Bedfordshire Child Death Overview Panel (CDOP) Policy and Guidance 2019

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1. Introduction

The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity. Families experiencing such a tragedy should be met with empathy and compassion. They need clear and sensitive communication. They also need to understand what happened to their child and know that professionals will learn from what happened. The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths

1.2 Overview

The Bedfordshire CDOP has been set up by Child Death Review (CDR) Partners, the Police, Bedford and Luton CCG; Bedford Borough, Central Bedfordshire & Luton Councils to review the deaths of children under the requirements of the Children Act, 2004 and Working Together to Safeguard Children, 2018.

1.3 Purpose

The purpose of the Bedfordshire 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 Bedfordshire, irrespective of the place of their death. The Bedfordshire CDOP will adhere to the statutory guidance: Child Death 2018: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

1.4 Statutory Requirement

When a child dies, in any circumstances, it is important for parents and families to understand what has happened and whether there are any lessons to be learned. The responsibility for ensuring child death reviews are carried out is held by 'child death review partners,' who, in relation to a local authority area in England, are defined as the local authority for that area and any clinical commissioning groups operating in the local authority area.

Child death review partners must make arrangements to review all deaths of children normally resident in the local area and, if they consider it appropriate, for any non-resident child who has died in their area.

The Children Act 2004 requires Child Death Review (CDR) partners to make arrangements to carry out child death reviews. These arrangements should result in the establishment of a Child Death Overview Panel (CDOP), to review the deaths of all children normally resident in the relevant local authority area, and if they consider it appropriate the deaths in that area of non-resident children. The review should then be carried out by a Child Death Overview Panel (CDOP), on behalf of CDR partners, and should be conducted in accordance with Working Together (2018

2.0 CDOP Panel responsibilities (Terms of Reference)

The functions of CDOP 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.

Within Central Bedfordshire, Bedford Borough and Luton the functions specified in the regulations and guidance will be undertaken by the Child Death Overview Panel (CDOP) on behalf of the Safeguarding Children Boards (SCB). CDOP will meet approximately every 6 weeks.

The Chair of CDOP is responsible for ensuring that CDOP operates effectively.

2.1 Operational Responsibilities

- Hold meetings at intervals to be agreed locally to enable the death of each child to be discussed in a timely manner. In Bedfordshire and Luton this will be approximately 6-8 weekly.
- 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 Joint agency Response is in line with the Child Death Review Statutory and Operational Guidance (England, 2018). **See Appendix 1**
- 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 and review the appropriateness of agency responses to each death of a child
- Make appropriate recommendations to the Bedford Borough, Central Bedford and Luton Safeguarding Children Boards (SCB), in order that prompt action can be taken to prevent future such deaths where possible.

2.2 Governance and Accountability

- The Child Death Review Panel is accountable to the Clinical Commissioning Groups (CCGs) and the Local Authorities (LAs).
- A concise summary of the key points from each panel will be provided to the CDOP chair and panel members.
- The Child Death Review Panel will provide 6 monthly reports to the CCGs and LAs, summarising any recommendations from the reviews of child deaths.
- CDOP action plan will be developed annually and reviewed quarterly within CDOP panel.

2.3 Panel Membership

- Public health (Chair)
- Designated Doctor for child deaths (and a hospital clinician if the Designated Doctor is a community doctor or vice versa)
- Children's services
- Police
- Safeguarding (Designated Nurse)
- Lead Nurse for Child Deaths (Bedford Hospital and L&D Hospital)
- Primary care (GP or health visitor)
- Nursing and/or midwifery
- Lay representation
- Coroner's office (as required)
- Education **(as required)**
- Housing **(as required)**
- Bedford Borough, Central Bedfordshire and Luton Local Authorities
- Ambulance Services
- Hospice (**as required**)

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

2.4 CDOP Arrangements - When a child Dies

- This describes the immediate decisions that professionals should make in the hours following the death of any child. This includes deciding whether a Medical Certificate for Cause of Death (MCCD) can be issued, or whether a referral to the coroner is necessary.
- The cause of death for most children who die is understood and the doctor who has attended the child at the end of their life (the "attending doctor") will be able to issue a MCCD and the death will be able to be registered. Consideration should be given to how best to support the family, and to what information needs to be gathered to inform the CDRM.
- However, if the death is from external causes, the circumstances are unclear, or safeguarding concerns or problems with care or service delivery are suspected, further investigations will be needed, to understand how the child has died.
- In order to respond appropriately to each death, senior professionals attending the child at the end of his/her life should consult with each other in order to determine the correct course of action. This is relevant to all child deaths, wherever they occur. **(See immediate decision and notifications on Appendix 2)**

2.5 Quorate

- The Child Death Review Panel will be quorate if there are five or more core members present at the meeting and must include attendance by CDOP designated doctors for child deaths and safeguarding leads from health and the local authorities.

2.6 Responsibilities of Panel Members

- Panel members should be familiar with their responsibilities and ensure that they read all relevant material in advance of panel meetings. **As outlined in the guidance**

2.7 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 Designated Doctors for Child Deaths.**

2.8 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.

2.9 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.

2.10 Publication

- The Bedfordshire Child Death Overview Panel (CDOP) arrangements will be published on the Pan Bedfordshire Inter Agency Child Protection Procedures website (https://bedfordscb.proceduresonline.com/) and all CCG website (https://www.lutonccg.nhs.uk/home/; https://www.bedfordshireccg.nhs.uk/home/) and the Safeguarding Children Board's websites (https://www.bedford.gov.uk/social-care-health-and-community/children-young-people/safeguarding-children-board/; https://centralbedfordshirelscb.org.uk/lscb-website/home-page; http://lutonlscb.org.uk/)

2.11 Review Date and Next Review Date

- The terms of reference of The Bedfordshire CDOP will be subject to an annual review, or more frequently, if required.

Next Review Scheduled: end 2020

Appendix 1

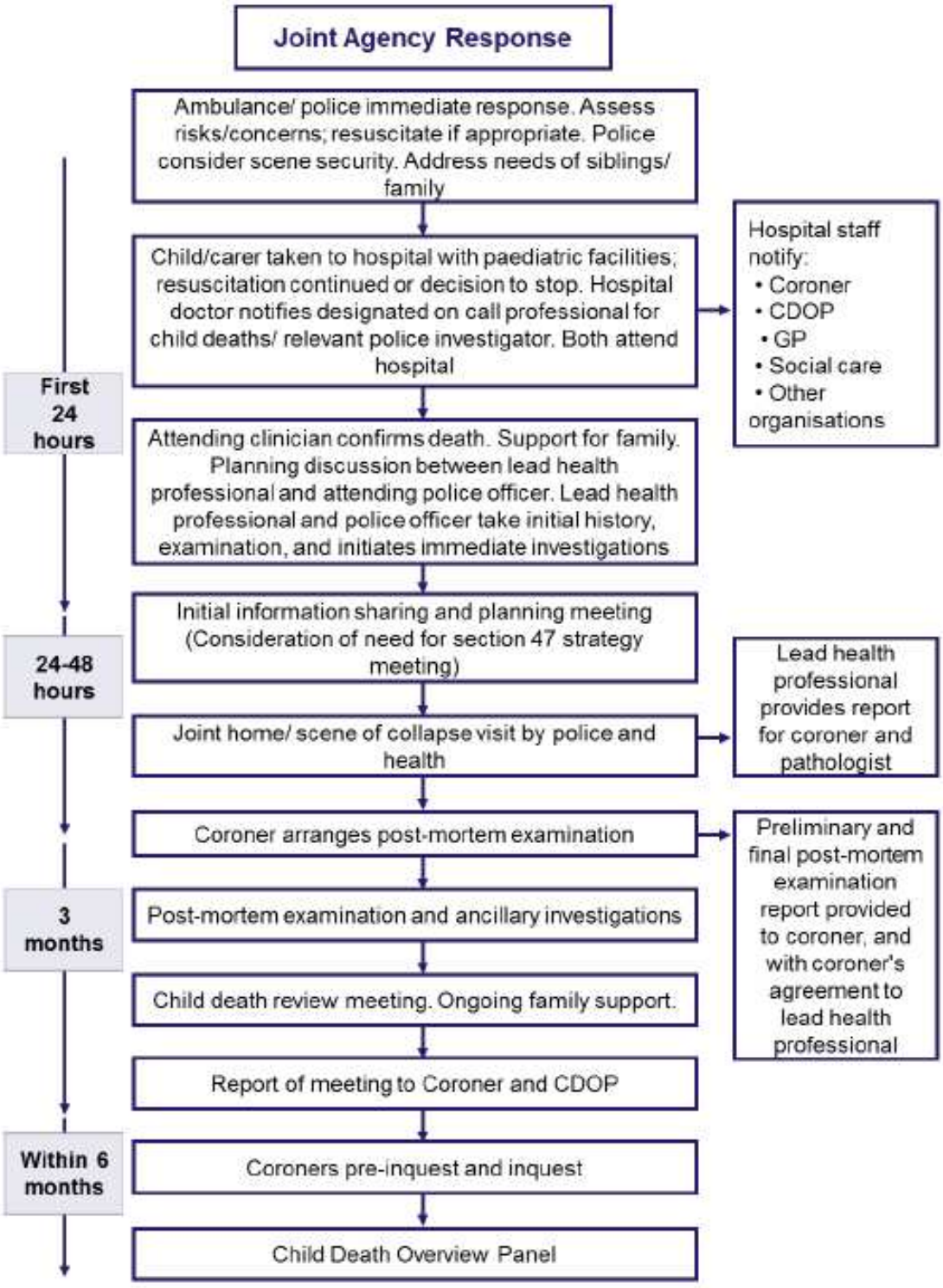

Figure 4: In this flow-chart, CDOP is used to represent the group established by CDR Partners that conducts the final stage of the child death review process.

Appendix 2

Immediate decision making and notifications