Pan Cheshire Child Death Overview Panel (CDOP)

Arrangements Overview

The Pan-Cheshire CDOP has been set up by Child Death Review (CDR) Partners for Cheshire which comprises Warrington, Halton, Vale Royal, Eastern Cheshire, South Cheshire and West Cheshire CCGs and Warrington, Halton, Cheshire East and Cheshire West & Chester Councils to review the deaths of children under the requirements of the Children Act 2004 and Working Together to Safeguard Children 2018.

Purpose

The purpose of the Pan-Cheshire CDOP is to undertake a review of all child deaths (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) up to the age of 18 years, normally resident in the Pan-Cheshire area, irrespective of the place of their death. The Pan-Cheshire CDOP will adhere to the statutory guidance: Child Death Review Statutory and Operational Guidance (England) 2018: https://www.gov.uk/government/publications/child-death-review-statutory-andoperational-guidance-england

CDOP Responsibilities

These are specified within the statutory guidance and include:

- To collect and collate information about each child death, seeking relevant information from professionals and, where appropriate, family members;
- To analyse the information obtained, including the report from the CDRM, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths;
- To make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing 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 identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction;
- To provide specified data to NHS Digital and then, once established, to the National Child Mortality Database;
- To produce an annual report for CDR partners on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process; and
- 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.

- To map prevalence of Adverse Childhood Experiences (ACEs) and other identified environment factors that can allow the panel to develop population based information to guide priority work to drive improvements in children's lived experiences across Cheshire.

For more details of local interpretation of these responsibilities please see our corresponding Memorandum of Understanding and Terms of Reference.

Operational Responsibilities

The Statutory guidance has identified a clear expectation on the operational requirements for Child Death reviews. These include:

- Hold meetings at intervals agreed locally to enable the death of each child to be discussed in a timely manner.
- Hold themed meetings where CDR partners arrange for a single CDOP, or neighbouring CDOPs, to collectively review child deaths from a particular cause or group of causes. Such arrangements allow appropriate professional experts to be present at the panel to inform discussions, and/or allow easier identification of themes when the number of deaths from a particular cause is small.
- Ensure that effective 'Rapid Response' arrangements are in place, to enable key professionals to come together to undertake enquiries into and evaluating each unexpected death of a child – this includes monitoring the local processes to identify and address any issues of quality and engagement
- 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 might be prevented in the future.
- Determine whether each death had modifiable factors.
- Make appropriate recommendations to the relevant areas governing body, in order that prompt action can be taken to prevent future such deaths where possible. The local pathway for governance is to be determined by each individual area to reflect the variation in new safeguarding arrangements
- Ensure that families receive an appropriate offer of bereavement support and escalate concerns where this does not seem to be embedded in practice

Governance and Accountability

Pan-Cheshire CDOP will meet as an independent body on behalf of the core CDR partners. Subsequently it will make recommendations on any necessary action to the relevant area representatives that sits on the Panel. It will be the role of the panel member to ensure that the recommendation is shared to the most appropriate local governing body. For example, the Health and Wellbeing Board or New Safeguarding Children Arrangements.

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Pan-Cheshire CDOP will provide the following to support oversight and scrutiny of the arrangements:

- A concise summary of the key points from each meeting will be provided summarising any recommendations from the reviews of child deaths
- An annual report and priority action plan

Membership

The Child Death Review Panel will be chaired by an independent Chair as outlined in the statutory guidance. They will be independent of the key providers in the area in which it operates. The vice-chair will be drawn from the wider panel membership. The chair will be recruited through a tender process and vice-chair nominated by the panel.

Panel Membership

Please refer to the Pan-Cheshire CDOP ToR which will elaborate on the specific expectations of members and quoracy. As a minimum the following roles will participate in the panel:

- Public health representative
- Designated Doctor for child deaths (and a hospital clinician if the Designated Doctor is a community doctor or vice versa)
- Social services representative
- Police representative
- Safeguarding (Designated Doctor or Nurse)
- Lead Nurse for Child Deaths
- Primary care representative
- Nursing and/or midwifery representative
- Lay representation
- Coroner's office representative
- Education representative
- Housing representative

In addition to the core membership, relevant experts from health and other agencies will be invited as necessary to inform discussions if and when needed.

Decisions and Disputes

Decisions will normally be reached by consensus. In the event of a disagreement, a vote of members will be taken. In the event of a failure to resolve the issue, the Chair will have the casting vote or discuss with the Business Manager resolution of outstanding issues.

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Conflict of Interest

Panel members must declare any conflict of interest at the outset of each meeting and panel members should not lead discussions if they are the named professional with responsibility for the care of the child. This will be indicated within the Panel registers of attendance and stored as a record.

Confidentiality

All information discussed at The Child Death Review Panel is STRICTLY CONFIDENTIAL and must not be disclosed to third parties, without discussion and agreement of the Chair.

Publication

The Pan-Cheshire Child Death Overview Panel (CDOP) arrangements will be published on the Cheshire East Council website - http://www.cheshireeastlscb.org.uk/professionals/child-death-review/child-death-review.aspx . All relevant partners will host links to this website from their own domains.

Review Date and Next Review Date

The terms of reference of Pan-Cheshire CDOP will be subject to annual review, or when significant changes determine a refresh is required.

Last Reviewed: 30 June 2019 Next Review Scheduled: 30 June 2020