South West London (SWL) Child Death Overview Panel (CDOP)

(The South West London area covers the boroughs of Croydon, Merton, Wandsworth, Kingston, Richmond & Sutton)

CDOP Arrangements for SWL CCGs (Croydon, Merton, Wandsworth, Kingston, Richmond, Sutton)

(These arrangements have been formally agreed by the CCG Accountable Officers and the Directors of Children's Services in their role as Statutory Child Death Overview partners)

Overview

The SWL CCGs CDOP has been set up by Child Death Review (CDR) Partners, the SWL CCGs and SWL Local Authorities 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 SWL 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 SWL geographical area (Croydon, Merton, Wandsworth, Kingston, Richmond, Sutton) irrespective of the place of their death. The SWL 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-ooperational-guidance-england .

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), 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 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, 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

- The SWL CDOP will hold meetings at intervals (10 meetings per year) to enable the death of each child to be discussed in a timely manner
- The SWL CDOP will hold themed meetings where CDR partners arrange for a single CDOP, or neighbouring CDOPs, to collectively review child deaths from a 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 the 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
- 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 SWL CCG, in order that prompt action can be taken to prevent future such deaths where possible

Governance and Accountability

- The SWL Child Death Review Panel is accountable to the individual CCGs Governing Body for each borough – Croydon, Merton, Wandsworth, Kingston, Richmond, Sutton. Within the Council to the relevant Children’s Services Senior Management Team
- An annual report will be available for the individual CCG Governing Bodies and Council Senior Management Teams that will summarise any recommendations from the review of child deaths
- The annual report will be presented to the relevant Safeguarding Partnerships across SWL
- A concise summary of the key points from each meeting will be available on request for relevant Quality & Performance Committees / Safeguarding Partnerships

Membership

The Child Death Review Panel will be independently chaired by a Director of Public Health. This will initially be for a period of 6 months, then for review. The vice-chair will also initially be a Director of Public Health who will stand for 6 months, then for review. In the first instance, appointments will be made by local nomination, with potential for a formal recruitment process should circumstances dictate.

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

Panel membership will be made up of the following professionals ensuring a good geographical split across the six boroughs of Croydon, Merton, Wandsworth, Kingston, Richmond and Sutton.

- Public health
- Designated Doctor for child deaths
- Local Authority
- Police
- Safeguarding Designated Doctor
- Safeguarding Designated Nurse
- Primary Care Representative (Named GP / GP with special interest)
- Nursing specialist lead and / or midwifery specialist lead – (for thematic meetings)
- Lay representation (Lay member from a SWL CCG)

Additional professionals will be considered on a case-by-case basis, for example from: coroner’s office, education, housing, council services, health and wellbeing board, Public Health England, ambulance services, or hospices.

Quoracy

The Child Death Review Panel will be quorate if there are a minimum of five core members present at the meeting and must include attendance by public health, a lead professional 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. In exception circumstances, there will be escalation to the Accountable Officer of the SWL CCG.

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 SWL Child Death Overview Panel (CDOP) arrangements will be published on the relevant CCGs and Council website. The arrangements will also be published on the local Safeguarding Children Partnership website.

Review Date and Next Review Date

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

Last Reviewed: 1st June 2019

Next Review Scheduled: 1st June 2020