Suffolk Child Death Overview Panel (CDOP)

CDOP Arrangements

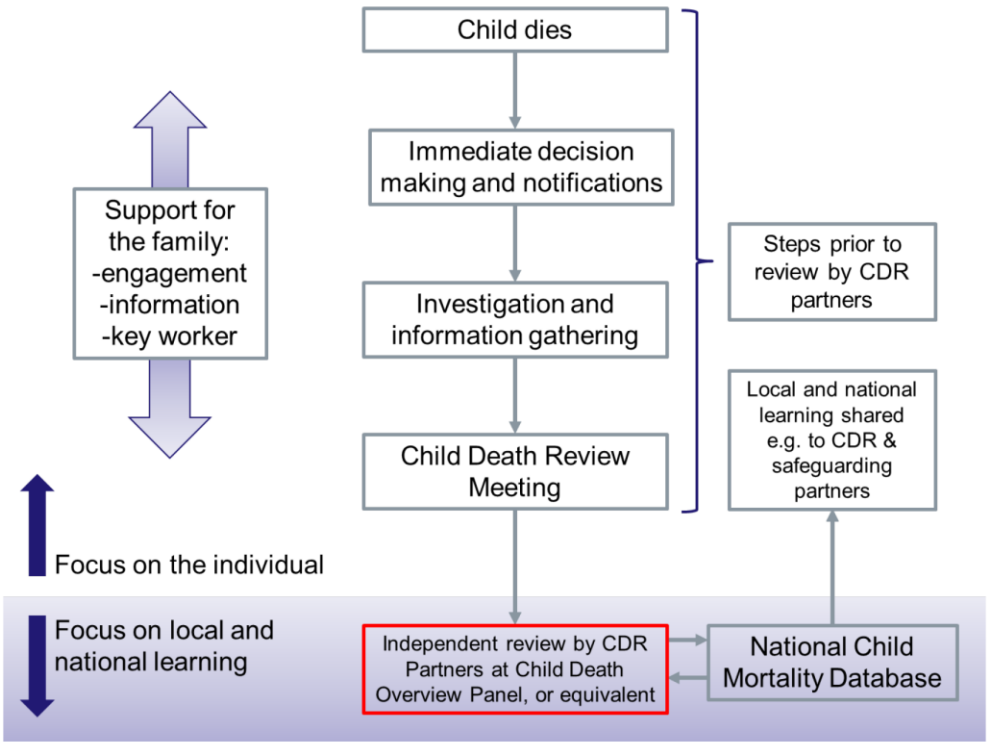
Overview

The Suffolk CDOP has been set up by Child Death Review (CDR) Partners, Ipswich and East, West Suffolk and Great Yarmouth and Waveney CCGs and Suffolk County Council 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 Suffolk 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 Suffolk, irrespective of the place of their death. The Suffolk 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-and-operational-guidance-england

The Child Death Review Process highlighting the CDOP



CDOP Responsibilities

- 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 Child death review Meeting (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 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.

Operational Responsibilities

- Hold meetings at bi-monthly intervals 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.
- Suffolk CDOP has linked with Norfolk CDOP through the use of eCDOP to enable learning from child deaths where the number of child deaths reviews in Suffolk, per annum does not reach the required 60 reviews.
- 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. A new Child Death Review (CDR) Team has been commissioned by Ipswich and East and West Suffolk CCGs. This team will ensure a coordinated health response to all child deaths and to ensure compliance with the Child Death Review National Standards (2018). This team will go live in September 2019.
- 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 Suffolk Safeguarding Children Partnership, in order that prompt action can be taken to prevent future such deaths where possible.
- Be a subgroup of the Suffolk Safeguarding Children Partnership (previously LSCB).

Governance and Accountability

- The Child Death Review Panel is accountable to the Suffolk Safeguarding Children Partnership (SCP) and is a sub-group of the SCP.
- A concise summary of the key points from each meeting will be recorded within eCDOP and available to the CDOP membership.
- The Child Death Review Panel will provide a report to a summary report provided to the SCP six monthly as a sub-group report, summarising any recommendations from the reviews of child deaths.
- The CDOP will provide a detailed annual report to the regional CDOP group to enhance learning at a regional level.

Membership

The Child Death Review Panel will be chaired by a Consultant in Public health**.** The vice-chair will be Designated Nurse for Safeguarding and Children and Child Death Reviews**.** The chair and vice-chair will be selected by agreement of the CDOP panel membership.

NB The Child Death Review Statutory & Operational Guidance states: "The CDOP should be chaired by someone independent of the key providers (NHS, social services, and police) in the area."

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)*
- Social services
- Police
- Designated Nurse for Safeguarding Children and Child Death Reviews (Vice- Chair)
- Child Death Review (CDR) Nurse
- Suffolk County Council Health
- Coroner's office
- Education
- Ambulance Services
- Hospice
- Acute Hospital Trusts
- Safeguarding Children Partnership Management Team

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

Quoracy

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.

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.

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 Doctor and Nurse resolution of outstanding issues.

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.

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 Suffolk Child Death Overview Panel (CDOP) arrangements will be published on the Suffolk CCGs website http://www.ipswichandeastsuffolkccg.nhs.uk/ https://www.westsuffolkccg.nhs.uk/ and the Suffolk County Council website https://www.suffolk.gov.uk/.

The arrangements will also be published on the Suffolk Safeguarding Children Partnership website https://www.suffolkscb.org.uk/

Review Date and Next Review Date

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

Last Reviewed: June 2019

Next Review Scheduled: June 2020