SUSSEX CHILD DEATH REVIEW PARTNERSHIP

GUIDE TO OPERATIONAL WORKING OF THE CHILD DEATH OVERVIEW PANEL

Sussex Child Death Review Partnership Details

Name of Child Death Review Partners	Sussex and East Surrey CCGs East Sussex County Council Brighton & Hove City Council West Sussex County Council
Name of CDOP	Sussex Child Death Review Partnership
Name of CDOP Coordinator	To be appointed
Contact details of CDOP Coordinator	Email address Telephone number
Name of Designated Doctor for Child Deaths	To be confirmed
Contact details of Designated Doctor for Child Deaths	Email address Telephone number
Local authorities covered by Sussex CDOP	East Sussex, Brighton & Hove, West Sussex
Published on	27 June 2019
Notifications of child deaths to be submitted at	www.eCDOP.co.uk/PANsussex/live/public

1. Purpose of Child Death Overview Panel

1.1 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 for that area and any clinical commissioning groups operating in the local authority area.

1.2 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 following document sets out the arrangements for a Pan Sussex CDOP.

1.3 This guidance will be shared with all staff engaged within the child death review process and be supported by training and/or awareness raising sessions as appropriate.

1.4 The Child Death Review (CDR) Partners are East Sussex County Council, Brighton & Hove City Council, West Sussex County Council, and Sussex Clinical Commissioning Group.

2. Statutory requirements of the Child Death Overview Panel

2.1 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 Sussex or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If CDR partners find action should be taken by a person or organisation, they must inform them.

2.2 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.

2.3 The Sussex Child Death Review Panel and review process will be funded by the Sussex CCGs and three local authorities (with funding contributions by the local authorities proportioned to local child populations).

3. Area of review by CDOP

3.1 The Pan Sussex CDOP will review the deaths of all children normally resident in the Local Authority areas of West Sussex, Brighton & Hove, and East Sussex. The CDOP, where it considers it appropriate, may also review the death of a non-resident child who has died in the area.

3.2 As recommended by Working Together 2018, a Pan Sussex CDOP would 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 deaths across Sussex

	ES	WS	B&H	**Total**
2017/2018	34	48	8	90
2016/2017	21	28	11	60
2015/2016	38	46	20	104

4. Panel responsibilities

4.1 The functions of CDOP include:

- 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, in order to confirm or clarify the cause of death, to determine any contributory factors, to determine whether the death was preventable, 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 national Child Safeguarding Practice Review Panel and the appropriate Local Safeguarding Children Partnership 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. Panel Membership

5.1 The CDOP is a multi-professional panel whose core membership includes senior representatives from the following agencies or roles:

Public Health	It is proposed that one PH representative will represent PH on behalf of the three Local Authority areas. This representative will rotate on an annual basis.
Designated Doctor for child deaths	It is proposed that there will be one CDOP Doctor across the three Sussex areas. There would need to be a deputy designated doctor function.
Designated Nurse or Doctor for Safeguarding	It is proposed that one Designated Nurse/Doctor will represent across the Pan Sussex CCG areas. This representative will rotate on an annual basis
General paediatrician from a Sussex Hospital	For main panel and a Neonatologist for neonatal panel meetings. Note location of child deaths in Sussex Hospitals[1]

[1] See Appendix A for Combined location of Pan Sussex deaths within Sussex Based Hospitals (April 2015 – February 2018)

Midwife and Obstetrician for neonatal panels	One each from a local hospital across Sussex rotating on an annual basis
Primary Care	Named GP when required
Police	Safeguarding Manager, Sussex Police Public Protection
Children's Safeguarding Services	It is proposed that one Head of Safeguarding will represent across the three LA areas. This representative will rotate on an annual basis
CDOP Coordinator	
Specialist Nurse for Child Deaths	
Lay representation	To be recruited from across Sussex.

5.2 In addition to the above, for the Main Panel to be quorate, representatives:

a) must be drawn from across the three local authority areas (for example, representatives must not be all from West Sussex), noting that in future the Designated Doctor and Nurse role may be Pan Sussex.
b) For the Designated Doctor for Child Death and the Specialist Nurse for Child Deaths to be present (or their deputy representative).
c) For the Local Authority and the CCG to be present.

For a neonatal panel to be quorate there must be a neonatologist and a midwife or obstetrician present

5.3 When a panel member is not available to attend a meeting a deputy should be sent. This deputy would represent the same role but from a different area.

5.4 In addition to the core membership, additional professionals should be considered on a case-by-case basis (as determined by the CDOP Coordinator and Chair). The timing of cases to be discussed at the CDOP panel will be planned to enable best use of additional professional's time at the meeting. The application of remote conferencing should be considered by CDOP to facilitate a co-ordinated approach where additional professionals are unable to attend in person.

5.5 Extended panel membership includes: Nursing, midwifery, obstetrician, neonatologist, Coroner's Office, Education, Housing, Ambulance Services, Hospices, LeDeR, CAMHS/Sussex Partnership Foundation Trust.

5.6 A Lay Member will be recruited to from across Sussex. However, if recruitment to the role a Lay Member is unsuccessful this would not affect the quoracy of the meeting.

5.7 Panel members should be familiar with their responsibilities and ensure that they read all relevant material in advance of panel 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. Panel Member responsibilities are outlined in Appendix B.

6. Chair

6.1 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.

6.2 The Child Death Review partners will commission an Independent Chair, with relevant knowledge and expertise of the child death review process, to provide independent scrutiny and challenge to the panel.

6.3 The Sussex and Surrey CCG will 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.

6.4 The Independent Chair would be expected to work for a minimum of 1 day per month (at an anticipated day rate of £500 per day) with additional time required for preparation and attending other meetings. The maximum cost of the Independent Chair to CDR partners would be £12,000 based on a maximum of 24 days per year.

7. Frequency of meetings

7.1 The Main CDOP panel will meet on a monthly basis. Time allocated to the meeting would vary, depending on the number of deaths to be reviewed, however it should be expected that panel members allocate the full day in their diaries. Given that the panel will need to review between 5-10 deaths a month, it is anticipated that the allocated time would be up around four hours.

7.2 Themed panel meetings, for example regarding neonatal deaths, would be held up to six times a year on the same date/location as the main panel meetings. Relevant professionals would be invited to these themed meetings.

8. Themed panels

8.1 Some child deaths will be best reviewed at a themed meeting. A themed meeting is one where the Sussex CDOP, or with neighbouring CDOPs, will 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.

8.2 At a local level, themed panels will include regular neonatal deaths and potentially unexpected deaths. The Sussex 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; for deaths across Sussex see Appendix C.

8.3 Themed panels should occur within 12 months of the child's death. The CDOP coordinator, Designated doctor for child death, and CDOP Chair will work together to decide which cases might best benefit from review at a themed panel.

9. CDOP administration

9.1 The Sussex Child Death Overview Panel will be facilitated by a CDOP Coordinator, who will work closely with the Chair and the Designated Doctor/s for Child Deaths (who has responsibility for the wider child death review process). In addition the CDOP Coordinator will work closely with the Specialist Nurse/s for Child Deaths.

9.2 The CDOP Coordinator should be notified according to local protocol (see http://sussexchildprotection.procedures.org.uk/) whenever a child dies.

9.3 The Child Death Review process will be supported by a local web-based case management system (eCDOP) which provides a secure way of submitting and managing child death review information.

9.4 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.

9.5 The CDOP Coordinator is responsible for notifying the Learning Disabilities Mortality Review Programme (LEDER) of the death of a child with a learning disability by email.

9.6 CDOPs should aim to review all children's deaths within six to eight weeks of 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.

10. CDOP Governance and reporting

10.1 The CDR partners must annually prepare and publish a report on what they have done as a result of the child death review arrangements and how effective the arrangements have been in practice. The report will be produced at the end of every financial year and a public version of the report will be published on the CDR partner's websites.

10.2 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.

10.3 This report should be shared with the the three area Health and Wellbeing Boards, and the three local Safeguarding Children Partnerships. It may also be shared with the relevant Council Scrutiny Committees and CCG Governing Bodies.

10.4 The Independent CDOP Chair, in consultation with CDOP Panel Members, should liaise with decision makers in partner organisations to share key learning and take forward any actions arising from recommendations made at CDOP.

10.5 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.

11. Child death procedures

11.1 Further details on the procedures for child deaths can be found on the Pan Sussex Child Protection and Safeguarding Procedures Website here: 11.1 Child Death Overview Panel (East Sussex/ Brighton and Hove) | Sussex Child Protection and Safeguarding Procedures Manual and 11.2 Child Death Overview Panel (West Sussex) | Sussex Child Protection and Safeguarding Procedures Manual

11.2 The Sussex Joint Agency Protocol for Unexpected Child Deaths can be found on the Pan Sussex Child Protection and Safeguarding Procedures Website here: 8.39 Unexpected Child Death | Sussex Child Protection and Safeguarding Procedures Manual

APPENDIX A – Combined location of Pan Sussex deaths within Sussex Based Hospitals (April 2015 – February 2018)

Hospital	Number	%	Sub Region
RSCH (includes TMBU,RAH)	57	54%	**B&H**
Conquest	26	24%	**East Sussex**
Eastbourne District General Hospital	2	1%	
Worthing Hospital	13	12%	**West Sussex**
St Richards	8	7%	
Princess Royal Hospital	4	2%	
TOTAL	**110**	**100%**	

APPENDIX B – PANEL MEMBER RESPONSIBILITIES

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;
- coordinate with a public health professional, if attending, in order to provide the CDOP with information about 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; and
- Prepare an annual report with the Designated Doctor and Public Health summarising the activities of CDOP.

CDOP Coordinator

The CDOP Coordinator should, 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 Form;
- 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 (Reporting Form);
- liaise with the Chair of the child death review meeting to receive that meeting's summary notes (draft Analysis Form); and
- record the CDOP's conclusions (final Analysis Form) and submit data to the Department of Health and Social Care and, once operational, to the National Child Mortality Database.

Designated Doctor for Child Deaths

The designated doctor should:

- be responsible for the child death review process;
- advise on the appropriate response to a death in an adult health setting;
- 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; and
- contribute to the preparation of the annual report

Specialist CDOP Nurse/Midwife

The CDOP nurse and/or midwife should:

- 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; and
- assist CDOP in its evaluation of perinatal deaths (antenatal and perinatal care and support for the child and mother).

Health professional (hospital/community)
The health professional shall:
- assist CDOP in interpreting medical information (including the post mortem examination findings and results of medical investigations) relating to the child's death; and
- advise CDOP on medical issues including child injuries and causes of child deaths, medical terminology, concepts and practices.

Police
The Police representatives should:
- 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; and
- liaise with other Police departments, and the Crown Prosecution Service as necessary.

Children's Social Care and Safeguarding
The Children's Social Care and Safeguarding representatives should:
- 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;
- identify cases that may require a further child protection investigation; and
- liaise with other local authority services.

Education Representative:
The Education representative should:
- assist CDOP in interpreting information about the education needs and the education service provided for the deceased child and other children within the household; and
- assist CDOP in providing appropriate any strategies to prevent harm.

Lay Representative:
The Lay representative should:
- provide additional expertise, for example, through previous professional involvement with children and families, experience of local context and services or involvement with a voluntary sector organisation; and
- be independent of statutory agencies.

Public Health
The Public Health professional shall:
- provide information to the CDOP panel about epidemiological and health surveillance data
- assist in the identification of patterns and trends in relation to child deaths
- assist in the identification of evidence based modifiable preventative risk factors
- Assist in the identification of potential public health preventative initiatives to reduce child deaths and to ensure these are considered by public health at a pan-Sussex or local authority level as appropriate.
- help prepare an annual report summarising the epidemiological data about child deaths

APPENDIX C – CASES REVIEWED AND REPORTED TO CDOP (TO INFORM THEME OF 'THEMED PANEL' MEETINGS)

	Cases Reviewed by CDOP in year								Cases Reported in Year												Total Deaths in Year			Pan Sussex
	Suicide				Malignancy				Adolescents				unexpected deaths				Neonatal Deaths							
Annual Data Report	ES	WS	B&H	**Total**	ES	WS	B&H	**Total**	ES	WS	B&H	**Total**	ES	WS	B&H	**Total**	ES	WS	B&H	**Total**	ES	WS	B&H	**Total**
2017/2018	1	0	1	**2**	4	2	4	**10**	3	4	2	**9**	15	19	4	**38**	15	19	3	**37**	34	48	8	90
2016/2017	2	2	1	**5**	3	3	0	**6**	1	4	2	**7**	2	12	3	**17**	10	9	7	**26**	21	28	11	60
2015/2016	3	1	1	**5**	4	4	1	**9**	7	7	3	**17**	14	15	7	**36**	16	17	8	**41**	38	46	20	104