# *Bury Rochdale and Oldham Child Death Overview Panel – Statutory Responsibilities and Child Death Arrangements Implementation Plan*

***June 2019***

Bury Council

Rochdale Borough Council

Oldham Council

NHS Bury Clinical Commissioning Group

NHS Heywood, Middleton and Rochdale Clinical Commissioning Group

NHS Oldham Clinical Commissioning Group

***Overview***

The Bury, Rochdale and Oldham (BRO) CDOP has been set up by Child Death Review (CDR) Partners, the Bury, Oldham and Heywood, Middleton, Rochdale CCG's and Bury, Oldham and Rochdale Council's to review the deaths of children under the requirements of the Children Act, 2004 and Working Together to Safeguard Children, 2018. The tripartite approach covers a population of 641,846. The sector operates within a Greater Manchester (GM) framework for CDOP which includes the production of a GM CDOP Report and development of agreed standards and processes across GM.

***Purpose***

The purpose of the BRO CDOP is to undertake a review of all child deaths (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) up to the age of 18 years, normally resident in Bury, Oldham and Heywood, Middleton, Rochdale, irrespective of the place of their death. The BRO CDOP will adhere to the statutory guidance: Child Death Review Statutory and Operational Guidance (England) 2018: https://www.gov.uk/government/publications/child-death-review-statutory-and- operational-guidance-england.

***CDOP Responsibilities***

- To collect and collate information about each child death, seeking relevant information from professionals and, where appropriate, family members
- In line with the revised statutory guidance the BROCDOP will oversee the development and embedding of processes where all child deaths will be reviewed by the health care provider and the review will include all multiagency professionals who may have knowledge of the family and involvement in their care.
- To support the work to develop the role of the Designated Doctor for Death in the next 12 months
- 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;
- 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; 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.

*Operational Responsibilities*

- Administrative support and the database is hosted within Rochdale Council and NHS HMR CCG
- The Three CCGs will jointly fund the administrative function of the CDOP
- Hold meetings at timely intervals to enable the death of each child to be discussed in a timely manner.
- Hold themed meetings where CDR partners arrange for a single CDOP, or neighboring 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 discussions, and/or allow easier identification of themes when the number of deaths from a particular cause is small.
- Ensure that effective 'Rapid Response' arrangements are in place, to enable key professionals to come together to undertake enquiries into and evaluating each unexpected death of a child.
- Review the appropriateness of agency responses to each death of a child.
- 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.
- Determine whether each death had modifiable factors.
- Make appropriate recommendations to the Bury, Oldham, Rochdale Health and Wellbeing Boards in order that prompt action can be taken to prevent future such deaths where possible.
- Report deaths of children with/ likely to have a Learning Disability to LeDeR (Learning Disability Mortality Review).
- Ensure LeDeR is represented at the CDOP meeting where the child will be discussed and consider potential input from a LeDeR reviewer

***Governance and Accountability***

- The Child Death Review Panel is accountable to the Health and Wellbeing Boards in Rochdale, Oldham and Bury
- An annual report will be provided to the Health and Wellbeing Board and exception reporting when required to other Partnership Groups and Boards
- An information sharing protocol is in place for the activity of CDOP

***Membership***

The Child Death Review Panel will be chaired by *a Consultant in Public Health and is rotated between the three Public Health teams every two years.* The vice-chair will be a CCG representative

***Panel Membership***

*Core membership for 2019/20*

- Public health, Council
- Designated Doctor with the lead for child deaths (Currently Pediatrician for Sudden Unexpected Death in children and infancy (SUDC) and a hospital clinician
- Social services
- Police
- Safeguarding (Designated Doctor and Nurse)
- Nursing and midwifery
- Lay representation (To be explored as part of the development of new arrangements)

*In addition to the core membership, relevant experts from health and other agencies will be invited as*

*necessary to inform discussions.*

- Primary care (GP or health visitor)
- Nursing and/or midwifery
- Coroner's office
- Education
- Housing
- Council Services
- Health & Wellbeing Board
- Ambulance Services
- Hospice

***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. This is will be reported to the relevant health and wellbeing board for approval

***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.
A confidentiality statement is signed at the start of every meeting.

***Publication***

The BRO Child Death Overview Panel (CDOP) arrangements will be published on the Bury, Oldham and Heywood, Middleton Rochdale CCG websites and the Bury, Oldham and Rochdale Council website. The arrangements will also be published on the Bury, Oldham and Rochdale Safeguarding Children Partnership website.

***Review Date and Next Review Date***

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

**Last Reviewed: June 2019**
**Next Review Scheduled: 31 March 2020**