Waltham Forest, East London and the City (WELC)
Child Death Review Overview ane (CDOP)

Terms of Reference
2019

Contents

These Terms of Reference to be reviewed annually. Next review due: October 2020.

1. Introduction

These terms of reference apply to the WELC CDR System Child Death Overview Panel (CDOP). The Partners to the WELC CDR System are the local authorities of Waltham Forest, East London (Hackney, Newham and Tower Hamlets) and City; together with the NHS Waltham Forest, Newham and Tower Hamlets; and Hackney clinical commissioning groups (CCGs).

The Children and Social Work Act (2017) and *Working Together* set out expectations for Child Death Review Partners (Local Authorities and Clinical Commissioning Groups) to make arrangements for the review by a Child Death Overview Panel (CDOP) of the deaths of all children normally resident in the relevant local authority are, and if they consider it appropriate the deaths in that area of non-resident children.

2. Purpose

Through a comprehensive and multi-disciplinary review of child deaths, the Child Death Overview Panel (CDOP) aims to better understand how and why children in The London Borough of Waltham Forest die and use the findings to take action to prevent other deaths and improve the health and safety of children in the Borough.

In carrying out activities to achieve this purpose, the CDOP will meet the functions set out in *Working Together to Safeguard Children 2018 (Chapter 5)* in relation to the death of any children who are residents of the borough.

a) Collecting and analysing information about each death with a view to identifying -

   i. any case giving rise to the need for a review mentioned in regulation 5(1)(e);

   ii. any matters of concern affecting the safety and welfare of children in the area of the authority;

   iii. any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

b) Putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

3. Scope, participation and functions

3.1 Scope

The CDOP will gather and assess data on the deaths of all children and young people from birth (excluding those babies who are stillborn) up to the age of 18 years old who are normally resident in the local area. This will include neo-natal deaths, expected and unexpected deaths in infants and older children. Where a child dies within the area and is resident elsewhere, that death shall be notified to the CDOP in the child's area of residence. Similarly, when a child normally resident in the area dies outside the local authority area, the CDOP should be notified. In both cases an agreement should be made as to which CDOP (normally that of the child's area of residence) will review the child's death how the two CDOPs will report to each other.

3.2 Participation: voice of the family

A primary objective for the CDOP must be to promote the inclusion of contributions from bereaved families with regard to their child's past and recent circumstances and life experience; and the treatment and processes relevant to and just prior to their child's death. The CDOP must assure itself that this incorporated into the individual case when it is reviewed at the CDOP meetings.

The CDOP must assure itself that in each case there is evidence that the needs of the family, in terms of follow up and bereavement support, have been met.

3.3 Annual report

The annual CDOP report should be written in plain English and placed in the public domain, summarising: the key learning arising from the child death review process, reports from themed panels, and actions that have been taken to prevent child deaths as a result of this learning.

3.4 Functions

The functions of CDOP include to:

a) Collect and collate information on each child death, seeking relevant information from professionals and, where appropriate, family members;

b) Analyse the information obtained, including the report from the child death review meeting, 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;

c) Make recommendations to the child death review partners and other organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children;

d) Notify the child safeguarding practice review panel and local safeguarding partners when it identifies that a child was abused or neglected;

e) 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, for the purposes of improving death registration;

f) Provide specified data to the department of health and then, once established, to the national child mortality database;

g) Produce an annual report for child death review 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;

h) 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.

i) Increase public awareness and advocate for the issues that affect the health and safety of children.

3.5 Reviewing deaths of non-resident children

The WELC CDOP has primary responsibility for discussing the cases of children who have died within the WELC footprint, regardless of where the children were resident. Although consideration should also be given to where the most learning can take place; and accordingly WELC CDR partners *may* review the deaths of non-resident children who have died within the WELC footprint. If this does not happen, the CDR Hub team must follow up with their counterparts in the area where the child is resident and submit the Analysis Form to the WELC CDOP in as timely a manner as possible.

4. CDOP administration

The WELC CDR Hub team will work closely with the CDOP Chair and the Designated Doctor for child deaths to:

a) Convene the CDOP meetings;

b) Ensure that the CDOP meetings are quorate;

c) Ensure that the members have timely access to relevant documents; and

d) Record outcomes from the CDOP meetings

e) Progress outstanding issues in a timely manner and return them to the next CDOP meeting.

4.1 Requests for information

The CDOP may request any professional or organisation to provide relevant information to enable or assist the purpose of reviewing each child's death. Professionals and organisations must comply with such requests. CDOPs should aim to review all children's deaths within six weeks of receiving the report from the child death review meeting 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.

5. Membership, expert representation and attendance

5.1 Membership

The CDOP is a multi-professional panel whose core membership should include senior representatives from the following agencies:

- Public health (often as Chair)
- Designated doctor for child deaths (*and a hospital clinician if the Designated Doctor is a community doctor or vice versa*)
- Health (Community/hospital)
- Social services
- Police
- Safeguarding (designated doctor or nurse)

- Primary care (GP or health visitor)
- Nursing and/or Midwifery
- CDOP (manager)
- Lay public /parent representation

Other professionals may be invited to sit on the Panel either as a co-opted member or if they are involved in specific cases as an ad-hoc member. Some of these professional may be from a core member agency, but bringing a discipline-specific expert perspective. For example, where a child had learning disabilities, the CDOP must assure itself that the LeDeR process has been implemented for review of the case, and that a relevant expert is in attendance at the CDOP discussions for all LeDeR cases. Other professionals may be from additional agencies, such as representatives from: the Coroner's officer, Education, Housing, Council Services, a Health and Wellbeing Board, the London Ambulance Service and/or local Hospices.

The role of each core CDOP member and the role of regular co-opted CDOP Members can be found in the appendices.

5.2 CDOP Chair

The CDOP should be chaired by someone independent of the key service providers in the area. For the WELC CDR system the Chair will be a Director of Public health.

5.3 Meetings and themed meetings

Panel members should be familiar with their responsibilities and ensure that they read all relevant material in advance of CDOP meetings. Conflicts of interest should be established 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.

The CDOP should aim to have themed to collectively review child deaths from a particular cause or group of causes. For themed meetings The CDOP must ensure that the Chair is suitably experienced and appropriate professional experts must be present to inform discussions. Examples of themes include neonatal, cardiac, cancer, SUDI/C, suicide and trauma. The frequency of such panel meetings would be dictated by the number of deaths in each category and an anticipated ability for an expert panel to review up to 12 deaths at a half-day session. Themed panels should take place within 12 months of the child's death. The WELC CDR Hub team and the Designated doctors for child death should work together to decide which cases might best benefit from review at a themed panel.

5.4 Rotational and ad hoc representation

The CDOP will meet monthly, for ten months each year (usually excluding August and December). The CDOP Chair and members will represent their discipline on behalf of their colleagues in the other WELC Partner areas/organisations on a rotating basis – each member attending for a minimum of three consecutive meetings. The Chair should be held for a minimum of six consecutive meetings.

The CDR Hub team is responsible for drawing up the rota at the beginning of each financial year.

Where a member or the Chair is unable to attend a meeting during their period of representation, it is the responsibility of that member/the Chair, to negotiate with the other WELC Partner areas/organisations to stand in for them.

5.5 Quoracy

A CDOP meeting will be quorate if there are four of the five core Partners represented throughout the meeting.

6. Confidentiality and Information Sharing

All cases discussed at the CDOP meetings must be anonymised. In relation to the discussions – all CDOP members and attendees (in any capacity) the CDOP meetings, are bound by legislation on data protection; including as it is set out in the WELC CDR Information Sharing Agreement (based on *Part B, London Child Protection Procedures: Sharing and Processing Personal Information*; currently being consulted on (September 2019))[1] At each meeting of the CDOP, all attendees whether a core, co-opted or ad-hoc member and observers will be required to sign an attendance sheet confirming that they have understood and signed the confidentiality agreement.

Accountability and reporting arrangements

6.1 National reporting

The outcome of the CDOP discussions must be recorded in the Analysis Form for each child. All ratified Analysis Forms must be submitted to the National Child Mortality Database (NCMD) by the CDR Hub team on behalf of the CDOP.

6.2 Local reporting

The CDOP is accountable to the four Local Safeguarding Partnerships (LSPs) comprising (the Local authorities) – City & Hackney, Newham, Tower Hamlets and Waltham Forest; and (the and the Clinical Commissioning Groups (CCGs) any parts of which fall within the local authorities' areas) – Newham, Tower Hamlets & Waltham Forest and Homerton CCGs. The LSPs have authorised the Xxxxxx LSP to hold the CDOP accountable on their behalf (see the *WELC CDR System Memorandum of Understanding 2019*).

The WELC CDR Hub team are responsible for developing the CDOP work plan, and preparing an annual WELC CDR report. Both the workplan and the report must be:

- Approved in draft by the CDOP;
- Circulated for consultation to the WELC Partner LSPs; and
- Approved in final form by the Xxxxxx LSP.

The LSPs should take responsibility for disseminating the lessons to be learnt to all relevant organisations, ensuring that relevant findings inform local strategies and act on any recommendation to improve policy, professional practice and inter agency working to safeguard and promote the welfare of children.

The LSCB will supply data regularly on every child death as required, e.g. by:

[1] https://www.londoncp.co.uk/chapters/sharing_info.html

The Department for Education to bodies commissioned by the department to undertake and publish nationally comparable, anonymised analyses of child deaths.

6 Conflict Resolution

The CDOP Chair should encourage panel members to form a consensus in their analysis of child deaths, if necessary by taking up issues outside the meetings; including with the other three Chairs. However, where a consensus is not agreed, the sitting Chair's decision is final.

Appendix 1. Roles and responsibilities of CDOP attendees

1. CDOP members

1.1 CDOP Chair

The Chair of the CDOP is responsible for ensuring that CDOP operates effectively and will:

- Chair CDOP meetings effectively and ensure that all statutory requirements are met;
- With the CDOP management team and the Designated Doctor take responsibility for co-ordinating meeting dates, panel agenda, the CDOP action plan, and the production of an annual report;
- Ensure that new panel members, members invited to CDOP, and observers sign a Confidentiality Agreement;
- If a public health professional will provide CDOP with information on epidemiological and health surveillance data;
- Assist CDOP in evaluating patterns and trends in relation to child deaths and in implementing public health prevention initiatives and programmes;

1.2 CDR Coordinator

The CDR Coordinator will, in conjunction with the Designated Doctor and CDOP Chair:

- Ensure the effective management of the notification, data collection and storage systems;
- Ensure the effective running of ordinary and themed panel meetings;
- Be the designated person to whom the child death notification and other data on each child death should be sent;
- Allocate a unique identifier number to a deceased child following receipt of the notification report (Form A);
- Seek to establish which agencies have been involved with the child or family either prior to or at the time of death and gain receipt of relevant information (Form Bs);
- Liaise with the Chair of the child death review meeting to receive that meeting's summary notes (draft Form C);
- Record the CDOP's conclusions (final Form C) and submit data to the Department of Health. Once operational, submit data to the National Child Mortality Database.

1.3 Designated Doctor for Child Deaths

The designated doctor will:

- Be responsible for the child death review process

- Advise on the appropriate response to a death in an adult ICU
- Advise CDOP regarding necessary experts required to inform ordinary and themed panels
- Advise CDOP in the identification of modifiable contributory factors
- Liaise, as appropriate, with regional clinical networks to ensure that themed panels are properly co-ordinated
- Assist CDOP in the development and implementation of appropriate preventative strategies to reduce the child deaths
- Prepare an annual report with the Chair summarising the activities of CDOP

1.4 Nurse/Midwife

The CDOP nurse and/or midwife will:

- Assist CDOP to evaluate health issues relating to the circumstances of the child's death
- Advise CDOP on nursing/midwifery practices that may have had a bearing on the child's heath or well-being
- Assist CDOP in developing appropriate preventative strategies
- Liaise with other nursing and allied health professionals as appropriate
- Liaise with other midwifery and obstetric colleagues as appropriate
- Assist CDOP in its evaluation of perinatal deaths (antenatal and perinatal care and support for the child and mother)

1.5 Health professional (hospital/community)

The health professional will:

- Assist CDOP in interpreting medical information (including the post mortem examination findings and results of medical investigations) relating to the child's death
- Advise CDOP on medical issues including child injuries and causes of child deaths, medical terminology, concepts and practices

1.6 Police

- The Police representatives will:
- Provide, as appropriate, CDOP with information on the status of any criminal investigation
- Provide CDOP with expertise on law enforcement practices, including investigations, interviews and evidence collection

- Assist CDOP to evaluate issues of public risk arising out of the review of individual deaths
- Liaise with other Police departments, and the Crown Prosecution Service as necessary

1.7 Safeguarding

The Children's Social Care and Safeguarding representatives will:

- Help CDOP to evaluate issues relating to the family and social environment and circumstances surrounding the death;
- Assist CDOP in interpreting information about the social care needs of the child and family and any provision of social care services
- Advise CDOP on children's rights and welfare, and on appropriate legislation and guidance relating to children
- Identify cases that may require a further child protection investigation
- Liaise with other local authority services

1.8 Education Representative

The Education representative will:

- Assist CDOP in interpreting information about the education needs and the education service provided for the deceased child and other children within the household
- Assist CDOP in providing appropriate preventative strategies

1.9 Lay Representative

The Lay representative will:

- Assist CDOP through providing an independent view;
- Represent the public and the family in interpreting and evaluating information

1.10 CDR Coordinator

The CDR Coordinator will:

- Be the designated person to whom the death notification and other data on each child death in the borough is sent to:
- Ensure the effective running of the notification, data collection and storage systems;
- Liaise as necessary with all relevant agencies and other local authorities to ensure smooth running of the notification system and panel operation;
- Liaise regularly with other Local Authorities through individual SPOCs/ Administrator and the London SPOC group;

- Facilitate the Rapid Response process;
- Facilitate the establishment of structures to support the CDOP as outlined in Working Together chapter 5;
- Determine meeting dates and send notices to Panel members;
- Prepare and circulate papers for each meeting and take and circulate minutes;
- Ensure that all CDOP core, co-opted, ad-hoc members and observers sign a confidentiality agreement;
- Prepare information on cases to be reviewed and with the Chair, agree cases for in depth review;
- Identify and agree with key personnel of all agencies their engagement and responsibilities within the model;
- Ensure that new members receive orientation to panel before their first meeting;
- Assist the LSCB in ensuring senior management in relevant agencies are aware of their roles and responsibilities in relation to *Chapter 5 Working Together to Safeguard Children*, discussing any problems with the chair as they arise;
- Support the Chair by providing information as required and assisting in the compilation of the annual report
- Ensure that effective cover is in place for absence;

2. The role of each co-opted CDOP member

2.1 NHS Acute Trusts

- Ensure the effective running of the notification, data collection and storage systems where Whipps Cross Hospital are involved
- Input around the care, safeguarding and medical practice undertaken of each case received at Whipps Cross Hospital
- Child and maternity clinical expertise through the named nurse for safeguarding children, the named midwife for safeguarding and a paediatric consultant specialist.

2.2 Hospices

- Expertise in palliative care and life limiting conditions

2.3 Coroner's office

- Expertise within the coroner's jurisdiction
- Understanding of statutory processes

Appendix 2. CDOP Membership example

Core members	
Director Public Health, Chair	
Designated Doctor for child death	
Named Doctor, Consultant Paediatrician, Xxxx Hospital, Bart's Health/Homerton	
Named Nurse Safeguarding Children, Xxxx Hospital, Bart's Health/Homerton	
Assistant Director Family Safeguarding and Family Support Service, Xxxx	
Designated Nurse for Safeguarding Children and Looked After Children, NHS Xxxx	
Director of Care, Xxxx Hospice	
Detective Inspector, Met Police, Child Abuse Investigation Command, Xxxx	
Named Midwife for Safeguarding Children, Xxxx, Bart's Health/Homerton	
NHS / Xxxx GP Clinical Lead for Safeguarding	
Coroner's office Manager	
Lay Representative	
CDR Coordinator	
Ad-hoc/invited members	
Education	
LAS	
Housing	