Croydon Child Death Overview Panel

Ninth Annual Report 2016/2017

Anonymised version

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1. INTRODUCTION

1.1. This is the ninth annual report of the Croydon Child Death Overview Panel (CDOP). The report provides a summary of the deaths reviewed by CDOP during 2016/2017.

1.2. Recommendations and learning points from the overview of deaths are provided within this report to which the CSCB (Croydon Safeguarding Children Board) has a responsibility to respond and take action, ensuring they are included in future education and interventions that could help prevent future child deaths, or improve the safety and welfare of children within the borough1.

1.3. Due to the very small numbers of child deaths reviewed, associations and significance cannot be applied to the findings. Details of cases have also been omitted where these would breach confidentiality.

2. EXECUTIVE SUMMARY FOR 2016/17

2.1. The child mortality rate in Croydon is lower than London and England, infant and neonatal mortality rates are higher than London but lower than England.

2.2. 34 deaths of children resident in, or the responsibility of, the London Borough of Croydon were notified to Croydon's Child Death Overview Panel (CDOP) in 2016/17. Nine reviews were completed; all deaths reviewed were done so within a year of the death, 56% within six months. The following information relates to those cases reviewed in 2016/17, regardless of the year of death. Deaths that occurred in 2016/17 but have not yet been reviewed are not reported and will be included in a future report following review.

2.3. Of the cases reviewed in 2016/17, no cases required a post mortem and none of the nine cases were subject to a Serious Case Review.

2.4. No cases reviewed in the period were subject to a current or previous child protection plan, subject to a statutory order, identified as a Child in Need or as a child seeking asylum.

2.5. The most deprived geographical areas in Croydon have the highest number of deaths in children under a year of age.

[1] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

2.6. No deaths were classified as Sudden Unexpected Deaths in Infancy (SUDI).

2.7. Issues and learning points were identified around raising awareness among health professionals around promotion of early booking with maternity services, raising awareness to broaden the understanding of the work of CDOP, very high BMI and Serious Incident processes.

3. BACKGROUND

3.1. Each child death is a sad and serious event but fortunately, it is rare for children to die in this country therefore the number of child deaths in any particular age range within a local area is small in number. This means that generalisations are rarely appropriate and for lessons to be learnt from the deaths reviewed, data needs to be collected and reported on nationally over a number of years. Current data collection methods mean that accurate regional and national data are not readily available.

3.2. Child Death Overview Panels were established in 2008 as a new statutory requirement and updated in 2015. It is the responsibility of the Local Safeguarding Board to ensure that a comprehensive review of every death of a child normally resident in Croydon under the age of 18 years is undertaken to understand better, how and why they die, to detect trends and / or specific areas which would appear worthy of further consideration.

3.3. The CDOP has specific functions laid down by statutory guidance including:

- Reviewing the available information on all deaths of children up to the age of 18 years (excluding stillbirths and terminations of pregnancy carried out within the law) to determine whether the death was preventable
- Meet regularly to review and evaluate the routinely collected data on all child deaths to identify lessons to be learnt or issues of concern relating to the safety and welfare of children in Croydon
- Collecting, collating and reporting on an agreed national data set for each child who has died.
- Make recommendations to the CSCB regarding any deaths where the panel considers there may be grounds for a serious case review
- Monitoring the support services offered to bereaved families
- Identify any trends that can be analysed and deliver interventions in response
- Report any immediate concerns to the CSCB that require a co-ordinated response to ensure the safety and well-being of all children in Croydon

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

3.4. The principles underlying the overview of all child deaths are:

- Every child death is a tragedy;
- Learning lessons;
- Joint agency working;
- Positive action to safeguard and promote the welfare of children.

3.5. See the appendix for organisation of the CDOP and the Terms of Reference.

4. DATA

4.1. Mortality rates

According to the Department of Education[2], the number of deaths of children registered in England has continued to decline, dropping from 3,857 in 2013 to 3,665 in 2016. The majority of these deaths were due to perinatal / neonatal event (32% of deaths in 2016) and chromosomal, genetic and congenital anomalies (26% of deaths in 2016).

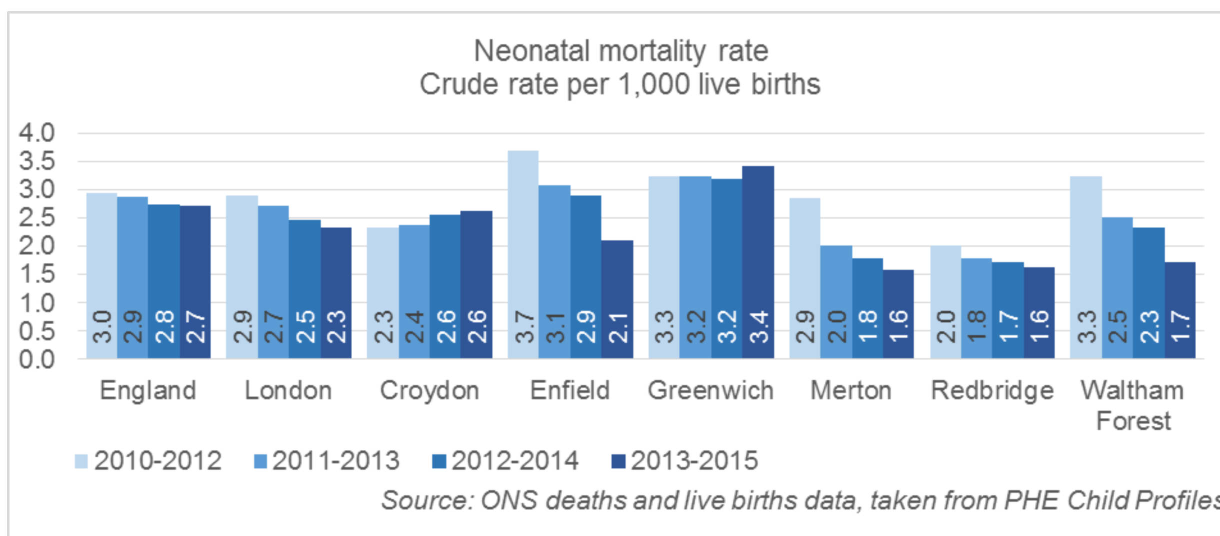
Deaths are often categorised into three groups;

- A ‘neonatal death’ is defined as the death of a child less than 28 days of age; this includes premature births but excludes stillbirths.
- An ‘infant death’ is defined as the death of a child within the first year of their life, but aged 28 days or over at time of death.
- A ‘child death’ is defined as the death of a child aged between 1 and 17.

4.1.1. Neonatal mortality rate

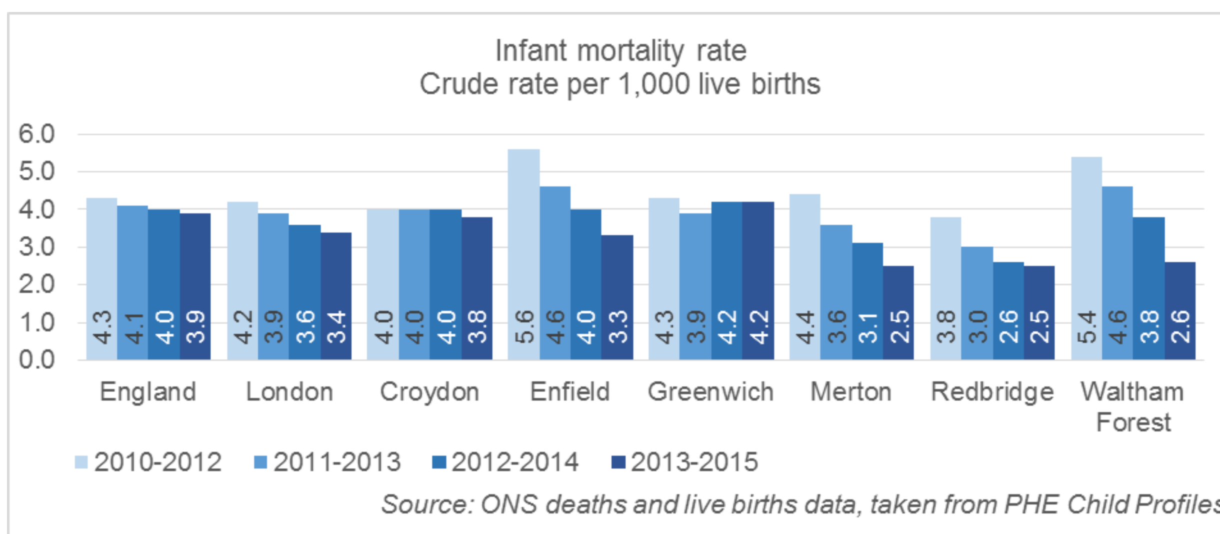
The rate of deaths in the 0-27 days’ old age group in Croydon is slightly increasing, unlike London England where rates are slightly falling. In 2013-15, Croydon had the second highest neonatal mortality rate when compared to its statistical neighbours.

[2] https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2016



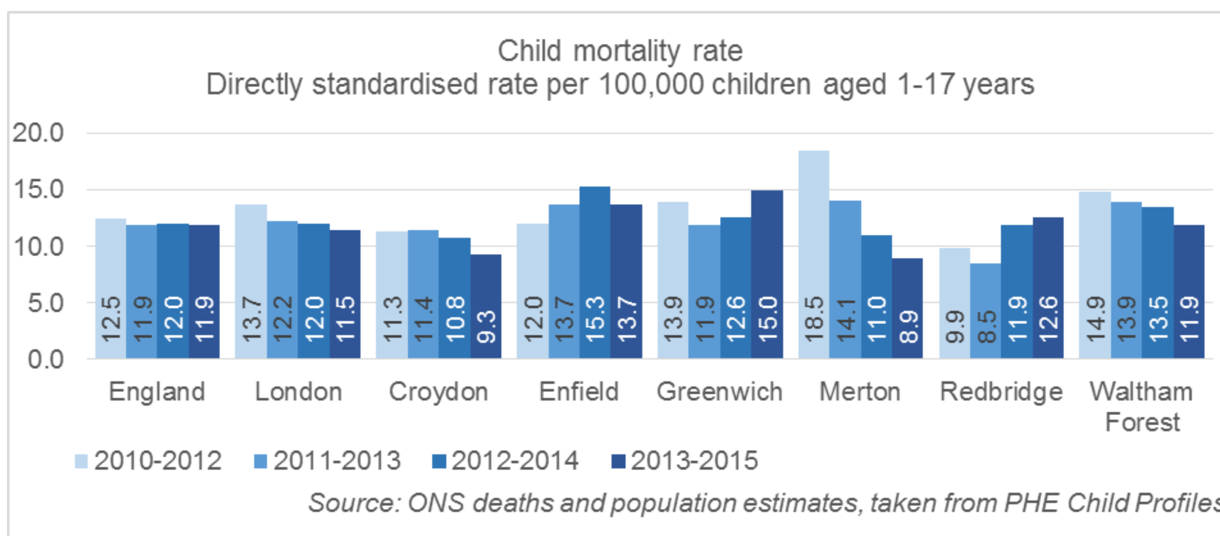
4.1.2. Infant mortality rate

The rate of deaths in the 0-1 year old age group in Croydon is relatively stable, unlike London and statistical neighbours where the rate is falling slightly. In 2013-15, Croydon had the second highest infant mortality rate when compared to its statistical neighbours.



4.1.3. Child mortality rate

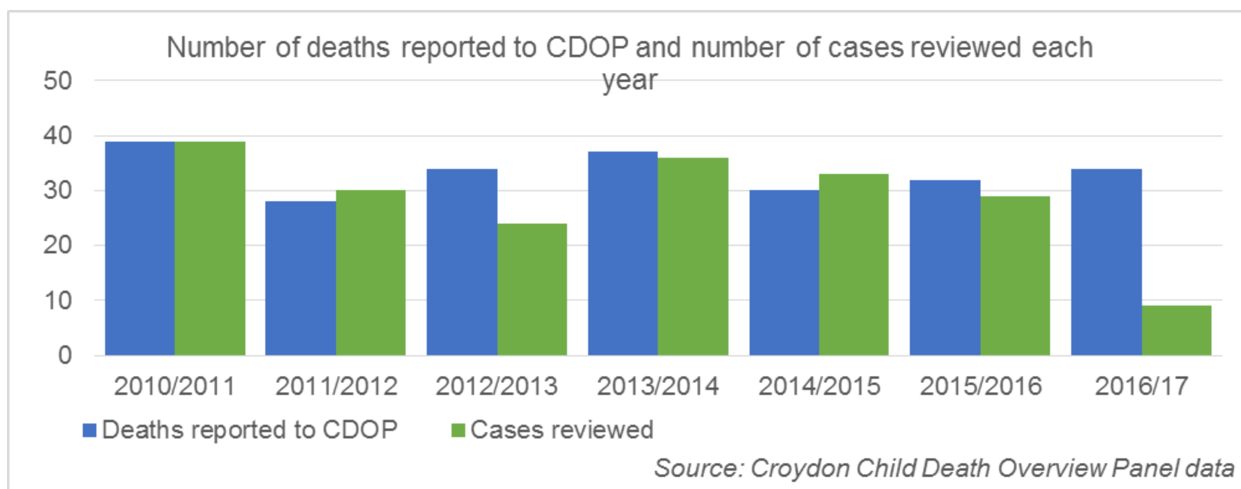
The rate of deaths in the 1-17 year old age group in Croydon is relatively stable, in-line with London and England trends. In 2013-15, Croydon had the second lowest child mortality rate when compared to its statistical neighbours.



4.2. Deaths reviewed in Croydon

4.2.1. <u>Number of child deaths and number of cases reviewed</u>

Between April 2016 and March 2017, 34 deaths of children resident in Croydon were notified to CDOP, of which seven were reviewed in the same year. A further two cases were reviewed which were of children who died in the previous year (2015/16) making a total of nine cases reviewed in the year.



Of the 31 cases awaiting review:

- 4 cases relate to children who died in 2015/16; 27 relate to child deaths in 2016/17
- 6 cases had been initially reviewed in 2016/17; however, coding errors in the data were identified at year-end and these cases will therefore be revisited by CDOP early in 2017/18 before definitive sign-off

- A further 13 deaths occurred less than 6 months from year-end and were awaiting information before they could be reviewed.
- Approximately eight cases were scheduled for review in the first meeting of 2017/18.

4.2.2. Time from death of the child to CDOP review

As part of the CSCB dashboard and in line with Department for Education annual data collection, an indicator of 40% was set for cases to be reviewed by 6 months; this is not seen as a performance indicator as there is often a time lag between a death and the review whilst all relevant information needed for the review is gathered. This time lag may be due to slow returns of Form Bs (data collection forms), the time taken for the post mortem or coroner's autopsy reports to be released, awaiting the findings of criminal proceedings or investigations into Serious Incidents or where the panel requested further information.

In 2016/17, all nine reviews had been conducted within a year of the child's death.

4.2.3. Place of Death

In all of the nine cases reviewed in the year, the child died in hospital.

4.2.4. Rapid Response, Post Mortem and Serious Case Review

Of the nine deaths reviewed in 2016/17, none had a post mortem and no cases were subject to a Serious Case Review.

Of all the 34 child deaths notified in the period 1 April 2016 to 31 March 2017 (including those pending review), 9 were unexpected and rapid response meetings were held as appropriate for these cases, plus for any expected deaths for which a rapid response was deemed necessary.

Rapid response meetings are considered a priority to be convened, where possible, within 5 working days of the child's death. This was not achieved in all cases but all rapid responses had taken place within six working days. Of the 34 deaths that occurred in 2016/17 (including those pending review), 11 were referred to the Coroner, 7 had a post mortem carried out and less than five are subject to an inquest. No cases are subject to a Serious Case Review.

4.3. Deaths reviewed in Croydon: Demographics

Due to small numbers we cannot provide data on the breakdown of reviewed cases by age.

4.3.1. At-risk groups

No cases reviewed in the period were subject to a current or previous child protection plan, subject to a statutory order, identified as a Child in Need or as a child seeking asylum.

4.3.2. Gestation period

Due to small numbers we cannot provide data on this.

4.3.3. Age and gender

Due to small numbers we cannot provide data on this.

4.3.4. Age and ethnicity

Due to small numbers we cannot provide data on this.

4.3.5. Deprivation

There is a strong association between deprivation and poor mortality outcomes: rates are lowest amongst the most disadvantaged families and highest in the most disadvantaged.

The index of multiple deprivation (IMD) is a method of ranking areas according to their level of deprivation by combining different indicators into a single score. It is calculated by combining different scores on a range of indicators relating to income, employment, health, education, housing and access to services. The most deprived fifth (quintile) of the population is described as “quintile 1” and the least deprived quintile is described as “quintile 5”.

In 2016/17, the children under one year of age whose deaths were reviewed were living in the more deprived areas of the borough. This may be linked to the determinants of health associated with deprivation (poorer personal, social, economic and environmental conditions are known to be associated with infant mortality) or it may partly reflect an over representation of children within the most deprived population quintiles. The children who died aged over one year that were reviewed were resident in less deprived areas. There were no deaths in the 20% least deprived areas of the borough.

4.4. Deaths reviewed in Croydon: Causes of death

4.4.1. Expected and Unexpected Deaths

An expected death is one that was anticipated 24 hours before the death; an unexpected death is where the death was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

Due to small numbers we cannot provide data on this.

4.4.2. Sudden Unexpected Deaths in Infancy (SUDI)

The term SUDI is the sudden death of an infant under one year that is unexpected by medical history and remains unexplained after a thorough post mortem examination and a detailed death scene investigation.

There were no cases reviewed where “sudden unexpected death in infancy” was classified.

4.4.3. Categories of death

The panel reviews cases and decides on the category of death that should be classified. There are two categories into which each death is classified:

- Modifiable factors (preventable): The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions could be modified to reduce the risk of future child deaths.
- No modifiable factors (unpreventable): The panel have not identified any potentially modifiable factors in relation to this death.

It is important to recognise that this categorisation is to inform efforts to reduce childhood deaths, it does not in itself carry any implication of blame on any individual party, but simply acknowledges where factors are identified which, had they been different, may have resulted in the death being prevented.

Due to small numbers we cannot provide data on this.

4.4.4. Causes of death

Due to small numbers we cannot provide data on this.

4.4.5. Factors identified and their contribution to vulnerability, ill-health or death

CDOP reviews information on relevant environmental, extrinsic, medical or personal factors that may have been present in the case and makes an assessment as to their contribution to vulnerability, ill-heath or death of the child. In some cases, the children reviewed may have had more than one factor identified.

Due to small numbers we cannot provide data on this.

5. ISSUES AND LEARNING POINTS

5.1 Issues and learning points identified

5.1.1. Following the review of cases, there was discussion about the need to raise awareness among health professionals around promotion of early booking.

5.1.2. Poor quality of information from particular sources or around elements of the child and their family made reviews more difficult in some cases. Awareness raising work is ongoing with partners to broaden understanding of the work of CDOP and to improve the quality and consistency of Form B submissions.

5.1.3. Obesity (very high BMI) has been flagged as a potential concern and will be monitored by CDOP. In addition, this will be raised across the London CDOP network to identify whether this is also been seen elsewhere.

5.1.4. Serious Incidents requiring investigation are defined as "*An event in health care where the potential for learning is so great or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.*"[3] The Serious Incident process and having the process properly managed is of ongoing importance.

5.2 Good practice

5.2.1. The CDOP members have agreed that good practice should be acknowledged at each review and summarised in the annual report to ensure positive sharing and learning within Croydon's agencies.

5.2.2. In 2016/17 the CDOP acknowledged:

- A number of excellent reports submitted by professionals that provided a particularly rich picture of the child and family's circumstances.
- Good multi-agency arrangements to support children's health needs were identified as beneficial.

5.3 CDOP network England and London

5.3.1. Croydon CDOP has participated in pan-London workshops co-ordinated by the Healthy London Partnership CDOP programme to share information and good practice and maximise opportunities to identify issues, trends and learning, in an effort to reduce the risk of future child deaths.

[3] NHS England (2015) *Serious Incident Framework* [Available at: https://improvement.nhs.uk/uploads/documents/serious-incidnt-framwrk.pdf]

5.4 Challenges during 2016/2017

5.4.1. The Chair of CDOP stood down at the end of 2016 prior to leaving post; a new interim Chair was appointed from January 2017. A handover period assisted in smoothing this change.

5.4.2. The Single Point of Contact (SPOC) for Child Deaths left post at the end of year and a new SPOC was appointed to take on the role from April 2017. A period of handover and mentoring for the new post-holder assisted in minimising the challenges associated with this staff change.

5.4.3. 2016/17 has highlighted business continuity risks linked to the availability of key members of the Child Death Overview Panel and contingency arrangements if they are unable to attend and the meeting is not quorate. This resulted in a meeting needing to be stood down at the end of 2016/17 and cases postponed to early 2017/18. Options to address this business continuity risk are being considered.

5.5 Actions completed for 2016/2017

5.5.1. Work has been undertaken to improve the quality of information returned by agencies (e.g. Form B's) for consideration at CDOP, to improve learning, including implementation of a revised Form B for maternity services.

5.5.2. Multiagency training was developed around the role of CDOP. A presentation pack has been developed, initially aimed at schools. Presentations have been given to the Education sub-group on 22.02.17, the Schools Designated Safeguarding Leads forum on 03.03.17, and Early Years Safeguarding Forum on 06.03.17. Approximately 140 delegates have been informed so far.

5.5.3. Issues identified nationally were included in local work for child safety week in June 2016, including information for parents and practitioners around baby slings and blind cord safety. There is now a permanent link on the website http://croydonlcsb.org.uk/children-and-young-people/keeping-yourself-safe/. During child safety week, the CSCB, in conjunction with Trading Standards, handed out packs containing token items with CSCB logo and website information, plus literature about child and home safety and blind cord safety cleats, plug socket covers, advice on nappy sack storage and carbon monoxide detectors. In total 600 packs were handed out either at this event or at subsequent events in the Whitgift Centre in Croydon town centre. A further promotion took place at the Croydon Safety Roadshow in September 2016.

5.5.4. The CDOP Single Point of Contact met with the manager of South London Coroners' office to improve links and develop information sharing between Coroner's office and CDOP. The Coroner now receives information relating to the Rapid Response. The CSCB Independent Chairperson and CDOP Chairperson

also met with the Senior Coroner to further develop relationships and to ensure that any Regulation 28 “Prevent Future Deaths” reports are received and recommendations actioned appropriately to reduce the risk of child deaths.

5.5.5. The CDOP Chairperson was a member of the Healthy London Partnership (HLP) CDOP Steering Group and CDOP members have attended HLP and NHS England workshops to learn about regional trends, learning, best practice and likely future changes in CDOP arrangements.

5.5.6. A review was undertaken of the local CDOP processes, including an assessment of adherence to Pan-London Child Protection guidelines, Working Together 2015 and Croydon CDOP’s own Terms of Reference. The report summarising the review’s findings was published at the end of March 2017.

5.5.7. Croydon CDOP has been involved in a whole-systems approach by partners across Croydon, led by the CSCB Health sub-group, to reduce the number of Sudden Infant Deaths in Croydon, including:

- Pre-birth Sudden Infant Death Syndrome (SIDS) risks and preventative measures are discussed in the antenatal parent education sessions led by midwives.
- Post birth SIDS risks and preventative measures are again discussed on discharge from acute and community midwifery staff.
- Ensuring monthly liaison meetings were in place between the Croydon Health Services (CHS) health visiting service and the midwifery teams for the purpose of discussing vulnerable women that could be targeted for additional services and support.
- The new birth visit packs used by Health Visitors include paper copies of SIDS guidance that reinforces the discussion about SIDS.
- Work is ongoing to ensure that women identified as having risk factors antenatally are provided with an enhanced service through Best Start. Future plans are intended to involve the development of targeted messages through Early Help (Children’s Centres etc) and GP Practices.

5.5.8. The CDOP Annual Report has been completed and statutory child death data returns for Department of Education have been submitted

5.5.9. A comparative piece of work looking at the proportion of cases identified as having modifiable factors has been completed.

5.5.10. A review was performed of all child deaths since 01/01/2016 to look for any suspicious patterns or clustering in cases of child mortality. This found no obvious clustering or increase in deaths beyond that expected through natural variation but identified the importance of reiterating the link between smoking and causes of death such as SUDI to frontline healthcare staff.

5.6 Action plan for 2017/8

Action

Identify emerging issues from 2016/17 annual report
Explore possibilities for family involvement in the CDOP process
Explore links around the risk of asthma deaths, air quality and local paediatric asthma services (as a result of national learning)
Continue work around awareness raising of CDOP and improving the quality of Form B submissions and extend this to other stakeholders, including GPs and social care
Review CDOP membership, roles and responsibilities, for example, the feasibility of themed meetings for which additional specialists may be invited
Continue to develop links with the Coroner and Registry Office
Consider the recommendations of the review of CDOP processes and identify which to prioritise and implement, in the context of wider changes to child death review work expected in the near future
Continue to engage with Healthy London Partnership and NHS England child death review development work, to ensure that Croydon CDOP can inform and is prepared for upcoming changes
Continue to work with CDOPs across London and nationally to understand trends and share learning
Continue to support the work of the CSCB Health sub-group around Sudden Unexpected Death in Infancy (SUDI) to ensure the developments from 2016/17 continue to be implemented and that Best Start maximises the opportunities to improve early identification of and action to reduce SUDI risks.
Carry forward an action from 2016/17 to ensure that historical NHS data is uploaded from its current CD storage onto the main Croydon SharePoint site.
Continue to achieve targets for cases to CDOP and RR meetings
Complete statutory child death data returns for Department of Education
Continue to work with CSCB Learning and Development to include learning points identified at CDOP within the training programme
Improve contingency arrangements to cover for key CDOP members in event of their unavailability, to reduce business continuity risks.
Review CDOP Terms of Reference to reflect any changes resulting from the above actions.
Improve arrangements for collation and quality assurance of data on the database.

APPENDIX: CDOP Organisation and Terms of Reference

The Process

The death of each child is notified to the Child Death Review Co-ordinator (CDRC) who is also the SPOC (Single Point of Contact) by telephone or email; this is followed with "Form A" giving initial details about the death.

All unexpected child deaths are subject to the rapid response process; when a meeting is required as part of the process it is chaired by the Designated Doctor for Child Death Reviews or the Head of Safeguarding/Designated Nurse. All professionals/agencies involved with the child that died are invited to attend. The information from the meeting is shared with CDOP.

For all children who die, whether expectedly or unexpectedly, an information gathering process is initiated. The completion of "Form B" (data collection form) is requested from all agencies and services involved in the death to provide as full a picture as possible of the circumstances directly and indirectly leading to the death.

Using information from a number of existing forms and sources e.g. neonatal unit summary/ discharge summary, hospital death summary, police forms, post mortems and rapid response meeting minutes has helped to improve the available information. However, it is still a challenge in obtaining completed Form Bs from some agencies and the quality and detail of some remain poor.

CDOP meetings are provisionally scheduled monthly and go ahead when the information gathered for cases is felt to be as complete as possible, allowing the review of a child death to go ahead. Where insufficient cases are ready for review, meetings are stood down and case discussion are postponed to the following month.

Each case is discussed and recorded using "Form C" (Analysis Proforma) based on information provided in the Form B and other supporting documentation. The data are entered on a child deaths database to support analysis of the data, points of interest for the CSCB and to inform this report.

Any identified learning and recommendations from the case reviews are communicated to the agencies involved, setting out the concerns and requesting feedback from the agency to confirm what actions have been/are being taken to address the concerns.

Rapid Response

The arrangements for a rapid response to the unexpected death of a child are well established in Croydon, as described above and is monitored by the CDOP. Where an

unexpected death is not believed to warrant a rapid response meeting, the rationale for this decision is logged and signed off by the Designated Doctor for Child Deaths.

Rapid response meetings are considered a priority to be convened, where possible, within 5 working days of the child's death. A log of the rapid responses is maintained and information is shared with the CDOP.

Panel Meetings

During 2016/2017, CDOP met five times to review information about child deaths.

The CDOP has a fixed core membership of experts drawn from the key organisations represented on the Croydon Safeguarding Children Board. Other members are co-opted to contribute to the discussion of certain types of death when they occur.

Table 1: Panel member attendance at CDOP meetings 2016/2017

Child Death Overview Panel Attendance					
	2016				2017
	20th June	15th August	12th September	12th December	9th January
Chair					
Public Health Principal	✓	✓	✓	✓	N/A
Director of Public Health	N/A	N/A	N/A	N/A	✓
Regular panel members					
Designated Doctor for CP & Child Death review process	✓	✓	✓	✓	✓
Designated Nurse for Child Protection (CCG)	✓	✓	✓	✓	✓
Named Midwife for Safeguarding (represented by Named Nurse)	×	×	×	×	×
Named Nurse for Children's Safeguarding	✓	✓	✓	✓	✓
CSCB Child Death Review Co-ordinator	✓	✓	✓	✓	✓
QA Manager (LADO) (Deputy Chair)	✓	×	✓	×	✓
CSCB Manager	×	✓	✓	×	✓
Police Child Abuse Investigation Team	×	×	×	✓	✓
CSCB Administrator	✓	✓	×	×	×
Guests/observers					
Director of Public Health		✓			N/A
Public Health Registrar		✓	✓		
Independent Chair, CSCB			✓		

Public Health Principal				✓	✓ (x2)
QA & CSCB business support team leader				✓	✓

✓ - attended meeting
× - apologies received

Administration

The administration of the CDOP process is amalgamated with the Rapid Response Meetings and is hosted within Croydon Council and funded by CSCB through contributions of partner organisations.

Representation

To ensure local, pan London and national co-ordination of, and input into, the CDOP processes, the CDOP Chair provides Croydon representation through local membership on the CSCB, the CSCB Executive Group and Health sub-group and attendance at the London CDOP Chairs' meetings.

CDOP Terms of Reference

The Child Death Overview Panel is a sub-group of the Croydon Safeguarding Children Board (CSCB) and oversees the Rapid Response Meeting. This document should be read in conjunction with "Working together to Safeguard Children" Chapter 5 (2015) HM Government.

Purpose

Through a comprehensive and multidisciplinary review of child deaths, the Croydon Child Death Overview Panel (CDOP) aims to better understand how and why children in Croydon die, providing relevant knowledge and skills to interpret the information gained and use our findings to take action to prevent other deaths and improve the health and safety of our children.

Responsibilities of CDOP

- Review all child deaths up to the age of 18, excluding babies who are stillborn and planned terminations of pregnancy carried out within the law.
- Collect, collate and review information on each death to identify:
- the need for a further review
- any matters of concern affecting the safety and welfare of children in Croydon

- wider public health or safety concerns arising from a particular death or from a pattern of deaths in Croydon
- Ensure the accurate identification of and uniform, consistent reporting of the cause and manner of every child death.
- Determine if the death was deemed preventable, where modifiable factors may have contributed to the death and decide whether any actions could be taken to prevent future deaths.
- Make recommendations to CSCB and other relevant bodies promptly so that action can be taken to prevent future such deaths.
- Identify significant risk factors and trends in individual child deaths and report these to CSCB.
- Refer to CSCB Chair any deaths where, from the available information, the panel considers there may be grounds to undertake further enquiries, investigations or a Serious Case Review.
- Identify lessons to be learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children.
- Evaluate specific cases in depth where necessary, to learn lessons or identify issues of concern.
- Identify significant risk factors and trends in individual child deaths and in overall patterns of deaths in Croydon, including relevant environmental, social, health and cultural aspects and any systemic or structural factors affecting children's well-being to ensure a thorough consideration of how such deaths might be prevented in the future.
- Identify public health issues and consider, with the Director of Public Health and other provider services how best to address these and their implications for both provision of services and training.
- Identify and advocate for needed changes in legislation, policy and practices to promote child health and safety and to prevent child deaths.
- Increase public awareness and advocacy for the issues which affect the health and safety of children.
- Where concerns of a criminal or child protection nature are identified, confirm that the police and coroner are aware and inform them of any specific new information that may influence their inquiries and inform the Chair of the CSCB.
- Improve agency responses to child deaths through monitoring the appropriateness of the response of professionals to each unexpected death of a child, reviewing the reports produced by the rapid response team and providing the professionals concerned with feedback on their work.
- Advise CSCB on the resources and training required locally to ensure an effective inter-agency response to child deaths.
- Co-operate with any London-regional and national initiatives.
- Collect a minimum dataset as required by the Department for Education and submit this annually for national data collection.

- Prepare an annual report for the Croydon Safeguarding Children Board who is responsible for disseminating the lessons to be learnt to all relevant organisations, and ensure that relevant findings inform the Children and Young People's Plan. They will also action any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children
- Develop and implement a work plan approved by Croydon Safeguarding Children Board.

Membership

Core attendees:

- Designated Doctor for Child Protection & Child Death Reviews
- Head of Safeguarding, Designated Nurse Children (Croydon Clinical Commissioning Group)
- Named Nurse Safeguarding and Child Protection (Croydon Health Services)
- Croydon Single Point Of Contact (SPOC) & Child Death Review Coordinator
- Public Health Principal (Chair)
- Police
- Social Care Quality Assurance Manager

Other members may be co-opted to contribute to the discussion of certain types of death when they occur.

Members may nominate a deputy to attend on their behalf, but must ensure that their deputy is fully briefed on their responsibilities.

Confidentiality

- Information circulated and discussed at the meeting will be anonymised prior to the meeting and where possible all Form B information be amalgamated onto one form.
- Any reports, minutes and recommendations arising from the CDOP will be fully anonymised and steps taken to ensure that no personal information can be identified.
- Any information that is being shared in the public interest for the purposes set out in Working together to Safeguard Children (2015) is bound by legislation on data protection.
- CDOP members will be required to sign a confidentiality agreement before participating in the CDOP and at the start of each meeting.
- Any ad-hoc or co-opted members and observers will also be required to sign an attendance sheet, confirming that they have understood and signed the confidentiality agreement.

Accountability

The CDOP is accountable to the chair of Croydon Safeguarding Children Board.

Frequency of Meetings

- CDOP is scheduled monthly but subject to cancellation if business determines this appropriate.
- There must be a minimum of 2 agencies in attendance in addition to the Designated Doctor for Child Protection & Child Death Review

Relevant papers

- Croydon Multi-agency Child Death Notification Protocol
- Form A - Initial Notification of the death of a child
- Form B – Agency Report Form
- Form C – Analysis Proforma
- CDOP Confidentiality Statement

Rapid Response Meetings Terms of Reference

(To be read in conjunction with Chapter 5 'Working Together to Safeguard Children' March 2015 HM Government)

The Rapid Response (RR) process applies when a child dies unexpectedly (birth up to 18th birthday), excluding babies who are still born or whether there is lack of clarity about whether the death of a child is unexpected.

An unexpected death is defined as the death of a child not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death.

Deciding on whether the death is unexpected and whether to implement the RR process is the responsibility of the designated paediatrician responsible for unexpected deaths in childhood.

Purpose

The purpose of the RR meeting, which is an element of the RR process, is to have a multi-agency case discussion to share information about the cause of death or factors that may have contributed to the death and to plan future care of the family.

This meeting ensures that the appropriate agencies are engaged and work together to:

- Respond quickly to the unexpected death of a child in accordance with locally agreed procedures
- Ensure support for the bereaved families, as the death of a child will always be a traumatic loss, more so if the death is unexpected.
- Ensure all relevant agencies are involved in the process and are aware of their roles and responsibilities
- Identify any safeguarding concerns around other children in the household or affected by the death
- Make immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the coroner as required
- Enquire and constructively challenge how each organisation discharged their responsibilities to an individual child's death, and whether there are any lessons to be learnt
- Collate information in the standard format
- Cooperate appropriately post death, maintaining contact at regular intervals with family members and other professionals who have on-going responsibilities to the family, to ensure that they are appropriately informed (unless such sharing of information would place other children at risk of harm or jeopardise police investigations)
- Consider media issues and the need to alert and liaise with the appropriate agencies
- Consider bereavement support for any other children, family members or members of staff

Attendance at Rapid Response Meeting

Core attendees:

- Designated Doctor for Child Protection & Child Death Reviews
- Head of Safeguarding, Designated Nurse Children (Croydon Clinical Commissioning Group)
- Named Nurse Safeguarding and Child Protection (Croydon Health Services)
- Croydon Single Point Of Contact (SPOC) & Child Death Review Coordinator
- Paediatrician
- Social Care Operational Manager

Representation from other lead agencies or services that may be in attendance:

- Hospitals where the child has died out of area
- Children's Hospital at Home (CHAH)

- London Ambulance Service (LAS)
- Police
- GP
- Child & Adolescence Mental Health Services (CAMHS)
- Education
- Representation from the Health Visiting Team
- Croydon University Hospital (CUH) Paediatric Staff-A&E Matron & Clinical Nurse Manager
- Helicopter Emergency Medical Service (HEMS)
- Midwifery
- Speech & Language Therapy (SALT)
- Physiotherapy
- Family support services
- Hospice
- School Nurses
- Deputy Designated Nurse, Commissioning on behalf of Independent Contractor Services
- Any other relevant agency/service

The meeting will be chaired by either the Designated Doctor for Child Protection & Child Death Reviews or the Head of Safeguarding, Designated Nurse Children (Croydon Clinical Commissioning Group).

Confidentiality

- All attendees will be required to sign a confidentiality agreement / attendance sheet before participating in the meeting to confirm that they have understood the requirements of confidentiality.
- Any confidential information will be transferred securely.

Accountability

The RR will report to the local Child Death Overview Panel who are accountable to the Croydon Safeguarding Children Board.

Frequency of meetings

RR meetings will be considered as a priority and be convened within 5 working days where possible, of the child’s death.

Follow-up of actions

- Actions agreed and logged at the RR meeting will be followed up by the Croydon SPOC & Child Death Review Coordinator.
- Any identifiable information will be anonymised prior to review by the local Child Death Overview Panel.
- Minutes will be distributed to all attendees and core members (regardless of their attendance).

The Terms of Reference will be reviewed annually.

Relevant papers

- Croydon Multi-agency Child Death Notification Protocol
- Croydon Rapid Response Flow Chart
- Form A - Initial Notification of the death of a child
- Child Death RR meeting Confidentiality Statement
- Child Death RR Meeting Agenda