Hampshire and Isle of Wight Child Death Overview Panel (CDOP)

CDOP arrangements

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'(CDRP) who, in relation to a local authority area in England, are defined as the local authority or local authorities for that area and any clinical commissioning groups operating in the local authority area.

Reviews should be carried out by a Child Death Overview Panel (CDOP), on behalf of CDR partners, and should be conducted in accordance with the Child Death Review Statutory and Operational Guidance 2018 and Working Together to Safeguard Children 2018.

The child death review partners are Hampshire County Council, Isle of Wight Council, Portsmouth City Council, Southampton City Council, the Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups, West Hampshire Clinical Commissioning Group, Portsmouth City Clinical Commissioning Group and Southampton City Clinical Commissioning Group (CCG).

Southampton, Portsmouth and the Isle of Wight will be treated as a single area of 'Hampshire and the Isle of Wight' for the purpose of undertaking child death reviews.

1. Purpose

1.1 The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in Hampshire and the Isle of Wight or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If CDR partners find actions that should be taken by a person or organisation, they must inform that agency / lead.

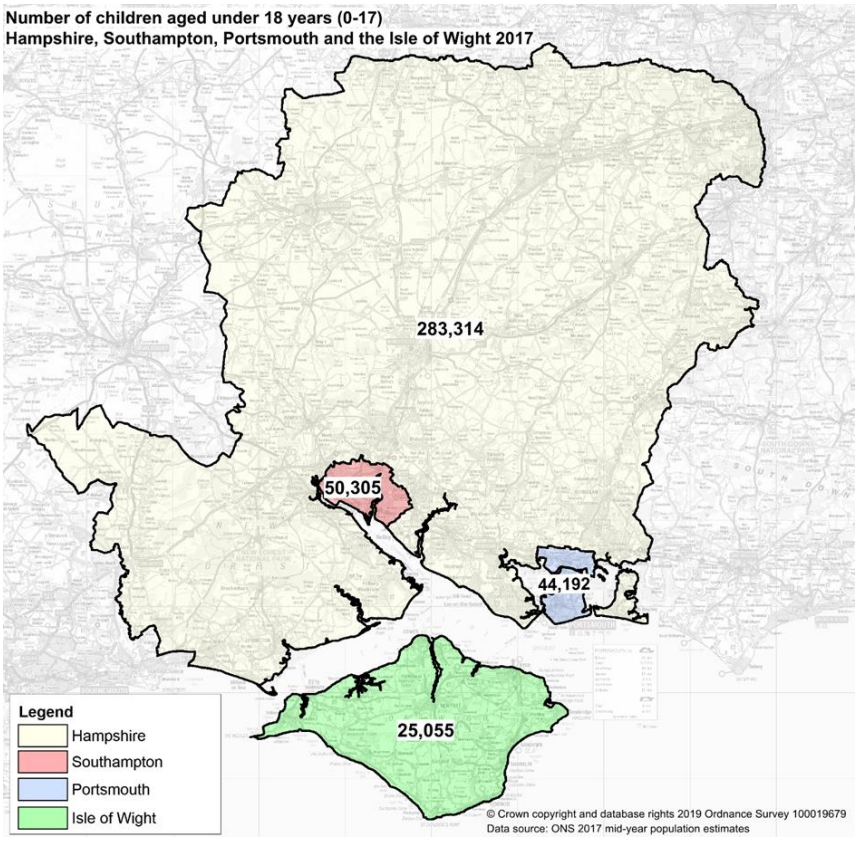
1.2 In addition, CDR partners:

- must, at such times as they consider appropriate, prepare and publish reports on:
    - what they have done as a result of the child death review arrangements in their area, and
    - how effective the arrangements have been in practice;

- may request information from a person or organisation for the purposes of enabling or assisting the review and/or analysis process - the person or organisation must comply with the request, and if they do not, the child death review partners may take legal action to seek enforcement;
- may make payments directly towards expenditure incurred in connection with arrangements made for child death reviews or analysis of information about deaths reviewed, or by contributing to a fund out of which payments may be made; and may provide staff, goods, services, accommodation or other resources to any person for purposes connected with the child death review or analysis process.

2. Area of review by CDOP

2.1 The Hampshire and Isle of Wight CDOP will review the deaths of all children up to the age of 18 (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) normally resident in the Local Authority areas of Hampshire, Isle of Wight, Portsmouth and Southampton. The CDOP, where it considers it appropriate, may also review the death of a non-resident child who has died in the area.



2.2 As recommended by Working Together 2018, the HIOW CDOP will typically review in excess of 60 deaths each year (see table below). This will better enable thematic learning in order to identify potential safeguarding or local health issues that could be modified in order to protect children from harm and, ultimately, save lives.

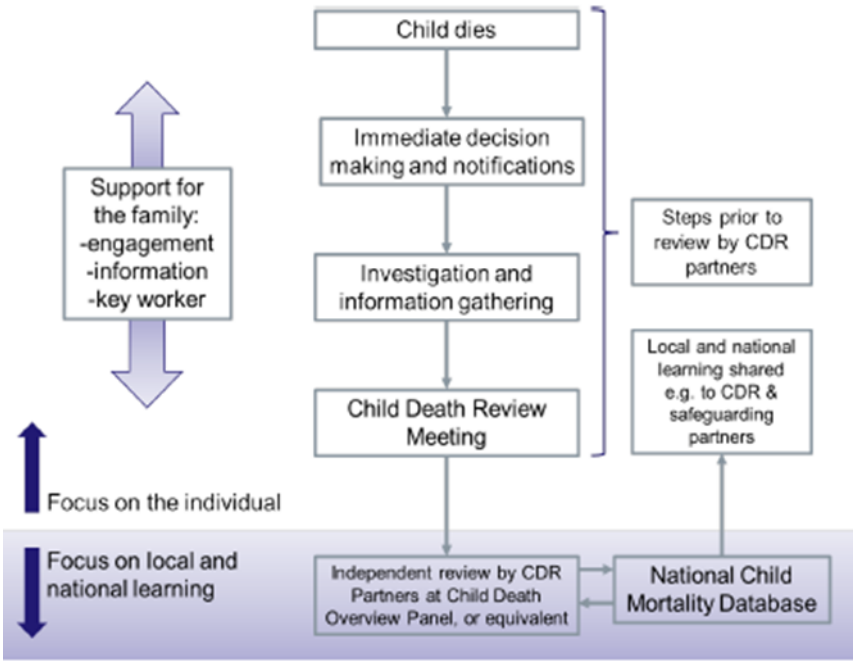
Table 1: Total Child deaths across Hampshire and Isle of Wight

	Hants	IOW	Ports	Soton	**Total**
2017/2018	92	4	10	14	120
2016/2017	61	6	11	23	101
2015/2016	76	8	9	24	117

(Data extracted from 4 LCSB CDOP Annual report)

3. Child death review process

3.1 The Hampshire and Isle of Wight CDOP will adhere to the statutory guidance: Child Death Review Statutory and Operational Guidance (England) 2018 with child death review process as shown below.



4. CDOP responsibilities

CDOP responsibilities are as follows:

- 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 Children Partnerships 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.

5. Operational responsibilities

5.1 The aim of the CDOP is to review the case six to eight weeks after receiving the report from the CDRM or the result of the coroner's inquest. The exception to this might be when discussion of the case at a themed panel is planned or when the death is subject to a local Serious Safeguarding Review.

5.2 Some child deaths may be best reviewed at a themed meeting. This is where the deaths resulting from a particular cause or group of causes are collectively reviewed. 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 case is small.

Examples of themed panels are neonatal deaths and deaths due to suicide, cancer and trauma. The frequency of themed panel meetings would be dictated by the number of deaths in each category, but the themed panel should occur within 12 months of the child's death. Designated doctors for child death will work together to decide which cases might best benefit from review at a themed panel.

The HIOW CDOP should also explore the option of conducting themed panels at a regional level for example on children with disabilities, adolescent deaths, suicide, and malignancy. The frequency of such panel meetings would be dictated by the number of deaths in each category.

5.3 Further operational responsibilities are as follows:

- Ensure that effective Joint Agency Review arrangements are in place, to enable key professionals to come together to undertake enquiries into and evaluating 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 might be prevented in the future.
- Determine whether each death had modifiable factors.
- Make appropriate recommendations to the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) Child Safeguarding Executive Group, and / or the Local Safeguarding Children Partnerships where appropriate, in order that prompt action can be taken to prevent future such deaths where possible.

5.4 The final details of the working of the panel will be agreed by the CDR with the independent chair once appointed but will be modelled on the existing CDOP arrangements used by the current Local Safeguarding Children Boards to review the deaths of children in their areas.

6. Governance and Accountability

6.1 The Child Death Review Panel is accountable to the overarching Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) Children's Safeguarding Executive Board.

6.2 The CDR partners will prepare and publish an annual report that will highlight local patterns and trends in child deaths, any lessons learnt, and actions taken by partners, and how effective the arrangements have been in practice.

In addition to the above statutory requirements, the report should include a summary of:

a) key learning arising from the reviews
b) reports from themed panels
c) any actions that have been taken to prevent child deaths as a result of this learning.

This report should be shared with the CCG Governing Bodies and Local Authorities, and the four local Safeguarding Children Partnerships. The Local Authorities may also wish to share the report with relevant Council Scrutiny Committees and Health and Wellbeing Boards.

6.3 The Local Authority Public Health representative and Designated Doctor for child deaths should liaise with decision makers in partner organisations to share key learning and take forward any actions arising from recommendations made at CDOP.

6.4 CDOPs should record the outcome of Child Death Review meeting discussions on a final Analysis Form and submit this to NHS Digital. Once it is operational, under instruction from the CDR partners, CDOPs should submit copies of all completed forms associated with the child death review process and the analysis of information about the deaths reviewed (including but not limited to the Notification Form, the Reporting Form, Supplementary Reporting Forms and the Analysis Form) to the National Child Mortality Database.

7. Membership

7.1 As per the Child Death Review Operational Guidance, the CDOP should be chaired by someone independent of the key providers (NHS, social services, and police) in the area. The Child Death Review partners will appoint an Independent Chair, with relevant knowledge and expertise of the child death review process, to provide independent scrutiny and challenge to the panel.

7.2 It is anticipated that one organisation of CDR Partners would lead the appointment process of the Independent Chair, to be in place from September/October 2019, and their recruitment processes will be used to form the basis of the appointment. The appointment will be for a period of two years. Performance reviews will take place on a six-monthly basis.

7.3 The Independent Chair would be expected to work for a minimum of 1 day per month (at an anticipated day rate of £450 per day) to prepare for and attend CDOP meetings. Additional time will be agreed with the CDR partners as and when needed to facilitate attendance at other meetings where required. The maximum cost of the Independent Chair to CDR partners would be £6,500 based on a maximum of 12 days per year.

7.4 The vice-chair will be identified from the CDOP membership

7.5 Core Panel Membership is as follows:

- Public Health
- Designated Doctor for child deaths (and a hospital clinician if the Designated Doctor is a community doctor or vice versa)
- Children's Social Care and Safeguarding
- Police
- Safeguarding (Designated Doctor or Nurse)
- Health professional (Midwifery)
- Lay representation

7.6 In addition to the core membership, relevant experts from health and other agencies will be invited as necessary to inform discussions and once the panel is established membership from other sectors will be considered for example Coroner's office, Education, Housing, Council Services, Health & Wellbeing Board, Ambulance Services, Hospice.

7.7 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 lead professionals from health and the local authority.

7.8 Panel members should be familiar with their responsibilities and ensure that they read all relevant material in advance of panel meetings.

7.9 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.

7.10 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.

7.11 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.

8. CDOP Administrative arrangements

8.1 The work of the CDOP will be led and coordinated by a dedicated staffing team comprising of a CDOP Manager and a CDOP Administrator. The Team, along with the Independent Chair, are funded by Child Death Review partners. The team will work closely with the Child Death Review Partners and Independent Chair, and partner agencies, to ensure the CDOP operates effectively and fulfils its statutory requirements.

8.2 The CDOP administrative office should be notified according to local protocol whenever a child dies.

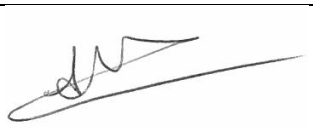
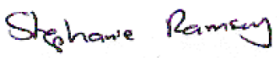
8.3 The CDOP may request any professional or organisation to provide relevant information to it, or to any other person or body, for the purposes of enabling or assisting the performance of the child death review partner's functions. Professionals and organisations must comply with such requests.

9. Funding

9.1 The CDOP will be funded by contributions from the Child Death Review Partners, split proportionately based on the number of deaths per local authority area. Accommodation, legal and communications services are provided by Hampshire County Council.

9.2 A review of the funding arrangements will be undertaken after the first year of operation to enable the child death review partners to consider the future resourcing requirements, agree the level of funding provided by each partner.

Signatures:

	Name	Signature	Title
Hampshire County Council	Simon Bryant		Interim Director of Public Health
Isle of Wight Council	Simon Bryant		Interim Director of Public Health
Portsmouth City Council	Jason Horsley		Director of Public Health
Southampton City Council	Hilary Brooks		Director of Children's Services
West Hampshire Clinical Commissioning Group (on behalf of the 5 Hampshire CCGs)	Ellen McNicholas		Director of Quality and Nursing
Portsmouth Clinical Commissioning Group	Dr Linda Collie		Chief Clinical Officer
Southampton Clinical Commissioning Group	Stephanie Ramsey		Director of Quality and Integration/Chief Nurse
Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups	Julia Barton		Executive Director of Quality & Nursing

This document was signed and published on 27 June 2019.