Croydon Child Death Overview Panel

Tenth Annual Report 2017/2018

Anonymised version

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1. INTRODUCTION

1.1. This is the tenth annual report of the Croydon Child Death Overview Panel (CDOP). The report provides a summary of the deaths reviewed by CDOP during 2017/2018.

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 borough[1].

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 2017/18

2.1. The child mortality rate in Croydon is lower than London and England. The neonatal mortality rate is equal to the London rate but lower than the England rate while the infant mortality rate remains higher than the London rate and lower than England.

2.2. 30 deaths of children resident in, or the responsibility of, the London Borough of Croydon were notified to Croydon's Child Death Overview Panel (CDOP) between April 2017 and March 2018. Less than five of these deaths were of babies born below 24 weeks gestation and will therefore not be reviewed by CDOP as per the panel's terms of reference.

2.3. 33 reviews were completed; six of these were cases that were re-reviewed in 2017 due to data quality issues in the initial review. Of the remaining 27 cases reviewed in 2017/18, none were reviewed within six months of the child's death. 65% of reviews (17 deaths) were conducted within a year of the child's death. The following information in this report relates to cases reviewed in 2017/18, regardless of the year of death. Deaths that occurred in 2017/18 but have not yet been reviewed are not reported and will be included in a future report following review.

2.4. Of the cases reviewed in 2017/18, eight cases required a post mortem and none were subject to a Serious Case Review.

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

2.5. Rapid Response meetings were convened for eight deaths of children notified during April 2017 – March 2018.

2.6. Nine of the cases reviewed in 2017/2018 regardless of the year of death had a Rapid Response meeting.

2.7. Less than five reviewed in the period were subject to a current or previous child protection plan, less than five cases were subject to a previous statutory order and less than five cases were previously identified as a Child in Need.

2.8. More than a third of the children living in Croydon whose deaths were reviewed in 2017/18 were living in the most deprived areas of the borough.

2.9. Less than five deaths were classified as a Sudden Unexpected Death in Infancy (SUDI).

2.10. Issues and learning points were identified around raising awareness to broaden the understanding of the work of CDOP, messages around car safety, risks of co-sleeping and strangulation by blind cords and improved access to specialist bereavement services.

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. New statutory guidance was issued for consultation in 2017/2018 and this was reviewed by the Croydon panel. This report is based on the existing guidance which includes:

- 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
- Meeting 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
- Making 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
- Identifying any trends that can be analysed and deliver interventions in response
- Reporting 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 to mitigate these factors

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 3,575 in 2017. The majority of these deaths were due to perinatal / neonatal event (34% of deaths reviewed in 2017) and chromosomal, genetic and congenital anomalies (25% of deaths reviewed in 2017).

Deaths are often categorised into three groups;

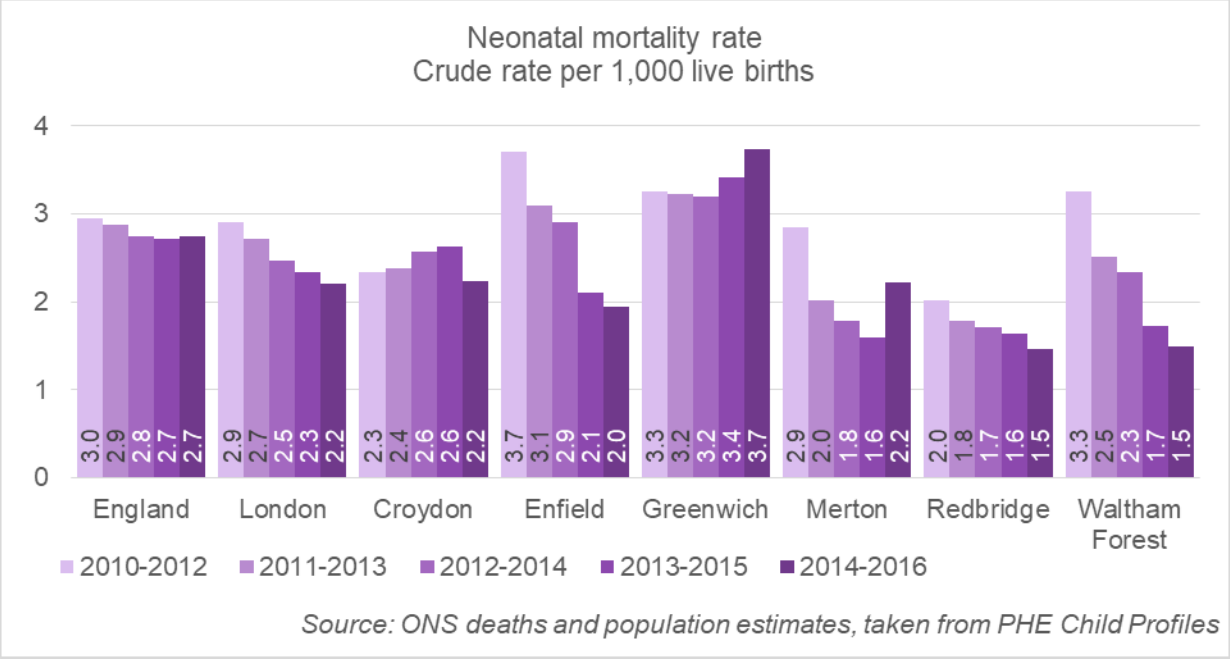
[2] https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2017

- 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 fell in the most recent year, reversing the slightly increasing trend of the previous 4 years. In 2014-16, Croydon had the second highest neonatal mortality rate (equal to the London rate but lower than the England rate) when compared to its statistical neighbours.[3]

Figure 1. Neonatal Mortality Rate

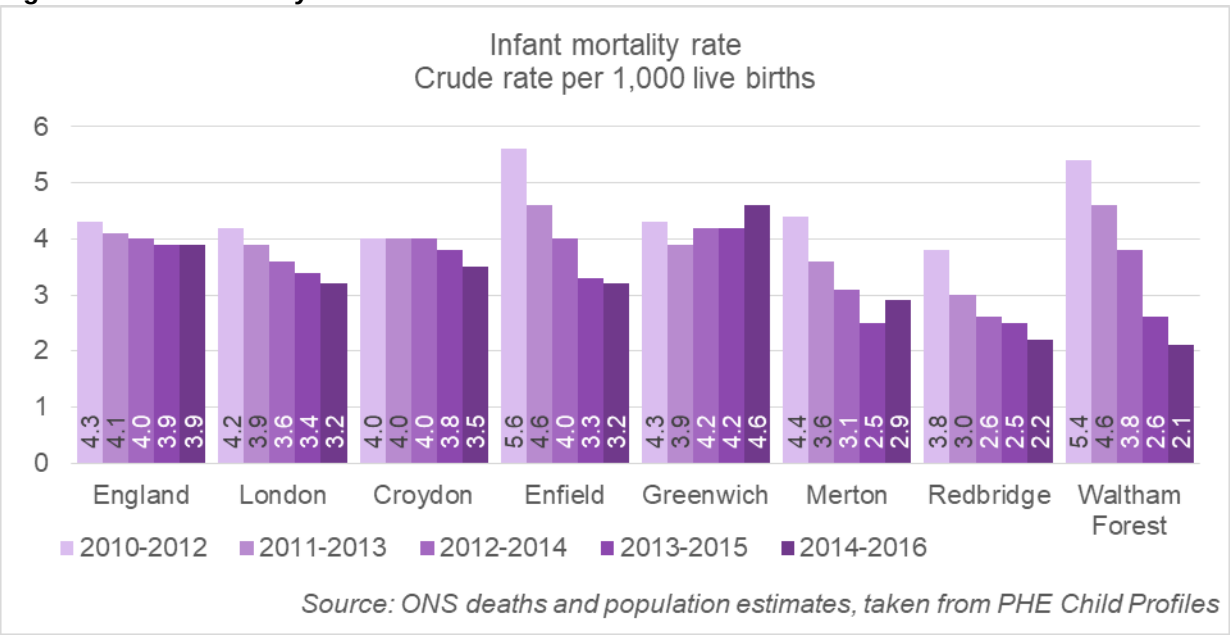


4.1.2. Infant mortality rate

The rate of deaths in the 0-1 year old age group in Croydon fell from 3.8 per 1000 live births in 2013-2015 to 3.5 per 1000 live births in 2014-2016. Despite the fall in 2014-16, this rate remains higher than the London rate and the rates of 4 out of 5 statistical neighbours.

[3] https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-overview

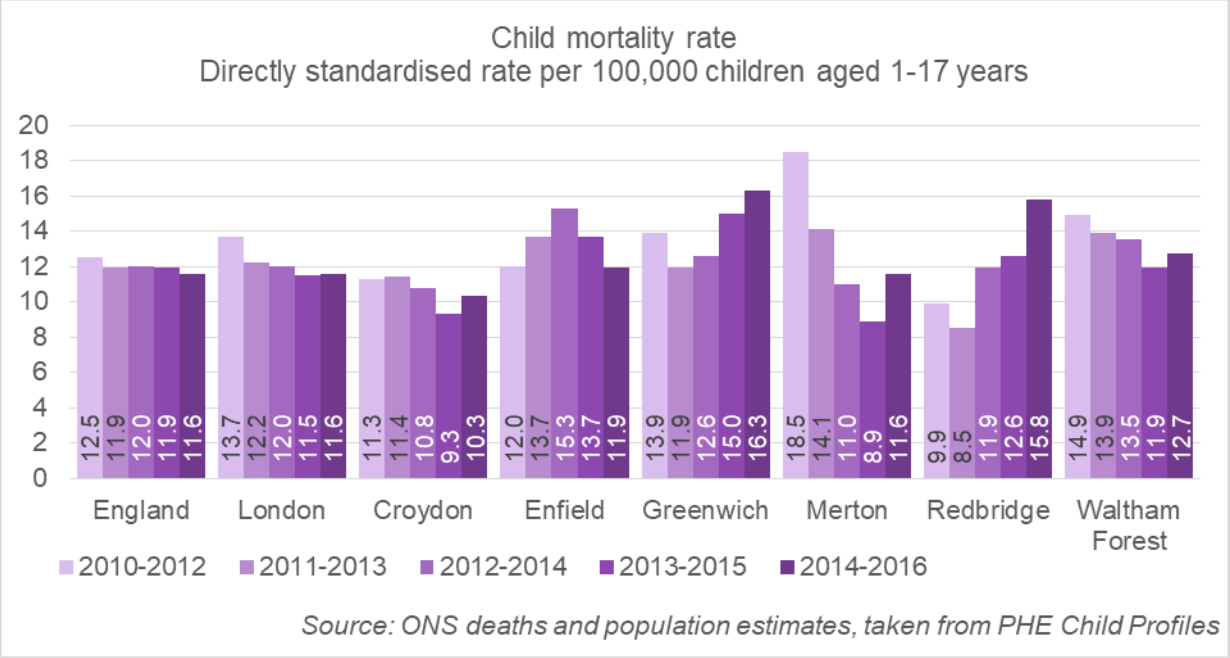
Figure 2. Infant Mortality Rate



4.1.3. Child mortality rate

In 2014-16, Croydon had the lowest child (1-17 age groups) mortality rate when compared to its statistical neighbours, London and England. The rate did increase slightly from 2013-2015 but is still lower than 2010 to 2014.

Figure 3. Child Mortality Rate



4.2. Deaths reviewed in Croydon

4.2.1. Number of child deaths and number of cases reviewed

Between April 2017 and March 2018, the CDOP was notified of 30 deaths to children resident in Croydon. Less than five of these deaths were of babies born below 24 weeks gestation and will therefore not be reviewed by CDOP as per the panel's terms of reference.

A total of 33 cases were reviewed in 2017/2018. The majority of cases were of children who died in previous years. Six cases were initially reviewed in 2016/17 however, coding errors in the data were identified and they were therefore revisited by CDOP early in 2017/18 for definitive sign-off. These cases are now included in the 2017/2018 numbers.

22 cases were awaiting review in March 2018. Seven are scheduled for review in April 2018 with the remaining cases awaiting further information / detailed results before they can be reviewed.

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 a performance indicator as there is often a necessary time gap between a death and the review whilst all required information needed for the review is gathered.

There are a number of factors which can contribute to this time gap:

- 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

The six cases that were re-reviewed in 2017 for data quality purposes have been excluded from this section. Of the remaining 27 cases reviewed in Croydon during 2017/18, none were reviewed within six months of the child's death. 65% of reviews were conducted within a year of the child's death.

4.2.3. Place of Death

The majority of deaths reviewed in 2017/2018 occurred in hospital.

4.2.4. Rapid Response, Post Mortem and Serious Case Review

Of the 33 deaths reviewed in 2017/18:

- Nine cases required a rapid response meeting

- Rapid response meetings are considered a priority to be convened, where possible, within 5 working days of the child's death. The majority of cases achieved this timescale and all rapid responses took place within six working days.
- 11 cases were referred to a coroner and eight cases had a post-mortem
- None were subject to a Serious Case Review

Of the 30 deaths reported in 2017/18:

- Less than five of these deaths were of babies born below 24 weeks gestation and were therefore not deemed appropriate for review by the CDOP as per the panel's terms of reference
- Eight cases required a rapid response, all of which were convened within 5 working days of the child's death
- Ten cases had a post-mortem
- None were subject to a Serious Case Review

4.3. Deaths reviewed in Croydon: Demographics

In 2017/18, 70% of all deaths reviewed were within the first year of life.

4.3.1. At-risk groups

Less than five deaths reviewed in the period had a previous or current statutory order identified and less than five deaths were identified as a previous Child in Need (though not at the time of death).

Less than five cases were previously subject to a Child Protection Plan (though not at the time of death). No cases were identified as a child seeking asylum.

4.3.2. Gestation period

Where known, the majority of the children who died as infants or neonates were born prematurely (less than 37 completed weeks of gestation).

4.3.3. Age and gender

65% of all deaths reviewed were male and two thirds of deaths occurred before the child reached their first birthday.

4.3.4. Ethnicity

78.8% of all child deaths reviewed were of children with a non-white British ethnicity. This is slightly higher than the GLA ethnic group population projections for 2016 that estimated that 71.3% of Croydon's population aged 0-17 years in 2017 did not have a white British ethnicity.

4.3.5. Deprivation

There is a strong association between deprivation and poor mortality outcomes: rates are lowest amongst the most advantaged 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 2017/18, more than a third of the children whose deaths were reviewed were living in the most 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 the higher numbers of children living in the most deprived population quintile areas of Croydon.

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.

A third of the child deaths reviewed in this period were defined as unexpected deaths.

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 less than five 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 the case should be classified under. There are two categories under 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.

Of the deaths reviewed, 18% of cases were identified as having modifiable factors. Due to confidentiality, further details cannot be made available in this report.

4.4.4. Causes of death

When looking at the known causes of death for all cases reviewed, the highest proportion of deaths were from perinatal/neonatal events (39%). These accounted for more than a half of the deaths in those aged under a year (57%). Due to confidentiality, further details cannot be made available in this report.

4.4.5. Factors contributing to vulnerability, ill-health or death

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

Of the 33 cases reviewed, the most common factor identified that may have contributed to vulnerability, ill-health or death of the child, or provided a full and sufficient explanation for the death, was acute sudden onset illness. Due to confidentiality, further details cannot be made available in this report.

5. ISSUES AND LEARNING POINTS

5.1 Issues and learning points identified

5.1.1. Following the review of cases, issues which were followed up during 2017/2018 included:

- Safeguarding information/training for bus drivers
- Bereavement and counselling services available to school nursing teams
- Audits of laryngoscope sizes
- Timing of Form B completion
- Evidence review of smoking and SUDI
- Messages around car safety
- Messages around risks of co-sleeping
- Messages around the risks of strangulation by blind cords
- Access to specialist bereavement services

5.1.2. The presentation of very young neonatal deaths to panel has highlighted the need to be clear about what cases should be coming to CDOP for review.

5.1.3. Awareness raising work with partners to broaden understanding of the work of CDOP and to improve the timeliness of Form B submissions is ongoing.

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 2017/18 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 London and England

5.3.1 Croydon CDOP has participated in the consultation of the proposed new national Child Death Review guidance and new CDOP arrangements for London. Croydon CDOP supports the principle that greater learning could be gained from CDOP cases if CDOPs worked across a wider South West London area e.g. two

Boroughs. The ability to identify trends is currently limited by the small number of cases in each area.

5.3.2 Croydon CDOP has also expressed an interest in working across London on the implementation of eCDOP which would enhance the current local improvements made to the systems for the tracking and recording of data.

5.3.3 Members of the CDOP panel have attended workshops co-ordinated by the Healthy London Partnership CDOP programme e.g. 'Tackling Asthma Deaths' and 'Bereavement Support in the London CDOP System' 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.

5.4 Challenges during 2017/2018

5.4.1 The Single Point of Contact (SPOC) for Child Deaths left the post in September 2017, having started the role in April 2017. Two new SPOCs in a period of 6 months highlighted the need to update the standard operating procedures for the role. The SPOC has been working to address this.

5.4.2 The CDOP panel took some time in 2017/2018 to review the Terms of Reference for the group. These were informed by an internal review of arrangements which was presented to the panel in August 2017. New terms of reference were agreed but it is recognised that these will need to be reviewed in light of the proposals for new CDOP arrangements across a number of SW London areas.

5.5 Actions completed during 2017/2018

5.5.1 *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.*

- The presentations were successful and both services have a better understanding of where to receive support and advice around the CDOP process.

5.5.2 *Review CDOP membership, roles and responsibilities, for example, the feasibility of themed meetings for which additional specialists may be invited.*

- The CDOP Terms of Reference were reviewed between August and October 2017. The roles and responsibilities of CDOP members were clarified during the review. This included discussions about deputising arrangements to allow meetings to happen in the absence of the Chair for example.

5.5.3 *Continue to develop links with the Coroner and Registry Office.*

- Good links have been created with both the Coroner and Registry Office.

5.5.4 *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.*

- Members of the panel attended information and consultation events and responded to the consultation.

5.5.5 *Continue to achieve targets for cases to CDOP and RR meetings.*

- The targets for RR meetings were met. As was identified in the data section of this report, a low percentage of cases were reviewed within 6 months. Slow return of Form Bs was been a contributory factor. It is recommended that addressing speedier return of Form Bs is a priority for 2018/2019.

5.5.6 *Improve arrangements for collation and quality assurance of data on the database.*

- A new database has been set up and this is supporting the quality assurance process.

5.6 Action plan for 2018/2019

5.6.1 Work closely with CCG, Safeguarding Board, SWSTP and Healthy London Partnerships supporting the implementation of the proposed changes around the child death process.

5.6.2 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 nationally.

5.6.3 Explore possibilities for family involvement in the CDOP process. Family involvement in the CDOP process is a key element of the proposed new Pan London arrangements and Croydon will work within these recommendations.

5.6.4 Introduce eCOP.

5.6.5 Continue to work with CDOPs across London and nationally to understand trends and share learning.

5.6.6 Complete statutory child death data returns for Department of Education.

5.6.7 Continue to work with CSCB Learning and Development to include learning points identified at CDOP within the training programme.

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 2017/2018, CDOP met eight 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 2017/2018

Child Death Overview Panel Attendance								
	2017						**2018**	
	19th June	**26th June**	**10th July**	**14th August**	**16th October**	**11th December**	**29th January**	**5th March**
Regular panel members								
Director of Public Health *(Chair)*	✓	✓	✓	✓	✓	✓	✓	✓
Designated Doctor for CP & Child Death review process	✓	✓	✓	✓	✓	✓	✓	✓
Designated Nurse for Child Protection (CCG)	✓	✓	✓	✓	✓	✓	×	✓
Named Professional for Children's Safeguarding and Child protection (CHS)	✓	✓	✓	✓	✓	✓	✓	×

SPOC and CDOP Coordinator CSCB	✓	✓	✓	✓	✓	✓	✓	✓
QA Manager (LADO) (Deputy Chair)	✓	×	✓	✓	✓	✓	✓	✓
CSC Service Delivery Manager	×	×	✓	×	×	✓	×	×
MET Police	✓	✓	✓	✓	×	×	✓	✓
CSCB Business Manager	×	✓	×	×	✓	✓	✓	×
Guests/observers								
CSCB Administrator	N/a	N/a	N/a	N/a	✓	N/a	N/a	N/a
Public Health Principal	✓	✓ (x2)	×(x2)	× (x2)	✓ (x2)	×(x2)	×(x2)	×(x2)
Business Support Coordinator MASH	N/a	N/a	N/a	N/a	N/a	N/a	✓	N/a

✓ - 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:

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