions or omissions to be communicated to CDOP Chair in advance of the meeting and if these cannot be answered, case withdrawn from the CDOP discussion for outstanding issue to be resolved / answered.</td>
</tr>
<tr>
<td>Expected</td>
<td></td>
<td></td>
<td>Brief summary discussion – 10 – 15 minutes.</td>
</tr>
<tr>
<td>SUDI</td>
<td>Brief (A4) summary descriptions of agency contact with the family prior to the death, and any lessons learned or questions unanswered from agency contact – suggest 3 or 4 headings for this summary prepared summary by CDOP manager providing overview note and key points for the CDOP review sent out in advance of meeting – resource and skills issue.)</td>
<td></td>
<td>Panel summary under agreed headings – or as agreed at London level – to be attached to the data to be sent to London Safeguarding Children Board</td>
</tr>
<tr>
<td>SIDS</td>
<td></td>
<td></td>
<td>e.g.</td>
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</tbody>
</table>

- clinical issues,
- preventability,
- lessons,
- social / cultural lessons
- recommendations
<table>
<thead>
<tr>
<th>Level 2</th>
<th>Core papers</th>
<th>Any reports on outcomes of the criminal proceedings / coroner’s inquest</th>
<th>Full discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>All alleged murders or violent deaths</td>
<td>Core papers</td>
<td>Any reports on outcomes of the coroners inquest / criminal proceedings / H&amp;S Executive enquiry, NPSA, serious case reviews or Internal Agency investigations or similar investigations or reviews.</td>
<td>CDOP summary under agreed headings to be attached to the data to be sent to London-wide data collector / body</td>
</tr>
<tr>
<td>Any death where criminal, coroner or civil proceedings or H&amp;S Executive process are being considered as a result of the death.</td>
<td>Core papers</td>
<td>Outcome of the SUI9 Serious Untoward Incident Report and Review). Internal Management Review (IMP).</td>
<td>- clinical issues</td>
</tr>
<tr>
<td>Such cases cannot come to the panel for full discussion until after these proceedings have ended.</td>
<td>Core papers</td>
<td></td>
<td>- preventability</td>
</tr>
<tr>
<td>Any death for which there has been an agency critical incident / Serious Untoward Incident Review.</td>
<td>Core papers</td>
<td></td>
<td>- clinical lessons</td>
</tr>
<tr>
<td>Any death which remains unexplained</td>
<td>Core papers</td>
<td></td>
<td>- social / cultural lessons</td>
</tr>
<tr>
<td>Any death where the ‘parenting’ or lifestyle or pre-death care, behaviour of parent, carer or key family member is a possible contributing factor in the child’s death</td>
<td>Core papers</td>
<td>May require additional reports from adult services, mental health services or substance misuse services.</td>
<td>As above, it will be helpful to have a London wide approach to the outcome summary from the CDOP discussion, to be developed over time under some agreed headings to aid review and data collection.</td>
</tr>
<tr>
<td>Level 2 continued</td>
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<tr>
<td>All traffic deaths</td>
<td>Core papers</td>
<td>Input to CDOP from traffic specialist – possible information about ‘school travel plan’ for child’s school, if appropriate, etc</td>
<td></td>
</tr>
<tr>
<td>All deaths resulting from suicides and self harming behaviours</td>
<td>Core papers</td>
<td>Psychiatric review of the papers?</td>
<td></td>
</tr>
<tr>
<td>Drowning, death by fire, death by animal</td>
<td>Core papers</td>
<td>Other relevant reports – police /HSE, Local authority, LAS, LFB etc</td>
<td></td>
</tr>
<tr>
<td>Accidents / unintentional</td>
<td>Core papers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any death where the death although ‘later’ may be directly earlier attributed to an act of violence, assault, lapse of care or self-harming behaviour some time before but which may not have been the immediate cause of death at the time of death</td>
<td></td>
<td>Relevant incident based reports from police and health professionals</td>
<td></td>
</tr>
<tr>
<td>Any death which has attracted public or media interest, subject to the governance panel of LSCB</td>
<td>Core papers</td>
<td>Possibly summary of public / media coverage</td>
<td></td>
</tr>
<tr>
<td>All deaths notified to DCSF / Ofsted under the notification system</td>
<td>Core papers</td>
<td></td>
<td></td>
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</table>

Full discussion
30 – 45 minutes
CDOP summary under agreed headings to be attached to the data to be sent London-wide
e.g.
- clinical issues
- preventability
- clinical lessons
- social / cultural lessons
- systems lessons
- practice lessons (pre and post death)
- recommendations

As above, it will be helpful to have a London wide approach to the outcome summary from the CDOP discussion, to be developed over time under some agreed headings.
<table>
<thead>
<tr>
<th><strong>Level 3 (serious case reviews)</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Any SCR into the death of a child after the SCR is complete</strong></td>
<td>Core data set only &lt;br&gt;But no additional agency summaries as this will have been covered in the IMRs for the SCR</td>
<td>SCR overview report/executive summary &lt;br&gt;Any actions of Management Sub Group or QA sub group if relevant &lt;br&gt;Any outcome from any criminal proceedings if relevant</td>
</tr>
</tbody>
</table>
Ealing Child Death Overview Panel Procedure – March 2017

Useful contacts:

**The Child Bereavement Charity**
- Support and resources for bereaved parents and families:
  - Helpline: 01494 568900 (office hours)
  - Website: www.childbereavement.org.uk

**The Compassionate Friends**
- Support and counselling for all bereaved persons:
  - Helpline: 0845 112 2304 (10.00am-4.00pm/6.30pm-10.30pm)
  - Website: www.compassionatefriends.org.uk

**Cruse Bereavement Care**
- Support for families bereaved through a sudden infant death (cot death):
  - Helpline: 0844 4779490 (9.30am-5.00 pm)
  - Website: www.cruse.org.uk

**Lullaby Trust**
- Foundation for the Study of Infant Deaths (FSID)
  - Support for families bereaved through a sudden infant death:
    - Helpline: 0808 802 6869
    - Website: www.lullabytrust.org.uk

Further information about the role of Hillingdon and Ealing Child Death Overview Panels can be found at:
- www.hillingdon.gov.uk/scb
- www.ealing.gov.uk/working-together-to-safeguard-children
- www.london.gov.uk/working-together-to-safeguard-children

If you have any questions please contact:

Your Consultant Paediatrician or
Carol Hamilton
Child Death Overview Panel
Manager
London Boroughs of Hillingdon and
Ealing
01895 279318

‘Working together to prevent Child Death’
Talking and thinking about a child’s death is a sensitive and difficult subject, which can be particularly upsetting for parents, families and carers. This leaflet provides a list of organisations that you may find useful.

**What the Law requires**

Government legislation now requires all local authorities, via their Safeguarding Children Board, to review the death of every child (up to the age of 18 years) in their area. This is because the government believes that it may help other children and families in the future. This will be done in two ways:

1. **Rapid Response**

   A rapid response is a process undertaken by a group of key professionals who come together for the purpose of enquiring into a sudden and unexpected death of a child.

   This may mean a visit to where your child died by a community paediatrician, and/or a police officer, health professional and/or social worker, which may take place within a few days of your child’s death.

2. **Review of all child deaths (under 18 years)**

   The Child Death Overview Panel, consisting of doctors, other health specialists and childcare professionals, must consider information about your child and the circumstances of their death. This will not happen until all other processes are completed which generally takes about 6 months.

**What is the purpose of a Review?**

The Child Death Overview Panel must consider whether they can make any recommendations to improve services for children and their families. These recommendations must be shared with the local health trusts, children’s services, the police and where appropriate, with specialist agencies such as the fire service or traffic authorities. These recommendations may assist in the planning of services for children and families in the future.

**You may feel able to contribute**

We will let you know when your child’s circumstances are to be considered by the Child Death Overview Panel and will invite you to write to us to share any information about your child that you feel may help the process. Unfortunately it is not possible for parents or family representatives to attend the Panel meetings.

All the information we gather will be treated with the deepest respect and in strictest confidence. We promise that none of our findings, recommendations or reports will name your child or family.

**The Coroner**

In certain circumstances, deaths must be reported to the coroner; for example, when a death is sudden and of unknown cause, due to injury, soon after an operation or when a doctor does not know the cause of death. Whilst the coroner is totally independent of the process, he/she will be asked to share any relevant information concerning the death of your child with the Panel.