



# Information pack: The new Child Death Review Requirements

Version 2

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## Executive Summary

The Children and Social Work Act (2017) and subsequent statutory guidance sets out reforms to the existing child death review processes in England. There are a number of significant changes from responsibility shifting from Local Safeguarding Children Boards (LSCBs) to a joint partnership of local authorities and clinical commissioning groups (CCGs), named Child Death Review Partners (CDRP); the establishment of a minimum geographical footprint for each CDRP; and changes to the review mechanism and family support functions. These changes must be implemented **by 29<sup>th</sup> September 2019** and each local CDRP must publish plans of how they intend to configure and resource themselves to meet these new requirements **by 29<sup>th</sup> June 2019**. In addition, the [National Child Mortality Database](#) (NCMD), a national programme which will collect and report on data of all child deaths across England was launched on 1<sup>st</sup> April 2019. From April 2019, CDRPs, through their local Child Death Overview Panels (CDOPs), the multi-agency panel established by each CDRP to review the deaths of children normally resident in their area, must supply data to NCMD on all open and new cases.

Stakeholders across London have been coming together to discuss how best to configure services locally to meet these requirements. The [Healthy London Partnership Child Death Review Programme](#) was established to support these discussions. This document outlines the background, challenges and considerations of the new requirements, provides an update on the progress across London to date and summarises the discussions from the HLP transformation workshops held between January – March 2019 for each London Sustainable Transformation Partnership.

## Background to the new Child Death Review Requirements

The Children Act 2004 introduced a requirement for local authorities in England to review the death of every child in England to determine whether there were any modifiable factors that could lead to system improvements. Local Child Death Review Partners (CDRP) were established to take ownership of the process, who in turn established local Child Death Overview Panels (CDOPs) that were charged with the role of investigating the circumstances and contexts for the death of every child in their region. Until recently, the child death review processes have been completed variably across England. There has been no minimum caseload / review requirement; large variation in the local governance arrangements; limited standardisation of the administration and local delivery leading to inconsistency in the data collected; and limited collation and sharing of learning. Many CDOPs had a predominantly medical focus and have not routinely engaged wider stakeholders such as the police and social care, as part of the review process. The administrative process was largely paper based and required significant resource to collect and collate information.

As a result, [The Children and Social Work Act \(2017\)](#) introduced reforms to improve and provide consistency to the child death review process, and the experience of bereaved families in this process. Subsequent [Statutory and Operational Guidance](#) published in October 2018 provided further clarity on the new requirements. Local authorities and clinical commissioning groups are required to come together for the first time to form new Child Death Review Partnerships (CDRPs) and take joint ownership of child deaths within their region. A minimum 60 cases must be reviewed annually by each CDRP and thematic analysis must be undertaken. Significantly, the Act also requires that CDOPs submit real time data to a new [National Child Mortality Database \(NCMD\)](#), a programme designed to collect and analyse data on all child deaths in

England from 1<sup>st</sup> April 2019. At the same time, there are significant changes to the data required to support the child death review process which were introduced on 1<sup>st</sup> April 2019. The [Working Together: transitional guidance](#) outlines that CDRPs will have until 29<sup>th</sup> September 2019 to meet the new statutory requirements. They must publish their plans to meet these new arrangements by 29<sup>th</sup> June 2019 and notify NHS England when they have done so, at [England.cypalignment@nhs.net](mailto:England.cypalignment@nhs.net).

Within London, approximately 700 children die each year. These deaths are currently reviewed by 28 CDOPs which broadly align along borough boundaries<sup>1</sup>. To support the London CDOPs meet the requirements of the Act, NHS England (London Region) has funded the Healthy London Partnership (HLP) [Child Death Review \(formally Child Death Overview Panel\) Programme](#) since September 2016. HLP was established in 2015 to bring about large scale transformation on behalf of London's 32 CCGs and NHS England (London).

## Key Dates - 2019

**28<sup>th</sup> January, 6<sup>th</sup> February & 7<sup>th</sup> March 2019** - NHS England held three national workshops on the new child death review requirements for stakeholders

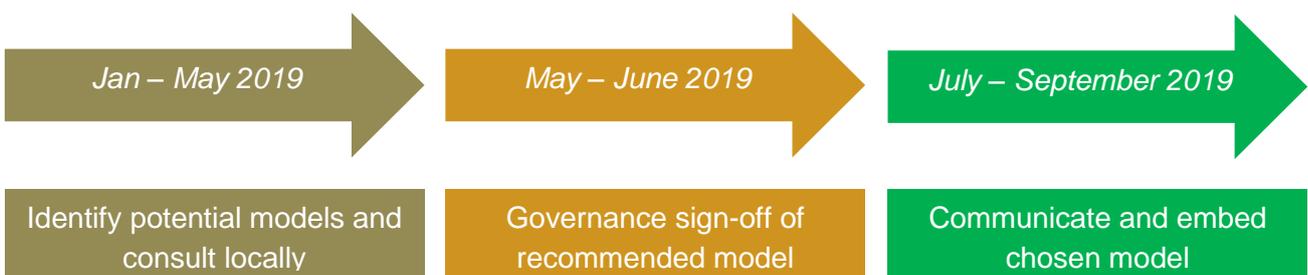
**20<sup>th</sup> & 29<sup>th</sup> March 2019** – NHS England ran two webinars centred on the new child death review requirements. For information from the NHS England workshops and webinars, please contact [England.cypalignment@nhs.net](mailto:England.cypalignment@nhs.net).

**1<sup>st</sup> April 2019** – The National Child Mortality Database went live. Department of Health & Social Care [transitional arrangements](#) outline that from 1<sup>st</sup> April 2019, all new child deaths and any open cases (those not yet reviewed by a child death overview panel) of children who died before that date should be added to the NCMD. The data collection requirements to support the review of each child's death also changed on this date, see the [gov.uk website](http://gov.uk) for further information.

**29<sup>th</sup> June 2019** – All Child Death Review Partners in England must publish their plans to meet the new requirements and send these plans to NHS England at [England.cypalignment@nhs.net](mailto:England.cypalignment@nhs.net). NHS England has confirmed that there is no standard template that these reports should align with.

**29<sup>th</sup> September 2019** – All Child Death Review Partners in England must complete the transition to the new arrangements. After this date they must be compliant with the new statutory requirements.

Below is an indicative timeline of activities over the coming months:



<sup>1</sup> Some CDOPs / boroughs have merged such as the tri-borough of Westminster, Hammersmith and Fulham & Kensington and Chelsea

## Changes to the Child Death Review Process

There are a number of changes to the existing child death review system. The primary changes are summarised below:

- 1. Change in responsibility for the child death review process from Local Safeguarding Children Boards (LSCBs) to local Child Death Review Partners (CDRPs)** – CDRPs will be formed from a collaboration of local authorities and clinical commissioning groups within the agreed geographical footprint that will hold joint responsibility for the child death review process.
- 2. Merger of existing Child Death Overview Panels** – CDRPs must represent a geographical footprint that will enable the review a minimum of 60 deaths each year in order for thematic learning to take place. CDRPs enact their child death review functions through their local multi-agency Child Death Overview Panel (CDOP). The average number of child deaths reviewed by each London CDOP is 25. As such, every London CDOP will need to merge with at least one other. The local governance framework for any new configuration will need to be agreed.
- 3. Requirement to perform a Joint Agency Response** – Resource will need to be identified to coordinate a new multi-agency response (on-call health professional, police investigator, duty social worker), if a child's death:
  - is or could be due to external causes;
  - is sudden and there is no immediately apparent cause (including SUDI/C);
  - occurs in custody, or where the child was detained under the Mental Health Act;
  - where the initial circumstances raise any suspicions that the death may not have been natural; or
  - in the case of a stillbirth where no healthcare professional was in attendance
- 4. Establishment of local multi-agency Child Death Review Meetings (CDRM)** - Resource will need to be identified to co-ordinate new local multi-agency meetings. The professionals involved in the child's care and investigation of the death from health services, social care, police, education and public health may need to be released to attend and / or feed into the relevant CDRM.
- 5. Establishment of a 'key worker' role to act as a single point of contact with the bereaved family for the duration of the death review process (several months)** – This is separate to bereavement support and will primarily be a signposting role as well as a first point of contact for the family and conduit for them with the organisations reviewing (and potentially investigating) the child's death. Resource will need to be identified to fulfil this function and factored into relevant job plans. Appropriate training will need to be provided to key workers.
- 6. Submission of data on each child death to the [National Child Mortality Database \(NCMD\)](#) from 1<sup>st</sup> April 2019** - CDRMs will need to ensure data is captured systematically and flowed to NCMD. Free usage of [eCDOP](#) case management system with capability to flow data to NCMD has been funded by NHS England (London Region) and provided to London CDOPs by HLP until April 2020. Thereafter local funding will need to be identified to continue to use eCDOP or any other case management system.

## Summary of the Challenges and Considerations – HLP workshops 2019

HLP supported one and ran four London STP sector workshops between January – March 2019 to support child death review professionals in London come together and discuss the challenges and considerations of the new statutory requirements.

Each workshop included a presentation on progress from the local CDR transformation leads from the region and a summary of the support offered to eCDOP customers from QES. HLP facilitated round table discussions which have been summarised below.



The information below is a summary of the discussions. This information should be used as guidance to inform local system transformation discussions. However, it should be noted that HLP, NHS England and the Department for Health and Social Care have not formally endorsed the positions and statements outlined below. These should be considered alongside the [Child Death Review: Statutory and Mandatory Guidance](#).

### Key Challenges

1. Ensuring multi-agency input
2. Resourcing new functions such as Joint Agency Response, the Child Death Review Meeting and the Key Worker function
3. Disproportionate burden on the acute sector
4. Ensuring appropriate training and oversight for key workers

### Key points

- Broad support for a named responsible officer within the CDRP for the child death review process and a clearly defined escalation process
- Designated Doctors provide a key function and should not be reduced as part of any centralisation and rationalisation
- CDRM should take place at the location where the most learning can be gathered
- CDOP / Chair should provide oversight for the CDRM
- Key functions (CDOP Chair, managers & administrators, key worker) should have protected time within their job plans and cross cover should be provided
- A review of systems should take place within 12 months of implementing the new processes

## 1. Governance & Accountability

### a) What new CDRP configurations should be formed to meet the new statutory requirements?

- This is for Clinical Commissioning Groups and Local Authorities to decide. However, the new CDRP footprint must cover an area that experiences a minimum 60 child deaths each year, the minimum felt to be useful thematic learning to take place
- The proposed London CDRPs (as of April 2019) are listed within the information pack on the [HLP Child Death Review Programme webpages](#).

### b) Where should ultimate responsibility for the child death review process sit?

- Responsibility rests jointly with the Clinical Commissioning Groups and Local Authorities within the CDRP footprint
- London stakeholders felt that one of the primary challenges would be in ensuring multi-agency input and engagement into the process. As a result, London stakeholders broadly supported having a named responsible officer for child death / review within each CDRP or STP region. This could be a senior officer from the STP. Alternatively there could be a nominal lead for child death review within each CCG and LA, such as the NHS officer for Quality on a CCG Board
- It was widely felt that the new requirements in effect placed a disproportionate burden upon the acute sector, given that the majority of deaths occur or are declared within this setting. It was therefore felt that trust Medical Directors and Directors of Nursing should have a close understanding of the new requirements
- Acute professionals outlined a significant risk that non-acute agencies within the CDRP footprint may fail to co-own the new process or view it as their responsibility and therefore fail to adequately engage with it

### c) What new resource is available to support the new child death review functions?

- The new functions place an extra / additional resource burden on existing local systems. However, no new central resource is being made available by NHS England across England
- Local transformation steering groups have undertaken mapping exercises to understand what dedicated resource is currently allocated across their CDRP footprint areas to support the child death review functions. Whilst some staff may currently support child death review in a full-time capacity (such as some CDOP managers / administrators), in many cases, the functions account for only a small proportion of time for a number of different professionals across the footprint
- A number of local CDRPs have developed business cases for additional resource for these new functions to ensure that their CDRP will be compliant with the new statutory requirements from 29<sup>th</sup> September 2019. It was widely felt that conversations regarding resource should include representation CCGs, LAs and Acute trusts
- There was a difference of opinion as to whether any additional costs should be split equally between each CCG and LA within a footprint area, or based upon the child population, or proportion of child deaths
- London stakeholders noted that as the CDRP footprints formed, opportunities existed for centralisation and rationalisation of resources. Whilst in some cases this could lead to efficiency savings, it was widely felt that it should not lead to a reduction of Designated Doctors for Child Death across a footprint area given the vital role they provide

**d) Will existing job roles need to change?**

- Potentially. This will depend largely upon decisions taken by each local CDRP
- If functions are centralised into a single team within the CDRP, there may be a requirement for staff to relocate to a different employer and / or location. In such cases, TUPE may need to apply and each CDRP should explore this with their local human resources teams
- London stakeholders broadly supported the inclusion of defined functions, such as the CDOP Chair, CDRM Chair and the key worker, within relevant job plans with protected time made available

**e) Where there is a dispute, for instance where there is failure to secure routine multi-agency input into the process, or enact system changes in response to identified learning, what should the escalation process be within the CDRP?**

- London stakeholders broadly supported a clear outlined escalation process within each CDRP that should be used when issues cannot be resolved locally. This should complement existing local structures. This could include the head of maternity/midwifery or the deputy chief nurse as a first stage. If resolution cannot be found then this could be escalated further to the Director of Nursing and / or the Medical Director before finally to any accountable officer for the CDRP or STP

**f) How should links between the CDRP and new local safeguarding arrangements be ensured?**

- Whilst the child death review process is separate to safeguarding, it was felt by London stakeholders that links to safeguarding structures, specifically following the dissolution of LSCBs, should be maintained. It was suggested that links to any strategic safeguarding meetings / local safeguarding partnerships should be developed

**g) How should data sharing be managed within the new footprint?**

- A legal basis for the collection and sharing of data for the child death review process is established within [The Children Act](#) 2004. As such, there is no barrier to sharing such data within the wider CDRP footprint
- However, data protection and data security principles would still apply. Local CDRPs should explore a framework that covers the sharing of data to the relevant agencies across the footprint for this purpose. For instance, this could take the form of a Data Sharing Framework / Agreement. Caldicott guardian support should be gained for this data sharing
- eCDOP includes functionality to anonymise data submitted by CDRMs to their overarching CDOP (except in cases where non redacted / de-identified documents had been uploaded into the system). CDRMs should be encouraged to anonymise data (where possible) before it is submitted to the overarching CDOP

**h) How should any electronic case management system to support the child death review process (such as eCDOP<sup>2</sup>) be funded beyond March 2020?**

- Details of how any case management system will be funded should be included within the CDRP plans to meet the new requirements that need to be published by 29<sup>th</sup> June 2019
- Where a CDRP plans to use an electronic case management system to support the child death review process, the recurrent costs should be included within any business case or local request for funding. For 2019/20, QES have outlined that the costs for a single

<sup>2</sup> There is no mandatory requirement for London CDRPs to use any specific case management system, such as eCDOP

CDRP using eCDOP to review 60-90 or 91-120 child deaths annually would be £9,813 and £12,927 (excluding VAT) respectively. For costs beyond March 2020, CDRPs should contact QES Ltd directly

**i) How should each CDRP ensure that learning identified is translated into system improvements?**

- Learning should be recorded and communicated to relevant agencies across the CDRP. The relevant quality meetings within the STP (at both CCG and LA level) should be identified and learning fed into these at regular intervals
- London stakeholders understood that information provision alone would not change clinical practice. Therefore, it was suggested that a range of training, newsletters, events and other activities be organised to ensure that learning and system changes were embedded locally. Reports should be routinely tabled to appropriate boards

**j) How should the CDRP ensure that the child death review process, and specifically the CDOP, operates effectively?**

- Each CDRP is responsible for ensuring that the local review of child deaths and implementation of local learning is completed to a high standard
- Where a named lead for child death is identified either within the STP or each CCG or LA, this individual(s) will hold responsibility for the process
- It was suggested that there may be value in having a named 'champion' for child death review within each of the various agencies within the CDRP (acute, mental health, social care, community, police, ambulance etc) and a communications lead for child death review
- It was widely felt that the systems implemented by 29<sup>th</sup> September 2019, would require review and potentially some refinement. It was suggested that such a review should take place between 6-12 months following their introduction

## 2. The Joint Agency response

As outlined on page 23 of the [statutory and operational guidance](#), and [Working Together to Safeguard Children](#), along with the process set out in [Sudden and Unexpected Death in Infancy and Childhood: multiagency guidelines for care and investigation](#), a JAR should be triggered if a child's death:

1. Is or could be due to external causes
2. Is sudden and there is no immediately apparent cause
3. Occurs in custody or where the child was detained under the mental health act
4. Where the initial circumstances raise suspicions that the death may not have been natural
5. In the case of a stillbirth where there was no healthcare professional in attendance

**a) How should a Joint Agency Response be convened?**

- It was suggested that the JAR, whilst different to existing Rapid Response meetings, could be managed in a similar way. Where Rapid Response meetings currently function well, London stakeholders felt that they should not be reinvented but rather tweaked to accommodate the additional functions required of the JAR
- A lead health professional should liaise with police, social care, education and other agencies, potentially by phone. This could be the senior attending paediatrician. They

should convene a meeting to determine what information needs to be collected, who needs to be contacted, and what investigations need to be triggered.

- It was felt that in many cases it would be appropriate for JAR meetings to be undertaken virtually
- b) Is it practical for ‘an initial information-sharing and planning meeting to take place before the family leave the emergency department’ as is outlined on page 24 of the [statutory and operational guidance](#)?**
- London stakeholders felt this requirement would be a significant challenge to the acute sector. However, they felt that whilst still ambitious, it may be possible to schedule a virtual meeting / telephone discussion within this timeframe
- c) Should the JAR function be supported out of hours?**
- This will be a decision for each CDRP. It was understood that out-of-hours JAR support was likely to provide a significant challenge for many local teams. However, some London stakeholders felt that an initial planning meeting, led by the relevant healthcare professional (such as a senior paediatrician), could take place out-of-hours. Otherwise, it should be held on the next working day
- d) How should the JAR run?**
- There must be cross-agency involvement. Information should be received from all relevant professionals involved in the child’s care prior to their death
  - It was felt that there would be value to those administering JARs, CDRMs and CDOPS, as well as the key workers, in having access to a map of all relevant organisations and agencies within the footprint, and lead contact for child death within each
- e) Who should Chair the JAR**
- JAR meetings, virtual or otherwise, should be chaired by the lead health professional
- f) Who should provide administrative support?**
- As many child deaths are confirmed within hospital, it was felt that the acute sector would be required to provide this function for at least the deaths that occurred in their setting, if not the wider CDRP
  - It may be possible for the team that currently provides support for the CDOP to also support this function
- g) Who should attend Joint Agency Response meetings?**
- All relevant professionals involved in the care of a child prior to their death should input into the JAR. However, they may not all be required to attend a physical meeting as this may occur virtually. This will be dependent upon the individual circumstances
  - It was suggested that representatives from any Multi Agency Safeguarding Hub (MASH) should join JAR meetings

### 3. The Child Death Review Meeting (CDRM)

As outlined on pages 28-32 of the [statutory and operational guidance](#), a CDRM is a new requirement that is different to existing Morbidity & Mortality (M&M) meetings. It should occur for every child’s death, have multi-agency representation and / or input and should have a focus on local learning. The administration and functioning of the CDRM was considered to be a significant challenge by the London stakeholders

**a) Who should Chair the CDRM?**

- The statutory guidance states that the CDRM should be chaired by a lead professional for the child death review process within the organisation where death was declared, or the lead health professional if a Joint Agency Response has taken place. This person should have designated time assigned for this within their job plan
- London stakeholders felt that it was important that the CDRM Chairs had experience of chairing meetings

**b) Who should provide administrative support to the CDRM?**

- This will need to be considered by each CDRP. Where the administration of the child death review function is centralised within the CDRP, the team that administers the existing CDOP functions may be able to support these meeting
- Cross cover should be factored in to ensure that these important meetings take place during staff leave or absences

**c) When should the CDRMs take place?**

- Every child's death should be reviewed at a local CDRM
- London stakeholders felt that CDRMs should take place at the earliest opportunity once the majority (if not all) of the information on a child's death had been gathered
- In certain circumstances, such as where a coronial investigation was taking place, it may be appropriate to hold the CDRM once the majority of the information on the child's death had been collected, rather than wait, for instance, for the final coroner's report. In such circumstances, it may be appropriate to hold an additional CDRM to review a specific child's death once the coroner's report had been issued. Similarly, in circumstances where professionals involved in the care of a child prior to their death are unable to join the CDRM, it may be appropriate to discuss that child's death at a second CDRM where specific attendance would be provided. The CDRM Chair is responsible for this determination

**d) Who should attend the CDRM?**

- The relevant professionals involved in the care of a child prior to their death should input into that child's CDRM. They should attend where practically possible, or dial in by telephone. In some circumstances written input alone may be acceptable
- London stakeholders identified a risk that CDRMs could become predominantly medical in focus and not have true multi-agency input as is required. The CDRM Chair should ensure that appropriate input is gathered from the various agencies involved, and escalate this as an issue in circumstances where it is not provided
- London stakeholders broadly felt that the CDRM should have an appropriate balance of attendees from the agencies within the footprint and not disproportionately favour one agency
- In instances where a child had been transferred from one trust to another, the balance in attendees from both trusts should be carefully considered to support an impartial review
- Whilst CDRMs could be scheduled in an ad-hoc way, many London stakeholders felt that there could be greater efficiency in pre-scheduling CDRM meetings for the year, such as on a monthly basis, where potentially 5-10 cases could be discussed. Specific cases would then need to be added to the agenda, and relevant professionals invited, once the relevant information had been gathered on individual deaths. If this model was adopted, a core membership would be required for the CDRM and other professionals would need to be invited depending upon the cases tabled for discussion
- Many stakeholders across London felt that the time spent on each case and the level of detail provided to CDRMs should be proportionate depending upon the case – some cases would require more time to be spent on the review than others

**e) Where should the CDRM take place?**

- This would depend largely upon where the administration for the CDRM was based. If it had been centralised then it may take place in a routine location. However, if it was to rotate across the footprint, some felt that tertiary centres may require additional resource
  - It was noted that not all NHS rooms provide teleconferencing facilities. It was felt that rooms with teleconference facilities should be prioritised for this function
- f) If a child dies outside an acute hospital (for instance in a mental health/community trust, in custody or state detention, or in a school) who should lead the CDRM?**
- The guidance outlines that responsibility for the CDRM should rest with the organisation of the lead health professional who declares the child's death
  - However, London stakeholders were in broad agreement that certain organisations (such as Mental Health Trusts) may not be best placed to deliver a high quality child death review given the low numbers of child deaths they may experience each year
  - Some stakeholders favoured the acute sector taking responsibility for all CDRMs within their CDRP. It was noted that this would increase the resource requirement on the acute sector
- g) Where a child has been transferred from one region to another, should the CDRM always take place where the child died, as is outlined within the guidance?**
- London stakeholders were broadly supportive that the CDRM should take place where the most learning was likely to be identified. In such circumstances, they supported a pragmatic discussion between the lead healthcare professionals from the two regions
  - In the event that these local professionals fail to agree on the most suitable region for the CDRM, an agreed escalation process should be followed
- h) How should multi-agency input be ensured?**
- It was widely felt that there would be a significant challenge in gathering input from all agencies (where relevant) into the CDRM. Where input is not provided, the agreed escalation process should be followed
  - It was suggested that there could be value in a responsible officer being identified and empowered by the CDRP to ensure that representation and/or input is gained
- i) Who should provide oversight of the process?**
- The CDOP and the CDOP Chair should provide oversight of the CDRM process. Learning and quality improvements should be fed both upwards from CDRMs into CDOPs, as well as to local professionals within the CDRP

#### 4. The Child Death Overview Panel

As outlined on pages 33-38 of the [statutory and operational guidance](#), CDOPs should take place and review all child deaths within a CDRP and should undertake themed reviews.

**a) How often should the CDOP meet?**

- Given the numbers of deaths within the new footprints, London stakeholders felt that these would likely need to meet monthly or bi-monthly. However CDRPs which only review the minimum 60 deaths each year may be able to run less frequently. This would vary depending upon the number of deaths within the region annually

**b) Who should Chair the meetings?**

- London stakeholders felt that it was important that the CDOP Chairs had experience in chairing meetings and did not rotate too frequently in order that continuity could be maintained and oversight of the embedding of any local learning monitored

- It was suggested that there could be value in having a co-Chair or Deputy-Chair. There was also a suggestion that there could be value in having two Chairs, one of which could review all neonatal deaths and another to review the remainder
- It was felt that there would be value in having an independent CDOP Chair. This role could be fulfilled by a Designated Doctor or even a clinician from outside the footprint if a reciprocal arrangement could be agreed

#### c) **Who should sit on the CDOP?**

- London stakeholders felt that there should be an appropriate balance between CCG and LA representation on the CDOP. Where a CDRP has a number of similar roles, such as a number of Directors of Public Health, these professionals could rotate onto the CDOP
- Consideration should be given to the size of the membership as too large a group could provide difficult to manage and / or remain quorate
- London stakeholders broadly supported having a core membership with others joining as required. [Pages 35-36 of the statutory guidance](#) outlines which agencies should provide the core membership
- It was suggested that invited members (depending upon the theme being reviewed) could include: widwives, oncologists, coroners, obstetricians, representatives from CAHMS, Housing, Hospices, Council services, Health and Wellbeing Boards, and Coronial services. It was felt that professionals conducting other mortality reviews such as the Learning Disability Mortality Review should be engaged.

#### d) **How should the CDOP undertake effective thematic learning?**

- Some London stakeholders felt that CDRPs should develop criteria for how they would run themed meetings. For instance, they may decide to have recurring themed meetings around neonatal deaths given the volume, but could review other themes once a specific number of cases had been reviewed (such as suicide, cardiac, oncology, trauma, SUDI)
- It was felt that it was important for specific agency attendance to be prioritised at specific thematic meetings. For instance it may be appropriate for police and ambulance services to attend any thematic review of traumatic death
- It was felt that learning should be fed both upwards from CDOPs into board structures, as well as to professionals within the CDRP

## 5. Development of the new 'key worker' role

As outlined on page 40 of the [statutory and operational guidance](#), the key worker role is not designed to be a stand-alone role but one which:

1. acts to signpost families to bereavement support
2. acts as a first point of contact for the family
3. supports (and represents) the family with information at various stages of the child death review process, specifically during any investigations (coronial, serious incident etc)

The key worker role is not expected to provide bereavement support, however, the role may be filled by a professional who provides bereavement support as part of their other functions. It was felt that there may be value in the key worker supporting families in their understanding of any post-mortem reports.

#### a) **Which agencies / roles have responsibility for providing the key worker function**

- There is no restriction on which agencies, roles or staff grade/band can fulfil this function. It will be for the local CDRP to determine whether all agencies within the footprint

contribute towards this (police, hospital, community and mental health trusts, social care, ambulance services, general practice etc). Whilst the statutory guidance outlines that the key worker would usually be a healthcare professional, it also states that their qualities and competencies are of greater importance than their professional background

- The key worker role should be filled by someone that the bereaved family feel comfortable with and who has received training. It may be appropriate for the key worker to be drawn from the agency from which the family is likely to have the most contact / touch points with
- London stakeholders felt that it was important that any professionals taking on the Key worker role had appropriate personality traits including empathy and resilience
- It was suggested that key workers should have access to local psychology teams
- Accommodation should be made to provide an alternate key worker if either the family or key worker feel that this would be appropriate
- Similar to the CDRM, there should be a pragmatic discussion about which CDRM will provide the key worker in instances where a child dies in a different region to where they lived

**b) What are the resource implications for the geographical footprint?**

- London stakeholders identified significant challenges with financing, resourcing and training key workers to fulfil these functions
- It was noted that in certain circumstances, such as where a coronial investigation was required, the child death review process could take in excess of 18 months. The potential therefore existed for Key workers to support a large number of families at any given time
- The resource implications for the CDRP would depend on the number of child deaths within the CDRP. Some CDRPs outlined that they intended to have a number of full time key workers to fulfil this function. Where there are existing teams (such as bereavement support or palliative care teams) with capacity to take some of this function on, it may be possible to spread this work out over a wider number of professionals. In such cases, it was suggested that there may be value in having a small number of central leads within the CDRP who could provide advice and guidance to any wider network of key workers
- Several London steering groups had outlined that they would request additional resource to meet this requirement. One local Steering Group member outlined that they had been successful in securing some funding from the Mental Health Investment Fund to support this function
- If stand-alone key workers are appointed, there must be appropriate cross-cover built in during times of absences

**c) Should the key worker function be provided solely during core business hours or should there be an on-call rota for weekends and evenings?**

- Many London stakeholders felt that there would be significant challenge in providing this function out-of hours. However, some felt that there would be value in providing a limited service at weekends

**d) Should the same key worker support the bereaved family throughout the review of their child's death**

- In an ideal circumstance, a single professional would act as a key worker to a bereaved family throughout the review of their child's death. However, as this process can in some circumstances take over 18 months, it may not be possible to have a single professional fulfil this role for the entire period
- In some circumstances a key worker may be appointed to a family in the immediate aftermath of their child's death and this function may then be transferred to a different key worker (e.g when a child dies outside the region where they lived)

- An alternative key worker should be made available to bereaved families when their primary key worker is on leave
- e) Who should hold responsibility for this service?**
- CDRPs hold overall responsibility for this function. However, there should be appropriate oversight of the key workers which could be fulfilled by an existing team such as bereavement support team
  - Where the key worker function is managed by a central team, that team should identify, select and allocate an appropriate key worker and ensure that the support that this function is provided to a consistent and high standard across the CDRP
  - In circumstances where the key workers within a CDRP are not managed by a single team, it may be appropriate for a team, such as the team that provides the administrative functions for the CDOP, to co-ordinate the key worker function
- f) What training should be provided for the key workers and who should be responsible for this training?**
- London stakeholders felt strongly that appropriate training should be provided to key workers given their proximity to the bereaved family and the potential for them to unintentionally cause further distress. This would help develop a standardised service. No known training for this role is understood to exist
  - It was widely felt that key workers should have defined clinical supervision
- g) Should job plans need to be updated to reflect this requirement?**
- It was felt that the key worker role should be reflected within the job plans of those individuals performing the function. It was also felt that there would be value in a standard job description for key workers being developed

## Service Transformation Progress across London (April 2019)

As of April 2019 there are 28 Child Death Overview Panels in London which broadly align with borough boundaries. Discussions have been taking place across London (and England) to configure new Child Death Review Partners (CDRPs) which will have responsibility for the local child death review process from 29<sup>th</sup> September 2019. Until February 2019, the focus of many of the local discussions had centred on the configuration of the new CDRP footprints. The focus has since moved towards mapping existing resource within the local footprints, the development of local models to meet the new requirements, and in some circumstances, the development of business plans to request additional resource.

It should be noted that the new requirements do place an additional burden on local systems and it may be necessary for local CDRPs to source additional resource to meet their statutory requirements. There are a number of different models that could be employed to meet the new requirements which will each have advantages and disadvantages. For instance, pooling existing CDOP administrative resource could potentially lead to some efficiency savings that could be used towards the administration, for instance, of the Child Death Review Meetings. Similarly, existing bereavement support teams may be able to take on some of the Key Worker responsibility, or that of advising and supporting a broad network of potential Key Workers from across the footprint. However, there is no single model/solution that will be applicable to all CDRPs. The models that will be published by CDRPs by 29<sup>th</sup> June 2019 are likely to vary as a result of the differing local resources available to support these functions, and the set up and configuration of services within the new footprint areas.

Below is a table of provisional plans to configure CDRPs to meet the minimum footprint of 60 child death reviews each year. If implemented, the number of London CDOPs will reduce from 28 to 8. Please note that these arrangements have not been finalised and are therefore subject to change\*. For further information about the progress towards the new child death review arrangements in your region, please contact the relevant key contact listed below.

### Key London sector contacts for system transformation

London region	Initial Service configuration plans	Key contact(s)
	<i>*These are accurate as 01.04.19 but subject to change</i>	
North Central	Plan to merge all 5 CDOPs into 1 large CDRP footprint which will review approximately 80 deaths/year:  1. Barnet, Camden, Enfield, Haringey, Islington	<a href="#">Jason Strelitz</a> , Consultant in Public Health, Camden & Islington & <a href="#">Dudzile Sher Arami</a> , Consultant in Public Health, Enfield
North West	Plan to have one overarching CDRP footprint area with two CDOPs:  1. Ealing, Hammersmith and Fulham, Kensington and Chelsea, Westminster & Hounslow 2. Brent, Harrow, Hillingdon	<a href="#">Carole Furlong</a> , Director of Public Health, Harrow & <a href="#">Chris Miller</a> , LSCB Chair and London Region Director for Association of Independent Chairs of LSCBs

South West	Plan to merge all 5 CDOPs into 1 large CDRP footprint which will review approximately 100 deaths/year:  1. Croydon, Kingston & Richmond, Merton, Sutton, Wandsworth	<a href="#">Gwen Kennedy</a> , Interim Director of Quality SWL Alliance
North East	Plan to have two CDRP footprint areas:  1. Barking, Dagenham, Havering & Redbridge  2. City & Hackney, Tower Hamlets, Waltham Forest, & Newham	<a href="#">Jacqui Himbury</a> , Nurse Director, Barking & Dagenham, Havering and Redbridge CCGs  <a href="#">Chetan Vyas</a> , Director of Quality and Development, Newham CCG
South East	Plan to have two CDRP footprint areas:  1. Bromley, Lambeth, Southwark  2. Lewisham, Greenwich, Bexley	<a href="#">Jenny Selway</a> , Consultant in Public Health, London Borough of Bromley  <a href="#">Pauline Cross</a> , Consultant in Public Health, Lewisham & <a href="#">Sarah Panjwani</a> , Consultant Community Paediatrician and Designated Doctor for CDR, Lewisham

### Funded Pan-London access to the eCDOP Child Death Review Case Management System - April 2018 - March 2020

In 2017 NHS Digital agreed funding for 12 month non-recurrent access to the child death review online case management system, e-CDOP, developed by QES, for all London CDOPs from 1<sup>st</sup> April 2018. Rollout across London was supported by Healthy London Partnership. The aims of this project were to:

- Support the London Child Death Review system to undertake standardised, high quality child death reviews, in doing so reduce administrative burden and unwarranted variation
- Support the system to meet the requirements of the new statutory requirements as outlined within the Act and [statutory and operational guidance](#)
- Enable the London system to meet strategic national objectives in regards to utilisation of digital technology, sharing data and learning from deaths
- Gain a greater understanding of the causes of child deaths across the London-region level by accessing valuable real time data with a view to improving systems and reducing future child deaths in London

Following feedback from London CDOPs and child death review stakeholders in January 2019, the public health commissioning team at NHS England (London Region) agreed to provide 12 months of non-recurrent funding to support continued access to eCDOP for the London CDOPs. **All London CDOPs will therefore be able to continue to use eCDOP without charge between 1<sup>st</sup> April 2019 – 31<sup>st</sup> March 2020.**

**However, from 1<sup>st</sup> April 2020, local CDRPs will need to fund any electronic case management system, such as eCDOP, to support with their child death reviews, from their local budgets. There will be no further central (London) funding for eCDOP beyond this point.**

In 2018, the University of Bristol, University of Oxford, University College London and QES formed a partnership to establish and deliver the National Child Mortality Database (NCMD). Since 1<sup>st</sup> April 2019 all CDOPs in England have been required to provide data to NCMD within 24 hours of receiving a notification of a child death. eCDOP enables an automated data transfer from each local CDOP to NCMD. eCDOP users have not, therefore, been required to log into NCMD and separately duplicate the data entry.

QES have been actively supporting local CDOPs as they prepare to merge to meet their minimum footprint requirements of 60 child deaths annually. They delivered a number of significant upgrades to eCDOP that came into effect on 1<sup>st</sup> April 2019 to ensure compliance with the new [Department of Health and Social Care reporting requirements](#). QES will continue to provide additional training and support to all eCDOP users to help support their transition to the new CDR arrangements. Further information on eCDOP and the provision of pan-London access to eCDOP until March 2020 is included within Appendix 1 and Appendix 2 respectively.

### Data on Child Deaths across London April 2018 – March 2019

For the first time, detailed data is being collected at a London region level on child deaths. 28/28 London CDOPs are now actively using and submitting data to eCDOP. 777 deaths have been notified through eCDOP since 1<sup>st</sup> April 2018. The average time to review a child death case is approximately 9 months, however, 127 child death reviews have been completed across London using eCDOP since 1<sup>st</sup> April 2018. This number will increase over time. Uptake of eCDOP by London CDOPs varied and as such, not all child deaths that have occurred across London since April 2018 have been captured. However, eCDOP is now starting to yield invaluable insights into the causes of child deaths across London.

	eCDOP Data reported as of 20 <sup>th</sup> March 2019
Deaths notified since 01.04.18 (previously Form A)	777
Cases started in eCDOP since 01.04.18	502
Cases completed in eCDOP since 01.04.18 (previously Form C)	127

The potential utility of the pan-London data will increase over time in line with the number of completed child death reviews managed through eCDOP. No other health population / region currently has access to such comprehensive and accurate data. Although NCMD will provide national analysis and thematic learning on child deaths across England in the future, it is unlikely to be in a position to report for some time. London has an opportunity to access and review population data with an ability to garner learning in 2019-20 and HLP will explore with stakeholders how best this data can be used over the coming months. Appendix 3 outlines headline data collected from eCDOP on child deaths from across London since 1 April 2018 (as of 20.03.2019).

## Meeting the new requirements: Support for the London System

### 1. The Healthy London Partnership Child Death Review Programme

The Healthy London Partnership [Child Death Review \(CDR\) Programme](#) has been funded by NHS London since late 2016. It is led by Ronny Cheung, Consultant Paediatrician at the Evelina Children's Hospital, and Donal O'Sullivan, former Consultant in Public Health and CDOP Chair for the London Borough of Lewisham. The programme is managed by [David McKinlay](#) and is supported by a Steering Group of stakeholders from across London, please see Appendix 4. The CDR Programme supports London CCGs and local authorities (Child Death Review Partners) and specifically those involved in Child Death Review Meetings (CDRMs) and Child Death Overview Panels (CDOPs), to understand and meet the new requirements, maximise their impact in the prevention of child deaths, and learn lessons to improve services for children and their families. The programme is currently funded until September 2019.

#### **Pan-London access to eCDOP**

The HLP CDR programme team have secured funding from NHS England (London Region) for free access to the eCDOP child death case management system for all London CDOPs from 1<sup>st</sup> April 2018 – 31<sup>st</sup> March 2020.

#### **Memorandum of Understanding with Inner South London Coroner**

The CDR programme has worked with HM Coroner for Inner South London, Dr Andrew Harris, and colleagues from health and police across South East London to agree a single pathway to guide health professionals in the aftermath of managing the unexpected death of a child. This includes a [memorandum of understanding](#) from the Coroner's officer pre-authorising certain processes after the death of a child; guidance for practitioners on statutory processes; and resources for bereavement support. While it carries legal weight only within the Inner South London jurisdiction of Coroner Harris, we would encourage other areas to work with their stakeholders (coroners, police, hospital and community trusts, and ambulance services) to use this as a template and develop and agree their own local versions in order to reduce the unnecessary variation in practice after a child's death.

This work builds on the excellent South West London pathway which was agreed in 2018. We hope that other coronial jurisdictions will, if appropriate, agree local guidance along these lines.

#### **Child Death Review eLearning**

The CDR programme is currently developing a free-to-access eLearning resource to support professionals involved in the review of child deaths. This is based upon the *Introduction to Child Death Review and Responding to Unexpected Child Deaths* course developed by Professor Peter Sidebotham from Warwick University. It is anticipated that this will be available from August 2019. Further information will be listed on the [HLP website](#) in due course.

#### **Bereavement Experience Measure (BEM)**

The CDR programme has worked with bereavement leads and families and drawn on other published guidance to provide a resource to outline the key principles of good bereavement care and provide a tool to support the collection of feedback from parents and carers. This BEM will be available from May 2019.

For further information about the HLP CDR Programme, please visit the [HLP website](#) or email David McKinlay, Child Death Review Programme Manager at [david.mckinlay3@nhs.net](mailto:david.mckinlay3@nhs.net).

## **2. Network of London Child Death Overview Panel (CDOP) Chairs**

London has an established network of CDOP Chairs, led by Jenny Selway, Consultant in Public Health, and CDOP Chair for the London Borough of Bromley. The CDOP Chairs meet regularly to discuss issues highlighted locally. They act as a forum for peer review and support. In recent months they have focussed discussions on the new statutory requirements. The London CDOP Chairs are listed within Appendix 5.

## **3. NHS England**

NHS England ran three national workshops on child death review, led by Jacqueline Cornish, National Clinical Director for Children, Young People and the Transition to Adulthood, and James Fraser, Consultant in Paediatric Intensive Care, University Hospitals Bristol. The first was held in London on 28<sup>th</sup> January 2019, the second on 6<sup>th</sup> February 2019 in Leeds and the third on 7<sup>th</sup> March 2019 in Bristol. They also ran two online webinars that were held on 20<sup>th</sup> March 2019 and 29<sup>th</sup> March 2019. NHS England intend to provide further support to any local system struggling to meet the new requirements. For further information, please contact the NHS England team at [England.cypalignment@nhs.net](mailto:England.cypalignment@nhs.net).

## **4. National Network of Child Death Overview Panels**

The [National Network of Child Death Overview Panels](#) (NNCDOP) has been meeting since December 2014 and has a number of functions including serving as a focal point for the regional CDOPs to share best practice, exchange information (including guidelines & publications) and support each other through the network pathways. NNCDOP runs an annual conference, the most recent of which took place on 13-14<sup>th</sup> March 2019 in Birmingham. For further information, please see the [NNCDOP website](#).

## Related National Programmes

There are a number of national programmes which centre on the review of deaths, or particular types of child death. These are summarised below. Given the overlap of these programmes, the potential exists for data entry duplication to occur if each child death is reported to all systems, especially given that some overlap. As such, CDRPs are advised to complete the child death review process rather than the Structured Judgement Review for children aged below 18 years. For those children whose deaths meet the criteria of the Perinatal Mortality Reporting Tool, data should be provided to this programme. However, this programme has taken steps to align its dataset with the new data requirements that will also feed into NCMD. The new data collection requirements for child deaths from April 2019 should therefore be able to satisfy the majority of requirements for both PMRT and NCMD.

### 1. *National Child Mortality Database*

The [National Child Mortality Database \(NCMD\)](#) aims to reduce premature mortality by analysing data on all deaths in children in England, aged between birth and their 18<sup>th</sup> birthday. Launched on 1<sup>st</sup> April 2019, it is the first national database of child deaths in the world. From 1<sup>st</sup> April 2019, all CDRPs in England have been required to submit data on all open and new child death review cases (those not yet reviewed by a child death overview panel) to NCMD. Submission of this data may be managed by local CDOPs. In addition to the [standard datasets included within the Notification, Reporting, and Analysis Forms \(formerly Form A, B and C\)](#), NCMD will launch a number of additional data collection forms that should be used when reviewing specific child deaths. NCMD aims to identify national themes and support system learning from these deaths.

### 2. *MBRRACE-UK*

The [Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK \(MBRRACE-UK\)](#) programme investigates the deaths of women and their babies during or after childbirth.

### 3. *Learning Disability Mortality Review Programme (LeDeR)*

The [Learning Disability Mortality Review Programme \(LeDeR\)](#) aims to standardise the reviews of people who have died with a learning disability and support system-wide learning. [eLearning is available](#) for those reviewing the deaths of those with learning disabilities.

On 20<sup>th</sup> March 2019, NHS England ran a conference to support quality improvements in healthcare of people with a disability: [Preventing deaths of people with a learning disability: Translating learning into action from mortality reviews to improve health and care outcomes and save lives](#).

### 4. *Perinatal Mortality Reporting Tool*

The [Perinatal Mortality Reporting Tool](#) programme aims to provide a standardised approach to perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales. From April 2019, the PMRT aims to align its dataset with that of the NCMD in order that data can be forwarded from PMRT to NCMD. This will prevent data entry duplication between the two systems.

## 5. *National Mortality Case Record Review programme*

The [National Mortality Case Record Review programme](#) aims to provide a standardised approach to the review of people who have died and support system-wide learning. It predominantly focuses on adult deaths.

### Useful Links

- [Child Death Review](#) (Healthy London Partnership)
- [Child Death Review Statutory and Operational Guidance \(England\)](#) (Department of Health and Social Care & Department for Education)
- [Working Together to Safeguard Children: Statutory guidance on inter-agency working to safeguard and promote the welfare of children](#) (Department for Education)
- [Working Together: transitional guidance](#) – *Statutory guidance for Local Safeguarding Children Boards, local authorities, safeguarding partners, child death review partners, and the Child Safeguarding Practice Review Panel* (Department for Education)
- [Child death reviews: forms for reporting child deaths](#) – *Forms to help child death overview panels (CDOPs) assess the causes of a child's death as part of the child death review process* (Department for Health & Social Care)
- [National Child Mortality Database: transitional arrangements](#) (Department for Health & Social Care)
- [eCDOP online recording, casework and reporting software for child deaths \(QES\)](#)
- [Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers](#) (NHS England)
- [When a child dies: A guide for parents and carers](#) (NHS England)
- [Information for families following a bereavement](#) (NHS England)
- [National guidance for NHS Trusts engaging with bereaved families](#) (NHS England)
- [Population factors & inequalities planning tool for pregnancy and early life](#) - *The tool allows those working in local government, CCGs and across local maternity systems to model improvements to benchmarks and shows how factors might influence stillbirth and infant death locally* (Public Health England)
- [The Children and Social Care Act 2017](#).

## Appendix 1: eCDOP

eCDOP is a web-based platform that offers an electronic case management solution to support the multi-agency child death review process. It has been developed by QES, a specialist developer of web and application based digital data solutions, in collaboration with Kent Safeguarding Children Board. It is understood to be the only commercial electronic case management system currently available to support the review of child deaths.

As of April 2019, there are 93<sup>[1]</sup> CDOPs in England. 65 CDOPs currently use eCDOP and a number of others have indicated their intent to do so. Following the introduction of NCMD, national adoption of eCDOP is likely to continue to rise given that it will remove the potential duplication of data entry. Key benefits/features of eCDOP include:

- A fully hosted and maintained web-based system which streamlines and centralises the child death review process, thereby significantly reducing the administrative burden, the resource requirements and case review processing timescales
- Compliant with the CDR statutory approach, including new CDR forms and processes, coming into effect from 1<sup>st</sup> April 2019
- Fully manages key meetings (e.g. RRM/JAR, CDRM, CDOP Review Meeting, etc.), including sharing key information securely between agencies.
- Allows multiple partners to access and supply information in multiple formats in a timely manner, across multiple devices including smartphones and tablets
- Rapid and secure sharing of multi-agency information from Form A (notification of death), Form B (pertinent records) and form C (review of death and recommendations)
- Automatic population of forms, reducing double data entry and the requirement for central collation
- Collation and presentation of information that is important to identify trends, share recommendations and deliver system level improvements, including reports, and dashboards
- Generation of automated reminders to improve efficiencies in data submission in line with required timelines
- Real time notification of Form A submission simultaneously to both Health and LSCB
- 24/7 secure web access for authorised users
- Designated contact to support local adoption
- System fully compliant with GDPR
- System will remove potential for duplication of data entry by enabling automated submission of data to NCMD from 1 April 2019

Formal feedback from London CDOPs is now being collected by the CDR programme team. Anecdotal feedback gathered by the programme team and Steering Group to date supports the position that eCDOP delivers a high-quality solution which; aids the local child death review process; reduces the administrative burden; removes potential duplication of effort, and unwarranted variation.

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<sup>[1]</sup> This number was previously closer to 153 though a number of CDOPs have merged over the past year

## **Appendix 2: Pan-London Access to eCDOP April 2019 – March 2020 Information sheet**

### **Pan-London eCDOP offer**

In 2018 Healthy London Partnership (HLP) facilitated the roll-out of free access and use of the [eCDOP](#) child death review electronic case management system for all London Child Death Overview Panels (CDOPs). Non-recurrent funding was provided by NHS Digital for London CDOPs for the 12 month period from 1<sup>st</sup> April 2018. No London CDOP was mandated to use eCDOP, however the offer was provided to inform local decision making around which system could best support local requirements. Since April 2018 26/28 London CDOPs have been actively using eCDOP. Following requests from local stakeholders, the public health commissioning team at NHS England (London Region) has agreed to 12 months non-recurrent funding for the provision of pan-London access to the eCDOP for all London Child Death Review Partners (CDRPs) from 1<sup>st</sup> April 2019 – 31<sup>st</sup> March 2020.

### **How is this arrangement being managed?**

HLP (and their partner Lewisham Clinical Commissioning Group) will manage the contractual relationship with QES Ltd on behalf of the funder, NHS England (London Region), and the London local authorities and clinical commissioning groups. HLP have agreed a contract with QES to provide access for the London Child Death Review Partners (CDRP) and the existing 28 London Child Death Overview Panels (CDOP) to eCDOP for the period 1<sup>st</sup> April 2019 – 31<sup>st</sup> March 2020.

QES Ltd will continue to provide eCDOP access to the London CDRPs/CDOPs. The 2018 Service Level Agreements (SLAs) between each of the London local authorities and / or clinical commission groups and QES Ltd will continue until 31<sup>st</sup> March 2020. Local CDRPs/CDOPs should contact QES Ltd directly for support and other queries regarding eCDOP.

### **Will each local authority and / or clinical commissioning group be required to renew the existing SLA?**

No. The terms and conditions of the original signed SLAs have been included within the HLP contract with QES. These have been extended for the duration of the HLP contract which runs from 1<sup>st</sup> April 2019 – 31<sup>st</sup> March 2020.

### **As an existing London CDOP using eCDOP, what steps do I need to take to continue using eCDOP on 1<sup>st</sup> April 2019?**

London CDOPs currently using eCDOP will not need to take any further action. Access will continue uninterrupted for 12 months from April 2019.

### **Does this offer provide access to all modules within eCDOP?**

All Working Together modules are included within eCDOP / this offer.

### **Will there be any changes to eCDOP from 1<sup>st</sup> April 2019?**

Yes, QES are implementing a number of upgrades to eCDOP including replacing the existing Form A, B and C with new Notification, Reporting and Analysis forms in line with the new

[Department of Health and Social Care guidance](#). There will be a number of other updates that come into effect from this date.

**Will QES be providing any support to eCDOP users and administrators to outline the new changes?**

Yes. In addition to the routine customer support provided by QES, they have hosted three webinars to support customers. QES have also developed an online eCDOP help site which contains training guidance and materials to support the transition to the new Working Together eCDOP version.

**Between April – October 2019 new CDRP footprints will form and CDOPs across London will merge to cover larger geographical areas. Will eCDOP be able to reflect and support these new working arrangements?**

Yes. Once a CDRP/CDOP has established its new footprint area and would like its local eCDOP system to reflect this, the local CDOP should write formally in this regard to Emma Barrand, Safeguarding Lead, QES at [emmabarrand@ges-online.com](mailto:emmabarrand@ges-online.com). The local eCDOP system will be updated within a few working days.

**Who is the data controller for the data submitted to eCDOP?**

The local CDRP is the data controller for any data entered into eCDOP. QES will act as data processor.

**How will data be managed across the new eCDOP footprint?**

This will need to be determined by each local CDRP. The statutory and operational guidance outlines a key new requirement for a range of agencies within the CDRP footprint to supply data for the purpose of the child death review. eCDOP has functionality to enable the anonymisation of specific data fields in order to mitigate, where possible, against the identification of personal / identifiable data. However it does not have the functionality to redact personal data included in uploaded documents, such as submitted PDF documents.

**Is eCDOP mandatory?**

No. Local CDRPs/CDOPs must determine what local system(s) to use to support the case management of the child death reviews within their geographical footprint. However, those CDRPs/CDOP that do not use eCDOP will need to arrange for relevant data to be shared / uploaded into NCMD for all new and open cases on an on-going basis.

**How will eCDOP be funded post March 2020?**

Local CDRPs/CDOPs wishing to access eCDOP post March 2020 will need to contact QES Ltd directly to procure eCDOP. This will need to be funded locally. There will be no additional central funding for this purpose.

The costs of eCDOP for 2019/20 are listed below. For costs beyond March 2020, please contact QES Ltd directly.

<b>QES funding model 2019/20 (available to all CDRPs in England)</b>	
<b>Number of deaths / year</b>	<b>Cost (£)*</b>
<25	Price On Application – Price calculated based on the size
60-90	9,813
91-120	12,927
>121	Price On Application – Price calculated based on the size

*\*All prices are per annum and exclusive of VAT.*

### **Who do I contact if I have any queries about eCDOP moving forward?**

General queries should be directed to the QES service desk at [info@ges-online.com](mailto:info@ges-online.com).

### Appendix 3: Headline data collected from eCDOP on Child Deaths across London since 1 April 2019 (20.03.2019)

Please note that the table below does not represent a complete data capture as London CDOPs commenced using eCDOP at different times

Child death notifications through eCDOP since April 2018			
CDOP	Male	Female	Unknown
LBBB	9	16	
Barnet	13	11	2
Bexley	5	11	1
Brent	17	7	1
Bromley	11	8	
City Hackney	15	3	
Croydon	12	17	
Ealing	16	10	
Greenwich	13	8	1
Haringey	10	8	4
Harrow	6	3	
Havering	8	11	
Hillingdon	10	11	
Hounslow	11	13	
Islington	1	1	
Kingston & Richmond	30	31	
Lewisham	15	17	1
London Newham	24	38	
Merton	6	3	1
Redbridge	14	24	1
Southwark & Lambeth	23	33	
Sutton	2	2	
Tower Hamlets	20	29	1
Waltham Forest	23	34	
Wandsworth	17	26	1
Westminster	21	35	1
<b>Total</b>	<b>352</b>	<b>410</b>	<b>15</b>
<b>Total</b>	<b>777</b>		

Cases started since April 2018	
CDOP	Cases Mar 19
Barking & Dagenham	16
Barnet	24
Bexley	13
Brent	21
Bromley	15
Camden	1
City & Hackney	12
Croydon	21
Ealing	19
Greenwich	16
Haringey	6
Harrow	3
Havering	13
Hillingdon	16
Hounslow	20
Islington	2
Kingston & Richmond	25
Lewisham	27
Newham	40
Merton	9
Redbridge	29
Southwark & Lambeth	39
Sutton	2
Tower Hamlets	30
Waltham Forest	31
Wandsworth	14
Westminster	38
<b>Total</b>	<b>502</b>

Age at death	Cases started Mar 19	Cases completed Mar 19
0	269	80
1	57	9
2	18	4
3	11	3
4	10	3
5	11	4
6	12	3
7	11	0
8	5	2
9	5	0
10	12	1
11	3	1
12	9	3
13	9	3
14	10	1
15	10	3
16	11	2
17	15	4
18	14	1
	<b>502</b>	<b>127</b>
Cause of Death		
Perinatal/neonatal event		46
Chromosomal, genetic & congenital anomalies		39
Malignancy		14
Chronic medical condition		12
Sudden unexpected, unexplained death		6
Acute medical / surgical condition		5
Infection		3
Trauma & other external factors		2
<b>Total</b>		<b>127</b>

## Appendix 4: HLP Child Death Review Programme Steering Group

Name	Representing
Ronny Cheung (Chair)	Clinical Director, HLP CDR Programme & Consultant Paediatrician
Arlene Boroda	Designated Doctor, LB Brent
Nicky Brown	Public Health
Nicky Brownjohn	NHS England
Charlotte Daman Willems	Consultant Paediatrician, LB Lewisham
Georgios Eleftheriou	Paediatric Consultant & HLP Acute M&M Lead
David Elliman	Former Consultant Paediatrician, GOSH /LB Haringey
Seb Florent	Metropolitan Police Service
Marilena Korkodilos	Public Health
Eugenia Lee	GP Commissioner, NHS Greenwich CCG
Ian Lewis	HLP local authority advisor
David McKinlay	HLP CDR Programme Manager
Chris Miller	LSCB Chair and London Region Director for Association of Independent Chairs of LSCBs
Nicola Needham	CDOP Coordinator, Public Health Partnerships, London Borough Newham
Sara Nelson	HLP Programme Lead, Children and Young People's Programme
Donal O'Sullivan	Clinical Advisor, HLP CDR Programme & former Consultant in Public Health and CDOP Chair
Tracy Parr	HLP Director of Transformation, Children & Young People
Jenny Selway	Consultant in Public Health / Chair of London CDOP Chairs' Network
Fiona Spargo- Mabbs	Director and Operations Manager, The Daniel Spargo-Mabbs Foundation
Gladys Xavier Redbridge	Deputy Director of Public Health / Head of Integrated Strategy and Commissioning, LB Redbridge
Ann York	HLP Children and Young People's Programme Mental Health Clinical Lead

## Appendix 5: London Network of CDOP Chairs (April 2019)

The 28 London CDOPs listed below are likely to merge for form 8 larger CDOP footprints from September 2019.

STP	CDOP	CDOP Chair
East London	Barking and Dagenham	Matthew Cole, Joint Director of Public Health
	City and Hackney	Dr Penny Bevan, Director of Public Health
	Havering	Mark Ansell, Consultant in Public Health
	Newham	Meradin Peachey, Interim Director of Public Health
	Redbridge	Dr Gladys Xavier, Deputy Director of Public Health / Head of Integrated Strategy and Commissioning
	Tower Hamlets	Esther Trenchard-Mabere, Associate Director of Public Health
	Waltham Forest	Joe McDonnel, Interim Director of Public Health
North London	Barnet	Natalia Clifford, Consultant in Public Health
	Camden	Jason Strelitz, Assistant Director, Consultant in Public Health
	Enfield	Stuart Lines, Director for Public Health / Duduzile Sher Arami, Consultant in Public Health
	Haringey	Asmat Nisa, Assistant Director of Public Health
	Islington	Jason Strelitz, Assistant Director, Consultant in Public Health
North West London	Brent	Dr Melanie Smith, Director Public Health
	Ealing	Vaishnavee Madden, Consultant in Public Health
	Harrow	Carole Furlong, Director of Public Health
	Hillingdon	Dr Christina Atchison, Consultant in Public Health
	Hounslow	Imran Choudhry, Director of Public Health
	Westminster, H&F, K&C	Emma Biskupski, LSCB Business Manager (interim Chair)
South East London	Bexley	Jill May, Designated Nurse Safeguarding Children
	Bromley	Dr Jenny Selway, Consultant in Public Health
	Greenwich	Dr Nikesh Parekh, Public Health Associate
	Lewisham	Pauline Cross, Consultant Midwife in Public Health Medicine
	Southwark and Lambeth	Kirsten Watters, Consultant in Public Health
South West London	Croydon	Dawn Cox, Public Health Principal
	Kingston and Richmond	Amanda Boodhoo, Associate Director of Public Health
	Merton	Julia Groom, Consultant in Public Health
	Sutton	Dr Imran Choudhury, Director of Public Health
	Wandsworth	Dr Peter Green, Designated Doctor for Child Safeguarding

## Appendix 6: Glossary of terms

### Child Death Review Meeting

The stage of the review process that precedes the independent multi-agency panel arranged by CDR partners. This meeting should be a multi-professional meeting where all matters relating to an individual child's death are discussed. The Child Death Review Meeting (CDRM) should be attended by professionals who were directly involved in the care of the child during his or her life, *and* any professionals involved in the investigation into his or her death. The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved, and should *not* be limited to medical staff.

For example, the CDRM could take the form of a final case discussion following a Joint Agency Response, a perinatal mortality review group meeting in the case of a baby who dies in a neonatal unit, or a hospital-based mortality meeting following the death of a child on a paediatric intensive care unit. These meetings could, as a way of standardising practice nationally, be known as a Child Death Review Meeting.

Outputs from CDRMs (draft Analysis Forms) should be shared with the group set up by CDR partners to conduct reviews, described in this guidance as a Child Death Overview Panel.

### Child Death Overview Panel / equivalent

A multi-agency panel set up by CDR partners to review the deaths of all children normally resident in their area, and, if appropriate and agreed between CDR partners, the deaths in their area of non-resident children<sup>1</sup>, in order to learn lessons and share any findings for the prevention of future deaths. This stage of the review process is described as a Child Death Overview Panel (CDOP) throughout this guidance.

In all cases, legal responsibility for ensuring that arrangements are made to review the death of a child lies with the Child Death Review Partners where the child is normally resident; more information can be found in chapter 5.

The CDOP should be informed by a standardised report from the CDRM, and ensures independent, multi-agency scrutiny by senior professionals with *no named responsibility* for the child's care during life. In practice, CDOPs 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.

### Designated doctor for child deaths

A senior paediatrician, appointed by the CDR partners, who will take a lead in co-ordinating responses and health input to the child death review process, across a specified locality or region.

### Forms: Notification, Reporting, Analysis

Three standard forms should be used in the child death review process:

- Notification Form (previously "Form A") for initial notification of a death to CDR partners;
- Reporting Form (previously "Form B") for gathering information from agencies or professionals who have information relevant to the case. Reporting forms should be completed by the relevant responsible officer and shared with the relevant CDOP. For certain child deaths, a supplementary Reporting Form should also be completed as required; and

- Analysis Form (previously “Form C”) initially drafted at the CDRM and completed at CDOP for evaluating information and identifying lessons to be learned. The Analysis Form is the final output of the child death review process. From April 2019 this information should be shared with the National Child Mortality Database. Specified data to NHS Digital for the transitional period will be notified to Child Death Review Partners separately. The mechanism for collecting, and the content of, this data will evolve as the National Child Mortality Database becomes operational.

All forms and templates to be used for reporting child deaths can be found on [GOV.UK](https://www.gov.uk). These forms should continue to be used until the introduction of the National Child Mortality Database, in 2019.

### **Joint Agency Response**

A coordinated multi-agency response (on-call health professional, police investigator, duty social worker), should be triggered if a child’s death:

- is or could be due to external causes
- is sudden and there is no immediately apparent cause (including SUDI/C)
- occurs in custody, or where the child was detained under the Mental Health Act
- where the initial circumstances raise any suspicions that the death may not have been natural
- in the case of a stillbirth where no healthcare professional was in attendance

The full process for a Joint Agency Response is set out in the [\*Sudden and Unexpected Death in Infancy and Childhood: multiagency guidelines for care and investigation \(2016\)\*](#).

### **Key Worker**

A person who acts as a single point of contact for the bereaved family, who they can turn to for information on the child death review process, and who can signpost them to sources of support. This person will usually be a healthcare professional. Core competencies for the key worker can be found within Appendix 5 of the [\*Statutory and Operational Guidance\*](#).

### **Lead health professional**

When a Joint Agency Response is triggered, a lead health professional should be appointed, to coordinate the health response to that death. This person may be a doctor or senior nurse, with appropriate training and expertise. This person will ensure that all health responses are implemented, and be responsible for ongoing liaison with the police and other agencies. Where no out-of-hours health rota for a Joint Agency Response exists in a locality, the role of lead health professional should be taken by the senior attending paediatrician.