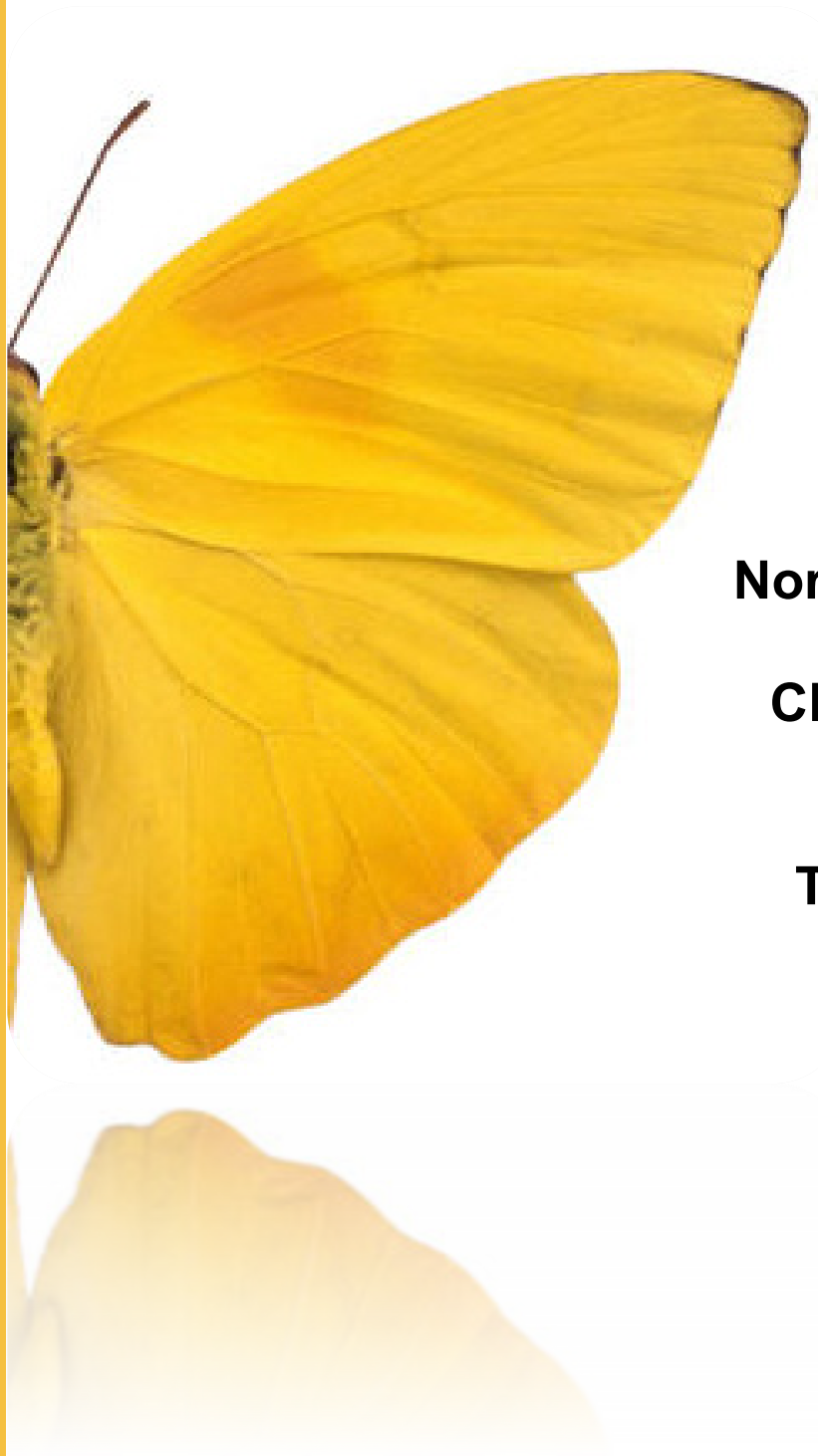


North and South of Tyne

Child Death Overview Panel

Terms of Reference

April 2020

CONTENTS

1.0 Introduction

1.1 The death of a child is a devastating loss that profoundly affects all those involved. The process of systematically reviewing the deaths of children is grounded in respect for the rights of children and their families[1], with the intention of learning what happened and why, and preventing future child deaths.[2] See appendix 1.

1.2 Each death of a child is a tragedy and all enquiries should seek to maintain an appropriate balance between forensic and medical requirements and supporting the family at a difficult time.

2.0 Legislation – Child Death Review Partners

2.1 The Children Act 2004[3] provided the legislative framework for the original Child Death Overview Panels (CDOPs) which were established in North and South of Tyne in 2008 and which were supported by well-established local child death review arrangements and reporting arrangements into the Local Safeguarding Children Boards (LSCBs). However, new legislation, the Children and Social Work Act 2017[4] has resulted in amendments to the Children Act 2004 and subsequently changes to the statutory responsibilities for child death reviews.

2.2 The responsibility for ensuring child death reviews are carried out is now held by the "***child death review partners***", who, in relation to a local authority area in England, are defined as the local authority (LA) for that area and any clinical commissioning groups (CCG) operating in the LA area. The statutory requirements for the child death review (CDR) partners are fully set out in appendix 2.

2.3 The CDR partners must make arrangements to carry out child death reviews and these arrangements should result in the establishment of a CDOP or equivalent, to review the deaths of all children normally resident in the relevant local authority area, and if they consider it appropriate, the deaths in that area of non-resident children. The CDOP should cover a geographical footprint that enables it to typically review at least 60 child deaths per year.

2.4 In order to comply with the statutory guidance[5] the CDR partners for the following localities have agreed to establish one CDOP to cover their combined geographical footprint:

- Northumberland
- North Tyneside
- Newcastle
- Gateshead
- South Tyneside
- Sunderland

[1] UN Convention on the Rights of the Child - summary
[2] Working Together 2018
[3] CA 2004
[4] Children & SW Act 2017
[5] CDR Statutory & Operational Guidance 2018

2.4.1 This CDOP, to be known as the ***North and South of Tyne CDOP,*** (the CDOP) will typically review at least 60 deaths per year which 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.

2.4.2 The CDOP will carry out its functions mindful of the potential impact upon the bereaved family and in accordance with the CDR Statutory Guidance. The CDOP is the final assurance point once all multi-agency information has been collected, collated and analysed at a local level via the Child Death Review Meeting and professionals who have known the child and family, including the key worker.

2.5 This document should be read in conjunction with individual agency procedures and those provided by the local safeguarding children board/partnership (LSCB/P) in the area of the child's normal residence. The 6 partnerships are currently working to align all policies and procedures.

3.0 Aim of the CDOP

3.1 Through a comprehensive and multidisciplinary review of child deaths, the CDOP aims to better understand how and why children in the North and South of Tyne area die and use the findings to:

- Recommend action to prevent other deaths
- Improve the professional response to child deaths
- Improve the health and safety of children
- Inform commissioning plans for services

3.2 The North and South of Tyne CDOP will conduct the independent multi-agency scrutiny on behalf of the local CDR partners responsible for ensuring that the review of deaths of all children normally resident in that area takes place.

3.3 It is recognised that the learning process begins with the Joint Agency Response and Child Death Review Meeting (CDRM) as well as the CDOP meetings.

4.0. Objectives

4.1 To agree, implement and monitor consistent CDR process across the North and South of Tyne area in accordance with Working Together 2018 using national templates.

4.2 To assure themselves that the information provided to the panel provides evidence that the needs of the family, in terms of follow up and bereavement support have been met.

4.3 To agree funding arrangements for the CDR process across the North and South of Tyne area.

4.4 To commission eCDOP and securely collate data on child deaths of residents in the North and South of Tyne area in line with the requirements of the Department for Education (DfES).

4.5 To formulate a training plan and ensure this is delivered across the CDOP footprint.

4.6 To collect and collate information about each child death, seeking relevant information from professionals and, where appropriate, family members.

4.7 To analyse the information obtained, including the report from the 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.

4.8 To make recommendations to the relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children.

4.9 To notify the local Safeguarding Partners when it suspects that a child may have been abused or neglected.

4.10 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 correcting.

4.10.1 To provide specified data to NHS Digital/the National Child Mortality Database.

4.11 To ensure effective liaison with other CDOPs which have responsibility for reviewing deaths which occurred in the North and South of Tyne area of children normally resident elsewhere in England and Wales.

4.12 To ensure effective liaison with other CDOPs nationally of those children normally resident within the North and South of Tyne area who have died outside their normal area of residence.

4.13 To agree and ensure appropriate and proportionate action is taken should any case need to be escalated to the relevant CDR partner or provider/other partner. See appendix 3.

4.14 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 chid death review process.

4.15 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.

5.0 CDOP Membership

5.1 Core Membership

- Independent Chair
- Deputy Chair to be one of the core members
- Public Health representation
- Designated Paediatricians for Child Death
- Northumbria Police – DCI, Safeguarding Department
- One Designated Nurse Safeguarding Children representing North and one representing South of Tyne
- Representative from North East Ambulance Service
- One Children's Social Care representative from North and one from South of Tyne
- One Neonatologist representative

5.2 In Attendance:

- North of Tyne CDOP Coordinator
- The panel welcomes observational visits from appropriate professionals with the prior permission of the Chair.

5.3 The Panel may co-opt other members as may be appropriate, subject to the same terms as other members, for example an Education representative or Midwifery lead dependent on the case(s) to be reviewed. The CDOP may consider appointment of a lay person as indicated in the statutory and operational guidance. Core membership is outlined at appendix 4.

5.4 Members will be responsible for providing and updating the distribution list to ensure all learning is disseminated across the provider landscape.

6.0 Declaration of Interest

6.1 Where a Panel member has either had professional responsibility or has been involved in the Local Case Discussion for a child who died, this should be declared to the Chair. The Chair will determine according to circumstances whether the Panel member should attend the Panel or should be asked to find a substitute from one of the other areas.

7.0 Confidentiality

7.1 All members will maintain strict confidentiality with respect to the identities of cases considered. Any members not covered in this respect by their own professional codes of conduct will be required to abide by their common law duty of confidentiality as a condition of participating in the work of the panel. At each meeting of the CDOP all participants will be required to sign an attendance sheet, confirming that they have understood the duty of confidentiality – see appendices 3 and 4.

8.0 The role of Chair

8.1 The CDOP will be chaired by someone independent of the CDR partners and providers within the area.

8.2 The Chair will have a contract for a **maximum** of three years subject to review and to an annual appraisal by a CDR partner.

8.3 The Chair will, with the support of the CDOP coordinator, ensure that agendas are planned to ensure ease of attendance and thematic review; for example, all neonatal deaths to be covered in a specific timeslot, any cases with police involvement to be covered in a specific timeslot etc. This will enable representatives to make best use of their time and resources.

8.4 The Chair and CDOP coordinator will ensure teleconferencing is available should individual representatives be unable to attend the meeting if appropriate.

9.0 Administration of the Panel

9.1 A CDOP coordinator will provide administrative support to the panel and ensure relevant paper work is circulated to panel members/uploaded to eCDOP in preparation for the meetings – at least 5 working days in advance.

9.2 A CDOP coordinator will work closely with the chair of the panel and the Designated Doctors for Child Death.

9.3 The CDOP coordinator should be notified in accordance with local protocols whenever a child dies.

9.4 The CDOP should aim to review all children's deaths at the next panel after receiving the report from the CDRM, or the result of the Coroner's inquest; unless a themed panel is to be convened; see below.

9.5 The CDR partners may agree to review child deaths from a particular cause or group of causes at one single CDOP or across neighbouring CDOPs. This allows for appropriate professional experts to be invited to the ***themed panel*** to inform discussions, and/or allow easier identification of themes when the number of deaths from a particular cause is small.

9.5.1 Examples of themed panels could include neonatal cases for North and South of Tyne. On a regional/bigger footprint themed panels could, for example, include cancer, suicide, trauma or sudden unexplained death in infancy/childhood.

9.5.2 Consideration may need to be given to inviting experts from neighbouring/regional clinical networks.

9.5.3 Themed panels should occur within 12 months of the child's death.

9.5.4 Designated Paediatricians for North and South of Tyne CDOP will work together to decide which cases might best benefit from a themed panel.

9.5.5 The CDOP will ensure appropriate consideration of the CDR process interface with other review processes, for example the Learning Disabilities Mortality Review Process[6] (LeDeR).

9.6 Parents/Carers can submit any information concerning their child's death to the local case discussion/child death review meeting via their key worker or via the CDOP coordinator.

10.0 Quoracy

10.1 The Panel will be quorate on the attendance of the Chair, the CDR Co-ordinator, at least one Designated Paediatrician must be present from North of Tyne and one from South of Tyne and one representative from the LA North of Tyne and one from South of Tyne.

11.0 Frequency of Meetings

11.1 Panel meetings will take place at least four times a year. They will last no more than 3 hours.

12.0 Governance

12.1 Each CDR partner is responsible for ensuring their internal agency governance and reporting framework is followed to ensure accountable officers/chief executives have oversight of the CDR arrangements. Locally CDR partners will agree the reporting arrangements from CDOP.

12.2 Relevant information will be provided to the appropriate area Coroner as required.

12.3 The CDOP Chair will ensure the CDR Partners prepare and publish an Annual Report which documents what has been done as a result of the arrangements and how effective the arrangements have been in practice.

12.3.1 The report must also include a summary of the key learning arising from the reviews, reports from themed panels and actions that have been taken to prevent child deaths as a result of this learning.

13.0 Access to records/Freedom of Information Requests for CDOP Papers (final analysis forms)

13.1 The CDOP involves agencies who are all Public Bodies and are subject to Data Protection and Freedom of Information legislation.

[6] LeDeR website

13.2 Working Together 2018 does not offer a definitive view of this situation, however, full and transparent disclosure is the aim of the CDOP on the basis of the information set out in 13.1.

13.3 On receipt of a request and signed consent from the child's parents/guardians for the CDOP papers, the CDOP will contact the relevant LSCB/P Chair and the relevant CDR partners and legal advice may be sought.

13.4 The CDOP papers will be reviewed by the Chair of the CDOP who will support redaction should 3rd party information be held.

13.5 Each request will be considered on its own merit.

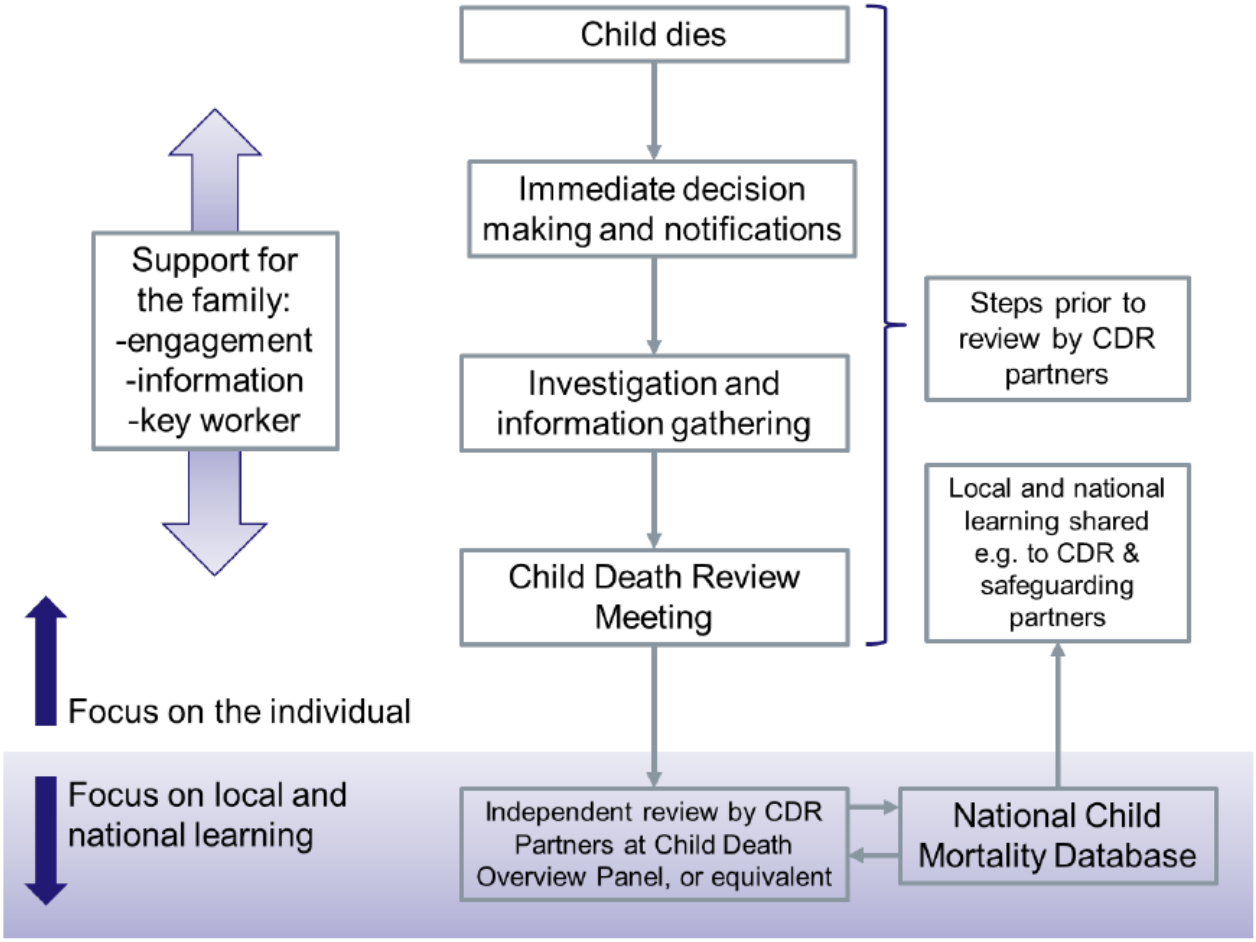
14.0 Complaints

14.1 Complaints about the CDOP process should be directed to the relevant Child Death Review Partner's complaints procedures.

15.0 Review of the Terms of Reference

15.1 These terms of reference will be reviewed annually, or sooner should there be any legislative changes.

Appendix 1 – The main stages of the child death review process



The chart illustrates the full process of a child death review as outlined in the statutory guidance.

Appendix 2: CDR Statutory Responsibilities – pg 94 WT 2018

Statutory Requirements[95]

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,' 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.

Child death review partners must make arrangements to review all deaths of children normally resident in the local area[96] and, if they consider it appropriate, for any non-resident child who has died in their area.

Child death review partners for two or more local authority areas may combine and agree that their areas be treated as a single area for the purpose of undertaking child death reviews.

Child death review partners must make arrangements for the analysis of information from all deaths reviewed.

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 the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If child death review partners find action should be taken by a person or organisation, they must inform them. In addition, child death review 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: and
- 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.

[95] The guidance in this chapter is issued under section 16Q of the Children Act 2004. Further guidance on child death review procedures will be issued by the government. While the contents of this chapter will be duplicated within that document, child death review partners should also have regard to that guidance to assist in their understanding of the steps taken by others prior to the child death reviews and analysis they carry out.

[96] For the purposes of child death reviews, a local area is the area within the remit of a local authority (referred to in the Act as a "local authority area").

Appendix 3: Confidentiality Statement

This Child Death Overview Panel Confidentiality Statement, was designed by University of Warwick

This statement must be signed when a Panel member joins the CDOP. It must also be signed by all Panel members at each meeting of the CDOP.

The purpose of the Child Death Overview Panel is to conduct a thorough review of all preventable child deaths in North and South of Tyne in order to better understand how and why children die and to take action to prevent other deaths.

In order to assure a co-ordinated response that fully addresses all systematic concerns surrounding child deaths, all relevant data should be shared and reviewed by the team, as permitted within the stipulations of the Data Protection Act 2018[7], including historical information concerning the deceased child, his or her family, and the circumstances surrounding the death. Much of this information is protected from public disclosure.

The North and South of Tyne child death review processes stipulate that in no case will any CDOP member disclose any information pertaining to any individual case outside the meeting other than pursuant to the mandated agency responsibilities of that individual. Any information obtained or recommendations or decisions made by the CDOP shall be treated as confidential by the undersigned. Public statements about the general purpose of the child death review process may be made in line with the child death review partners' processes for managing media interest as long as they are not identified with any specific case.

Any information obtained or recommendations or decisions made by the CDOP shall be kept in a place of special security.

Panel members who receive information but do not attend the meeting undertake to confidentially destroy or securely return all papers to the Panel.

The undersigned agrees to abide by the terms of this confidentiality policy.

[7] https://www.gov.uk/government/collections/data-protection-act-2018

Appendix 4 – Panel Members/lead contacts

Representative	Northumberland	North Tyneside	Newcastle	Gateshead	South Tyneside	Sunderland
Independent Chair	Covers all areas					
Designated Nurse Safeguarding Children	One rep for North			One rep for South		
Designated Doctor Child Death						
Named Professional Safeguarding NEAS	Covers all areas					
Detective Chief Inspector, Safeguarding Department Northumbria Police	Covers all areas					
Director of Public Health	Covers all areas					
Neonatologist	Covers all areas					
Children's Social Care	One rep for North			One rep for South		

Appendix 5

CDOP Escalation Process