Derby and Derbyshire Child Death Overview Panel

Statutory Responsibilities and Arrangements Implementation plan

Final Version

Signatories to the Derby and Derbyshire Child Death Overview Panel implementation plan

Derby and Derbyshire Clinical Commissioning Group:

Brigid Stacey – Chief Nurse / CCG Executive Lead for Safeguarding children and Adults

Derby City Council:

Dr Cate Edwynn, Director of Public Health

Derbyshire County Council:

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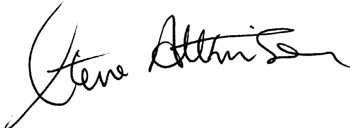
Derbyshire Safeguarding Children Board



Steve Atkinson, Independent Chair

Derby City Safeguarding Children Board

Christine Cassell, Independent Chair

Derby and Derbyshire Child Death Review Partners

Child Death Overview Panel
Statutory Responsibilities and Arrangements

Overview

The Child Death Review Partners for Derby and Derbyshire are the Directors of Public Heath for Derby City Council and Derbyshire County Council and the Chief Nurse for Derby and Derbyshire Clinical Commissioning Group. The partners will ensure that all Child deaths are reviewed under the requirements of the Children Act 2004 as amended by the Children and Social Work Act 2017 and Working Together 2018.

Purpose

Derby and Derbyshire Child Death Review Partners will ensure that the Child Death Overview Panel (CDOP) will undertake a review of all child deaths (excluding both those babies who are still born and planned terminations of pregnancy carried out within the law) up to the age of 18 years normally resident in Derby and Derbyshire and if they consider appropriate any non-resident child who has died their area. The Child Death Review Partners and CDOP will adhere to the statutory guidance: Child Death Review Statutory and Operational Guidance (England) 2018.

"*The process of systematically reviewing the deaths of children is grounded in respect for the rights of children and their families, with the intention of learning what happened and why, and preventing future child deaths."* (Working Together to Safeguard Children 2018)

Child Death Review Partners Statutory Responsibilities

The Derby and Derbyshire Child Death Review Partners have made arrangements for a structured and consistent approach to review all deaths of children under 18 years of age in line with Working Together 2018. The geographical footprint of Derby City and Derbyshire County reflects the network of NHS health providers, Police and Social Care providers for the local area. The arrangements are as follows:

- The child death review process will be modelled on, and adhere to, Child Death Review Statutory and Operational Guidance (2018) this will include the continued utilisation of the Child Death Overview Panel as the chosen forum for reviewing all child deaths.
- The Child Death Review Partners have agreed funding for a Designated Doctor for Child Death and a Lead Nurse for the Child Death Review process which incorporates the Link/Key worker role as stated in the statutory guidance. These posts will be recruited to by 29 September 2019.
- The partners have agreed funding for e-CDOP an electronic case management system which automatically reports into the National Child Mortality Database. This has been active from 1st April 2019.
- The Partners will have oversight and be assured of the development and progress of the Child Death Review Process and CDOP through an agreed governance and reporting mechanism
- The Child Death Review Partners will publicise information regarding the arrangements for reviewing child deaths in Derby and Derbyshire.

Child Death Overview Panel Responsibilities

- To collect and collate information about a Child's death, seeking relevant information from professionals and where appropriate family members
- To analyse the information obtained, including the report from the Child Death Review Meeting in order to confirm or clarify the cause of death, to determine any contributing factors, and to identify any learning arising from the child death review process that may prevent future deaths

- To make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths and will promote the health safety and well-being of children
- To notify the Child Safeguarding Practice Review Panel and local Safeguarding Partners when it suspects that a child may have been abused or neglected
- To notify the Medical Examiner (once introduced) and the doctor who certified the cause of death, if it is identified there are any errors or deficiencies in an individual child's registered cause of death.
- To provide specific data to NHS digital through the National Child Mortality Database
- To produce an annual report for Child Death Review Partners on local patterns and trends in child deaths, and any lessons learnt and actions taken and the effectiveness of the wider child death review process.
- To contribute to local, regional and national initiatives to improve learning from child death reviews including where appropriate approved research carried out within the requirements of data protection

Child Death Overview Panel Operational Arrangements

- CDOP will meet monthly to enable the deaths of children to be discussed in a timely manner and within the statutory timeframe of six months. Exceptions are where there is a current criminal or coronial investigation.
- Neonatal themed panels will be held four times a year; the core membership will remain unchanged with additional professional experts to inform the panel.
- Other themed panels will be considered and determined by the needs of local child deaths
- Ensure that effective rapid response arrangements for sudden deaths are in place, to enable key professionals to come together to undertake enquiries into and evaluate and make an analysis of each unexpected death of a child.
- Review the appropriateness of agency responses to each death of a child.
- Review relevant environmental, social, health and cultural aspects of each death to ensure a thorough consideration of how such deaths may be prevented in the future.
- Determine whether each death had modifiable factors.
- Make appropriate recommendations to Derby and Derbyshire Safeguarding Children Partnership where there are concerns of abuse and neglect in order that prompt action can be taken to learn from and prevent future deaths where possible.
- Report and inform the LeDeR process of any deaths of children over 4years who have a Learning Disability.

Panel Membership

The Child Death Overview Panel will be chaired by the Derby and Derbyshire Clinical Commissioning Group Designated Nurse for Safeguarding Children. The Vice Chair is a Consultant from Public Health. This will be reviewed annually when the terms of reference are reviewed.

CDOP is a multi- professional panel. The core membership will include senior representatives from the following agencies:

- Public Health within Derbyshire County Council and Derby City Council
- Designated Doctor for Child Deaths
- Lead Nurse for Child Death Review
- Hospital Paediatrician if the Designated Doctor is a Community Paediatrician or vice versa
- Social Care representative from Derby City and Derbyshire County Children Services
- Police
- Designated Nurse or Doctor for Safeguarding Children
- Primary Care representative

- 0-19 service representation from Derby City and Derbyshire County Health Providers
- Paediatric Nursing
- Lay representation

Neonatal Themed Panel

The membership of this panel will be as above with additional members:

- Neonatologist
- Midwifery/Bereavement Midwife
- Obstetrician input if not attending
- Neonatal Specialist Nurse

In addition to the core membership of CDOP relevant experts from health and other agencies will be invited as necessary to inform the discussion.

Quoracy

The Child Death Overview Panel will be quorate if there are five or more core members present at the meeting this must include attendance by lead professionals from health and the two Local Authorities.

Decisions and disputes

Decisions will be normally reached by consensus. In the event of a disagreement, a vote of members of the panel will be taken. In the event of a failure to resolve an issue, the chair will discuss this further with the Designated Doctor for Child Death and the Vice Chair to come to a resolution.

Conflict of interest

Panel members must declare any conflict of interest at the outset of each meeting. Panel members should not lead discussions if they are the named professional who had responsibility for the care of the child prior to her death.

Confidentiality

All information discussed at the Child Death Overview Panel is **strictly confidential** and must not be disclosed to a third party without discussion and agreement of the Chair. A confidentiality agreement will be read by all members of the panel at the beginning of each Derby and Derbyshire CDOP meeting.

Governance and Accountability

The Child Death Overview Panel is accountable to the Derby and Derbyshire Child Death Review Partners.

Minutes of each meeting are recorded and are available with permission from the Chair to the Child Death Review Partners.

A summary of key learning is available and reported to the Child Death Review Partners.

The Chair of the Child Death Overview Panel will report quarterly to:

- The Health and Well Being Boards for Derby City Council and Derbyshire County Council
- Safeguarding Committee within Derby and Derbyshire Clinical Commissioning Group

The report will include numbers of child deaths reviewed. Recommendations and learning and any delays on reviewing child deaths due to criminal or coronial investigations

The chair of the Child Death Review Panel and Designated Doctor for Child Death will write and present an Annual Report. This will be presented to the Child Death Review Partners and to Derby and Derbyshire Safeguarding Children Partnership.

Any concerns regarding responsibilities and functions of the child death review process and the Child Death Overview Panel will be reported and escalated to the Child Death Review Partners by the Chair or Vice Chair of CDOP

Implementation

The CDOP plan will be implemented on 29th September 2019; at this point the Derby and Derbyshire Child Death Overview Partners will take responsibility for the implementation of the new arrangements as set out within this document.

Publication

The Derby and Derbyshire Child Death Review Partners and Child Death Overview Panel arrangements will be published on:

Derby and Derbyshire Clinical Commissioning Group website
Derbyshire County Council website
Derby City Council website
Derbyshire Safeguarding Children Board website
Derby City Safeguarding Children Board website
Derby and Derbyshire Safeguarding Children Partnership website from September 2019

The Child Death Review Partners will also notify NHS England of the new arrangements by emailing England.cypalignment@nhs.net **before the 29th June 2019**