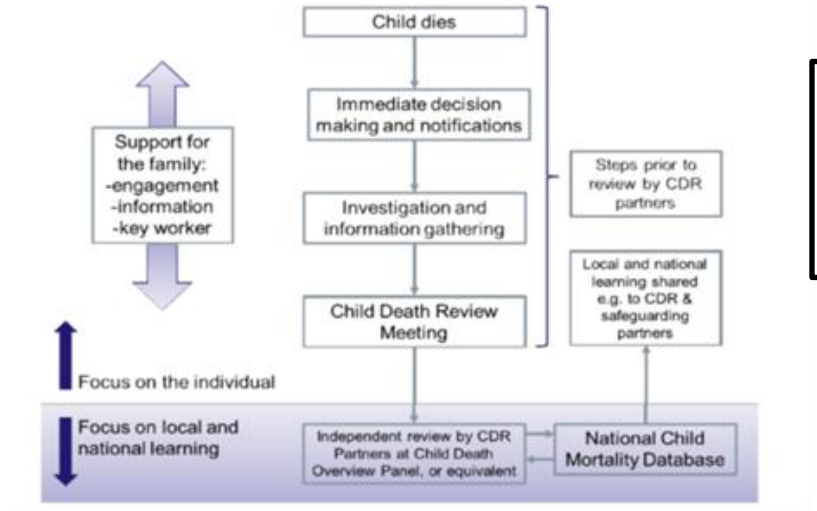
What is required from the new Child Death Review reforms

Significant statutory changes to the process of reviewing child deaths across England will come into effect from 29th September. These are outlined within the Child Death Review: Statutory and Operational Guidance (England) and summarised within the Healthy London Partnership Information pack: The new Child Death Review requirements. One of the key requirements is that there is genuine 'multi-agency' input into the review of each child's death. These 'agencies' include, but are not limited to: primary and secondary healthcare (including general practice); police; ambulance; children's social care and safeguarding; education; and coroner services.

Local authorities and clinical commissioning groups have come together across London to establish seven new partnership footprints to manage child death reviews. These Child Death Review Partners oversee Child Death Overview Panels (CDOPs) who conduct the local child death reviews.

The Children and Social Work Act 2017 outlines clearly that where a Child Death Review Partner, their CDOP, or those responsible for administering the review on their behalf, requests information to support a child death review, ***The person or body to whom a request under this section is made must comply with the request***[1]. Each agency may be required to submit information and attending meetings for each child's death that is reviewed.

Whilst there will be variation in the way that the child death process is administered locally, this document outlines the minimum common requirements of each agency in the review process. It does not list who should take the lead on various activities in circumstances where this is subject to local agreement.



New child death review process from the Child Death Review: Statutory and Operational Guidance (England)

[1] *Section 25, 16N(1) Children and Social Work Act 2017*

Aspects of the Child Death Review Process	Health (Acute, Mental, Community)	GP	Police	Ambulance	Social care	Education	Coroner
Provide accurate contact information to those responsible for administering or managing the child death review process across the footprint - In order for the child death review process to function effectively, each agency should ensure that an accurate list of key contacts from their agency who have responsibility for and who will act as a liaison point within their agency to support the child death review process, is provided and maintained	✓	✓	✓	✓	✓	✓	✓
Submit a notification of a child's death – whilst this function may usually be enacted by the attending doctor, there is no restriction on the job role or the agency which submits a child death notification. Timely notification is important as this will trigger other system notifications. Notifications can be completed online via the eCDOP website (see below for links)	✓	✓	✓	✓	✓	✓	✓
Join a Joint Agency Response meeting (where applicable) – Where the circumstances of a child's death require a JAR to be held, all relevant professionals involved in the care of the 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.	✓	✓	✓	✓	✓	✓	
Provide information to any relevant investigation (where applicable) such as coronial or NHS serious incident investigation	✓	✓	✓	✓	✓	✓	✓
Attend a Child Death Review Meeting – The relevant professionals involved in the care of a child prior to their death should input into that child's CDRM. These will vary depending upon the nature of the child's death. The CDRM Chair will determine whether attendance is required in person, via teleconference, or whether written input alone acceptable	✓	✓	✓	✓	✓	✓	
Attend Child Death Overview Panel meetings – A representative from each agency should attend relevant CDOP meetings. The	✓	✓	✓	✓	✓	✓	✓

representative(s) must have designated responsibility for communicating identified learning and required system improvements to the wider agency within the footprint and reporting back on progress							
Provide information to inform the annual footprint Child Death Review report into the resultant system improvements that have been implemented over the previous year following learning identified at CDOP meetings	✓	✓	✓	✓	✓	✓	✓

Overview of the Child Death Review Process

Child dies

Not all of the activities listed below will take place for each child's death and some of the required activities will vary depending upon the nature of the child's death

Immediate aftermath of a child's death

1. Notify the parents (if unaware of the child's death)
2. Identify the available facts about the circumstances of a child's death
3. Determine whether the death meets the requirements of a Joint Agency Response
4. Determine whether a Medical Certificate of Cause of Death can be issued
5. Determine whether an issue relating to health care or service delivery has occurred or is suspected and therefore whether the death should be referred to the coroner and/or a serious incident investigation
6. Identify how best to support the family determine whether any actions are necessary to ensure the health and safety of others, including family or community members, healthcare patients and staff
7. Submit a Child Death Notification Form (this can be completed through eCDOP)
8. Notify Child Health Information System (CHIS)
9. Notify the General Practitioner
10. Notify any other professionals who may have been involved in the child's care
11. Appoint a Key Worker to the bereaved family

Investigation and information gathering period – not all of the tasks listed below will take place. Those that do, may take place in a different order or concurrently

12. Hold a Joint Agency Response meeting (where applicable). For further details of this process, see Page 20 of Sudden and Unexpected Death in Infancy and Childhood: multiagency guidelines for care and investigation
13. Collate information from all agencies involved in the child's care (Child Death Reporting Form)
14. Hold a hospital post-mortem examination (where applicable)
15. Conduct a coronial investigation (where applicable)
16. Conduct a NHS serious incident investigation (where applicable)

Review into the child's death

17. Hold a local Child Death Review Meeting
18. Hold inquest (where applicable)
19. Collate information including from the Child Death Review Meeting (Child Death Analysis Form)
20. Hold an independent Child Death Overview Panel meeting
21. Collate thematic learning and communicate proposed system improvements to the relevant agencies within the footprint
22. Report annually on the thematic reviews, the learning collated and resultant system improvements embedded

London Child Death Review Partnership Footprints and Leads

STP	New Child Death Review Partnership Leads
North Central	One partnership footprint covering: Barnet, Camden, Enfield, Haringey and Islington. Duduzile Sher Arami, Consultant in Public Health, London Borough of Enfield, dudu.sher-arami@enfield.gov.uk, 0208 379 3135
North East	Two partnership footprints: 1. Barking, Dagenham, Havering & Redbridge - Jacqui Himbury, Nurse Director and Caldicott Guardian, NHS Barking and Dagenham, Havering and Redbridge CCGs, jacqui.himbury@nhs.net, 0203 182 2919 2. City & Hackney, Tower Hamlets, Waltham Forest, & Newham - Chetan Vyas, Director of Quality and Safety, NHS Waltham Forest, Newham and Tower Hamlets CCGs, chetan.vyas1@nhs.net, 020 3688 2325
North West	One partnership footprint with two CDOPs covering: Brent, Ealing, Harrow, Hillingdon, Hounslow, Westminster, Hammersmith & Fulham, and Kensington & Chelsea. Diane Jones, Chief Nurse & Director of Quality, NHS Collaboration NWL CCGs, diane.jones11@nhs.net,
South East	Two partnership footprints: 1. Bromley, Lambeth, Southwark – Jenny Selway, Consultant in Public Health Medicine, London Borough of Bromley jenny.selway@bromley.gov.uk, 020 8313 4769 2. Lewisham, Greenwich, Bexley - Consultant Midwife in Public Health / Public Health Strategist, London Borough of Lewisham, Pauline.Cross@lewisham.gov.uk, 07392 862065
South West	One partnership footprint covering: Croydon, Kingston and Richmond, Merton, Sutton and Wandsworth. Gwen Kennedy, Interim Director of Quality SWL Alliance, gwen.kennedy@swlondon.nhs.uk, 07711 018479

Glossary

Child Death Overview Panel (CDOP)	An independent 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, in order to learn lessons and share any findings for the prevention of future deaths. A CDOP must take place following a CDRM
Child Death Review Meeting (CDRM)	A local multi-agency panel review meeting where all matters relating to an individual child's death are discussed. A CDRM must take place following the death of all children and prior to a CDOP meeting
Child Death Review (CDR) Partner	A partnership of the local authorities and clinical commissioning groups responsible for the child death review process for a specific geographic footprint area
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
eCDOP	The child death review electronic case management system developed by QES Ltd
Joint Agency Response (JAR)	A coordinated multi-agency response triggered by the lead health professional in the immediate aftermath of a child's death that has met certain specific criteria. These criteria are outlined on page 23 of the statutory and operational guidance
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
Lead health professional	The person responsible for the CDR process and chairing the local CDR Meetings within an agency. Where a JAR is triggered, the lead health professional is the person responsible for coordinating the health response to that death. This person may be a doctor or senior nurse, with appropriate training and expertise
Medical Examiner	A medical practitioner whose responsibilities include ensuring: that the cause of death is accurately recorded by the attending practitioner; that timely and appropriate referral to the coroner occurs (where appropriate); and that possible clinical governance concerns are highlighted
National Child Mortality Database (NCMD)	A national programme responsible for the collection and maintenance of a comprehensive database of all child deaths across England, and the publication of thematic learning
QES Ltd	The commercial company that have developed the eCDOP child death review electronic case management system

Notifications for child deaths Across London (as of 01.10.19)

Please note that as the 7 new Child Death Review Partnerships merge over the coming months, they may replace their individual CDOP links with one partnership link.

CDR Footprint	New Child Death Review Partnership Leads	
North Central	Barnet	https://www.ecdop.co.uk/Barnet/Live/Public
	Camden	https://www.ecdop.co.uk/camden/Live/Public
	Enfield	https://www.ecdop.co.uk/enfield/Live/Public
	Haringey	https://www.ecdop.co.uk/haringey/Live/Public
	Islington	https://www.ecdop.co.uk/islington/Live/Public
North East - BHR	Barking and Dagenham	https://www.ecdop.co.uk/barkingdagenham/Live/Public
	Havering	https://www.ecdop.co.uk/havering/Live/Public
	Redbridge	https://www.ecdop.co.uk/redbridge/Live/Public
North East - WELC	City and Hackney	https://www.ecdop.co.uk/cityhackney/Live/Public
	Newham	https://www.ecdop.co.uk/LondonNewham/Live/public/
	Tower Hamlets	https://www.ecdop.co.uk/towerhamlets/Live/Public
	Waltham Forest	https://www.ecdop.co.uk/walthamforest/Live/Public
North West	Brent, Ealing, Harrow, Hillingdon, Hounslow, Westminster, Hammersmith & Fulham, and Kensington & Chelsea	https://www.ecdop.co.uk/NWLondon/Live/Public
South East - BGL	Bexley	https://www.ecdop.co.uk/bexley/Live/Public
	Greenwich	https://www.ecdop.co.uk/greenwich/Live/Public
	Lewisham	https://www.ecdop.co.uk/lewisham/Live/Public
South East - BLS	Bromley	https://www.ecdop.co.uk/bromley/Live/Public
	Southwark and Lambeth	https://www.ecdop.co.uk/southwarklambeth/Live/Public
South West	Croydon	https://www.ecdop.co.uk/croydon/Live/Public
	Kingston and Richmond	https://www.ecdop.co.uk/kingstonrichmond/Live/Public
	Merton	https://www.ecdop.co.uk/merton/Live/Public
	Sutton	https://www.ecdop.co.uk/sutton/Live/Public
	Wandsworth	https://www.ecdop.co.uk/wandsworth/Live/Public