Hertfordshire Child Death Overview Panel (CDOP)

Hertfordshire CDOP Arrangements

Overview

The Hertfordshire CDOP has been set up by Child Death Review (CDR) Partners, East and North Herts/Herts Valleys CCGs and Hertfordshire County Council to review the deaths of children under the requirements of the Children Act (2004), Working Together to Safeguard Children (2018) and Child Death Review Statutory and Operational Guidance (2018).

Purpose

The purpose of the Hertfordshire CDOP is to undertake an independent review of all child deaths (excluding those babies who are stillborn, late fetal loss where a death certificate has not been issued and planned terminations of pregnancy carried out within the law) up to the age of 18 years, normally resident in Hertfordshire, irrespective of the place of their death.

CDOP Responsibilities

- To collect and collate information about each child death, seeking relevant information from professionals and, where appropriate, family members.
- To send and receive - Form A -Notification of Child Death completed by the Provider Organisation where the child died. Form B -Child Death Review Reporting Form completed by all practitioners involved with the child. Form C -Child Death Review Analysis Form completed by the relevant organisation at the Child Death Review (CDR)
- To analyse the information obtained, including the report from the Child Death Review Meeting, to enable confirmation or clarification relating to 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.
- 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

- To hold meetings bi-monthly, to enable the death of each child to be discussed in a timely manner. Extraordinary meetings may be held where this is necessitated.
- To progress themed meetings when appropriate, 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
- To enable discussions, and/or allow easier identification of themes when the number of deaths from a particular cause is small.
- To ensure that effective 'Rapid Response' arrangements are in place, thus enabling key professionals to come together to undertake enquiries into and each unexpected death of a child.
- To review the appropriateness of agency responses to each death of a child.
- To 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.
- To determine whether each death had modifiable factors.
- To make recommendations to the Safeguarding Children's Partnership and Public Health, as appropriate, in order that prompt action can be taken to prevent future such deaths where possible.
- To ensure that bereavement support is available to families (and to a child/young person's friends as appropriate)
- An eCDOP system has been adopted to provide a secure, flexible and web-based solution which allows our CDOP process to be fully managed efficiently, with effective sharing of multi-agency information

Governance and Accountability

- The Hertfordshire Child Death Review Panel is accountable to the Hertfordshire CCGs and Hertfordshire County Council.
- A concise summary of the key points from each meeting will be provided to the Child Death Review Partners.
- The Child Death Review Panel will provide an Annual Report to CCGs, Local Authority and Hertfordshire Safeguarding Children Partnership, summarising any recommendations from the reviews of child deaths. Further reports/assurance documents may be submitted as requested.

Membership

The Child Death Review Panel will be chaired by East & North Herts CCG**.** The vice-chair will be a Public Health officer and will be selected according to Statutory and Operational Guidance (2018).

Core Panel Membership

East & North Herts CCG

- Public health
- Designated Doctor for Child Death
- Children's Social Care
- Police (Child Abuse Investigation Unit)
- Safeguarding (Designated Doctor or Nurse)
- Lead Nurse for Rapid Response Service for Unexpected Child Death in Hertfordshire
- Primary care (GP or health visitor)
- Medical Professional from Hospital Trusts (WHHT and ENHT)
- Coroner's office

In addition to the core membership, relevant experts from health and other agencies will be invited as necessary to inform discussions. This is of particular reference to representation from the LeDeR programme.

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 Business Manager 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 Hertfordshire Child Death Overview Panel (CDOP) arrangements will be published on the East and North and Herts Valleys CCG websites **www.enhertsccg.nhs.uk, www.hertsvalleysccg.nhs.uk** and the Hertfordshire County Council website **www.hertfordshire.gov.uk** The arrangements will also be published on the Hertfordshire Safeguarding Children Partnership website https://www.hertfordshire.gov.uk/services/childrens-social-care/child-protection/hertfordshire-safeguarding-children-partnership/hscp.aspx

Review Date and Next Review Date

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

Next Review Scheduled: Prior to 30th June 2020

Template based on an Exemplar Document by:
Liz Balfe – National Safeguarding Children Reforms Facilitator liz.balfe@dhsc.gov.uk