National Network of
Child Death Overview Panels
(England & Wales)

February 2016
Contents

Introduction 3
The Regulations Relating to Child Death Reviews 4
Responsibilities of CDOPs 5
Main Objectives of CDOPs 5
Regional and National Importance 7
National Network of CDOPs (NNCDOP) 8

Mission Statement

The Vision 9
The Aim 9
The objectives 9

Membership 11

Membership categories 12

Regional representatives 13

Constitution and terms of reference 14

NNCDOP Executive Committee 19
Introduction

In accordance with the Children’s Act 2004, in England, with effect from April 2008, Local Safeguarding Children Boards (LSCBs) have a statutory responsibility for reviewing the deaths of all children from birth up to the age of 18 years, who are normally resident within the area of the LSCB. This function is undertaken by a Child Death Overview Panel (CDOP), a subgroup of the LSCB. A single CDOP may undertake the review of all child deaths on behalf of one or more LSCBs.

Currently, there are over 90 CDOPs responsible to 148 LSCBs; on-going amalgamations mean that the exact number is difficult to specify at any one point in time.

Subsequent national guidance and regulations have served to unify some operational aspects with the guidance having been updated (Working Together to Safeguard Children, 2015).

CDOPs are multi-agency forums engaged in identifying modifiable factors in a child’s death with a view to reducing the number of similar deaths in the future. They are also involved in identifying patterns and trends and informing LSCB partner agencies of outcomes to assist in the planning of resource provision.

CDOPs are the only body that reviews all child deaths and benefits from the inclusion of information from Coronial processes, Serious Case/Critical Case Reviews and internal agency reviews.

The Regulations Relating to Child Death Reviews  (WTSC 2015)
The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

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.

There is no legal mandate within Wales to undertake child death reviews, however, the Welsh Government support a national Child Death Review (CDR) programme. This has been established with input into the core team from a designated doctor based in the Safeguarding Children Service. The child death review process involves collation of data from various sources into a national database, with periodic selection of related causes of death for thematic review. Each thematic review involves a bespoke panel who are tasked with triangulating evidence from database population analysis, research and other literature and review of anonymised individual circumstances. The thematic panel then formulate their advice on preventing future deaths in the form of recommendations to identified stakeholders, or as key messages.
Responsibilities of CDOPs

- Each death of a child is a tragedy and enquiries should keep an appropriate balance between forensic and medical requirements and supporting the family at a difficult time.

- Professionals supporting parents and family members should assure them that the objective of the child death review process is not to allocate blame, but to learn lessons.

- The purpose of the child death review is to help prevent further such child deaths.

Main Objectives of CDOP

The primary purpose of CDOPs is to review individual deaths, to identify themes and trends to inform strategic planning on how “best to safeguard and promote the welfare of the children in their area”.

The responsibility for determining the cause of death rests with the coroner or the doctor who signs the medical certificate of the cause of death (and therefore is not the responsibility of the CDOP).

The main functions of the CDOP include:

- reviewing all child deaths, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;

- collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;

- discussing each child’s case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;
• determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;

• making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;

• identifying patterns or trends in local data and reporting these to the LSCB;

• where a suspicion arises that neglect or abuse may have been a factor in the child’s death, referring a case back to the LSCB Chair for consideration of whether an Serious Case Review (SCR) is required;

• agreeing local procedures for responding to unexpected deaths of children; and

• cooperating with regional and national initiatives – for example, with the National Clinical Outcome Review Programme – to identify lessons on the prevention of child deaths
Regional and National Importance

In reviewing the death of each child, the CDOP is to consider modifiable factors, for example, in the family environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level.

The CDOP submits aggregated findings from all child deaths and informs local strategic planning, including the local Joint Strategic Needs Assessment (JSNA), on how to best safeguard and promote the welfare of children in the area. Each CDOP is required to prepare an annual report of relevant information for the LSCB. This information in turn informs the LSCB annual report.

As part of the Child Death Review process information about each death is collected by the CDOPs and forwarded to the Department for Education (DfE) which analyses the data and publishes the annual report.
National Network of CDOPs (NNCDOP)

The First National CDOP Conference was organised by Dr Nisar Mir & Mr Nicholas Rheinberg from Cheshire Coronial Service and was held in Warrington on 8 December 2014. Judge Peter Thornton, Chief Coroner England and Wales was the Chief Guest and delivered the Keynote address. There were representatives from 68 CDOPs across England and over 30 papers and posters were presented.

During the deliberations of the meeting it was observed that:

- There is considerable variability in the size of the CDOPs, the structure and functioning of the CDOPs as well as the way different CDOPs collect and submit their data
- Key areas of the data variables are vaguely defined with subjective interpretations making the national interpretation of the modifiable factors extremely difficult
- What has been of great concern is the lack of national leadership to co-ordinate lessons learnt, sharing of information and national learning
- There is lack of co-ordination between various government departments in reducing the childhood deaths with focused and targeted strategies

Judge Peter Thornton, supportive of the National CDOP Network’s efforts, raised their concerns with Mr Edward Thornton, Parliamentary Under Secretary of State for Children and Families (letter 16 December 2014).

The National Network of CDOP set up a working party which met in Birmingham on 18th June 2015.
Mission Statement

The Vision

We want every child to receive optimal care to have the best chance of a healthy survival.

The Aim

The network wants all agencies and professionals, involved in child care services, to work closely together to develop and implement effective strategies to prevent child deaths, and provide a sensitive response in situations where a child death occurs.

The objectives

The Network shall:

- Serve as a focal point for all the regional CDOPs to share best practices, exchange information (including guidelines & publications) and support each other through the network pathways
- Support the development of a national database like the Child Death Review Database (CDRD) development project
- Develop audit tools and redefine the current database variables so as to have a uniform standard for defining modifiable factors
- Identify themes emerging from the national data on pattern of child deaths across the country by working closely with the Departments of Education and Health
- Initiate and develop strategies for reducing child deaths nationally by working closely with the respective departments
- Develop training standards for the CDOPs so that there is consistency across the country in the child death review process
• Establish training standards and continuous professional development for CDOP professionals e.g. administrators, coordinators, chairs and panel members
• Influence national policies relating to CDOP
• Develop research opportunities
• Act as a national liaison with child death related charities and professional bodies
NNCDOP Membership

The NNCDOP is being established as a non-governmental organisation (NGO), a non-profit group at a national level for the benefit of every CDOP in England & Wales, but will only be truly effective if it is supported by all the agencies involved in the child death review process across the UK.

During the first two years NNCDOP aims to develop its infrastructure, streamline and standardise the procedures across the country and develop a pool of resources and a communication network.

There is no membership fee and it is in the interest of all CDOPs to join and support the organisation.

Listed below are the anticipated benefits that constituent CDOP members should accrue.

1. Joining NNCDOP is an opportunity to be involved at the national level and thus being able to influence various governmental and non-governmental policies towards child deaths in the country
2. Sharing of information, practices, guidelines, leaflets and publications between the member CDOPs at no cost
3. Contribution to the ‘Best Practices’ pool and adoption of these at local CDOP level at no cost
4. Free submission of papers at the annual conference
5. Reduced registration fee at the annual conference
6. Summary of annual report of each CDOP to be published in the NNCDOP Annual Report
7. Free quarterly newsletter
8. Quarterly submission of the local CDOP data to the National CDOP data pool
9. Access to the restricted member area on the website
10. The NNCDOP shall be able give feedback to the contributing CDOPs about their performance on key areas against the national average

Membership categories

There are two categories of membership: group membership and individual membership.

**Group Membership** is for organisations like Child Death Overview Panels, National Child Death Review groups and allied agencies who share the common goal of improving the child health survival both at home or at the international level. This would include university departments involved in research in child health or organisations which have been actively seeking public support and/or creating public awareness about child health and survival.

**Individual membership** is for any professional who has been or is actively involved in work that in the field of child health directly or in the organisational capacity, governance, audit, research, public health or community welfare programmes that share the ultimate goal of reducing child deaths at home or abroad.
Regional Representatives

NNCDOP shall aim to have regional representatives from across the country who shall have the responsibility of developing liaison with the member CDOPs in their region and act as bridge between the Executive Council and the local CDOPs.
National Network of Child Death Overview Panels England & Wales

Constitution and Terms of Reference of the Executive Committee

Terms of Reference:

1. The Child Death Overview Panel National Network (CDOPNN) shall be an independent non-governmental organisation (NGO) with membership from participating CDOPS and other organisations
2. The CDOPNN will have an Executive Committee (EC) to progress the business. The EC with the exception of the administrative staff shall be honorary

Aim:
To reduce child death in England and Wales

Objectives:

The network shall:

- serve as a focal point for all the regional CDOP to share best practices, exchange information (including guidelines & publications) and support each other through the network pathways
- Support the development of a national child death database
- Develop audit tools and redefine the current database variables so as to have a uniform standard for defining modifiable factors
- Identify themes emerging from the national data on pattern of child deaths across the country by working closely with the Departments of Education and Health
- Implement strategies for reducing child deaths nationally by working closely with the respective departments
- Develop training standards for the CDOPs so that there is consistency across the country in the child death review process
• Establish training standards and continuous professional development for CDOP professionals e.g. administrators, coordinators, chairs and panel members
• Influence national policies relating to CDOP
• Develop research opportunities
• Act as a national liaison with child death related charities and professional bodies

Membership & Constitution:
The core membership of the EC will be drawn from the multi-disciplinary workforce and reflect national guidance (Working Together (2015)) and represent CDOPs across England and Wales.

• Chairperson
• Vice Chairperson
• Administrator
• Honorary Treasurer
• Members representative of different regions (6)

The EC may co-opt other members as appropriate for the work, subject to the same terms as other members.

Chairperson:
1. Chair the EC meeting, annual conference and the annual general meeting (AGM)
2. Work closely with the CDOPNN Administrator in all matters related to CDOPNN (See duties below)

Hon Treasurer:
1. Shall be responsible for maintaining and upkeep of all financial activities of CDOPNN
2. Shall work closely with the chairperson in preparing the annual financial report
CDOPNN Administrator:
CDOPNN Administrator provides administrative support to the network:

1. Assists the chairperson on all matters related to the CDOPNN
2. Arranging and administrating CDOPNN EC meetings
3. Arranging and administrating CDOPNN annual meetings
4. Developing and maintaining database and contact details of all CDOPS
5. Liaise with CDOP co-ordinators on all CDOPNN matters
6. Requesting information from CDOPs/ agencies/ professionals about best practices and developing a national pool of these practices
7. Supporting individual CDOPs in implementing best practices
8. Preparation of the annual report
9. Preparation and dissemination of the quarterly newsletter
10. Supporting the Chair in reporting of performance indicator information to Department for Education (DfE), Department of Health (DOH) and related agencies of the participating CDOPs
11. *Developing and maintaining a computerised system to record core data, information, and recommendations from participating CDOPS
12. *Maintaining records, statistical information
   *Subject to availability of funding

Competing interests:
To be declared by all panel members at the start of each meeting.

Confidentiality:
All members will maintain strict confidentiality with respect to the identities. 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 CDOPNN.
Term of service:
Membership will be reviewed every three years or more frequently if appropriate (example a member unable to attend more than two meetings per annum), and the term of membership shall be for initial three years.

Chairperson:
The chairperson will have an initial tenure of post for 3 years.

A Vice Chair will be appointed from the panel membership for a term of 3 years.

Administration of the Panel:
The CDOPNN will be serviced by an administrator funded by CDOPNN with the from the participating CDOPS.

Quoracy:
The Panel will be quorate when 6 members are in attendance including the Chair or Vice Chair.

Frequency of Meetings:
The EC meetings will take place at least four times a year and shall be governed by agenda or tasks at hand.

Modification of the Constitution:
Any proposed modification to the constitution must have the approval of the majority of the membership of the EC and would then be submitted to all the participating CDOPS who shall then have a choice of approval or withdraw from CDOPNN membership.

Annual General Meeting:
All constitutional matters, annual report, finance and proposed CDOPNN activities shall be discussed at the AGM to be held before or after the annual conference.
Governance:
A Partnership Agreement between each of the participating CDOPs and the CDOPNN will govern the sharing of data and information between the CDOPs and the CDOPNN whenever appropriate.
NNCDOP Executive Committee

An interim committee was formulated to develop the infrastructure for the NNCDOP and it is hoped that the committee shall be reformulated in 2016 to have a wider and regional representation.

*Dr Nisar A Mir (Chair)*
Paediatrician Pan-Cheshire CDOP
HM Assistant Coroner Cheshire

Mr Mike Leaf (Vice Chair)
Director of Health Improvement, Public Health and Wellbeing
Lancashire County Council

Irene Wright (Honorary Treasurer)
Manager Pan-Merseyside CDOP

Beverley Heatman
Manager Child Death Review Programme Public Health Wales

Vicky Sleap
Manager CDOP West of England, Swindon, Wiltshire and Gloucestershire

Rich Dowell
Manager Pan-Dorset CDOP

Michael Lay
Chair CDOP in Greater Manchester

Dr Eduardo Moya
Lead Paediatrician for Child Deaths Bradford Teaching Hospitals NHS Foundation Trust

Joy Moran
Lead Nurse Child Death Review Team Nottingham City and Nottinghamshire CDOPs

Carol Evanson-Coombe
Service Manager Peninsula Child Death Overview Panel

*Contact:*

nisar.mir@whh.nhs.uk
Telephone: 01925 662215  Mobile: 07808779033
Visit www.NNCDOP.com for
• The Network activities
• The Network Newsletter
• To make a contribution to the Newsletter

III Annual Conference
Birmingham
22 February 2017

Abstract submission & booking forms available on
www.NNCDOP.com