Plan to meet the requirements of Working Together 2018 and the Child Death Review Statutory and Operational Guidance

Croydon Clinical Commissioning Group and London Borough of Croydon Health Services

June 2019

Section 1: Contact Details of Child Death Review Partners

Name of Child Death Review Partners *This section should include detail of All the child death review partners of your area. Please add more rows if needed.*		
Name of organisation	Croydon Clinical Commissioning Group	☑ Clinical Commissioning Group ☐ Local Authority
Name of contact for child death reviews within organisation	Dr Shade Alu Designated Doctor for Child Death Reviews	
Email address of contact	shadealu@nhs.net	
Telephone number of contact	02082746371	
Name of organisation	London Borough of Croydon	☐ Clinical Commission Group ☑ Local Authority
Name of contact for child death reviews within organisation	Shaun Hanks Head of Quality Assurance & Safeguarding	
Email address of contact	shaun.hanks@croydon.gov.uk	
Telephone number of contact	0208 726 6000 (ext 47486)	
Please indicate the lead CDR partner *(NB: this must be one*	Croydon Clinical Commissioning Group	

of the organisations listed above)	
Please indicate which CDR partner(s) are responsible for commissioning the new arrangements if different from above	

Section 2: Details of Child Death Overview Panel (CDOP or equivalent structure, hence referred to as CDOP).

Details of CDOP or equivalent *This section should include details of the area covered by your CDOP*	
Name of CDOP	South West London Child Death Overview Panel
Name of CDOP Manager / Administrator	To be appointed
Email address of CDOP	To be confirmed
Telephone number of CDOP	To be confirmed
Please list ALL the local authority areas covered by your CDOP	Croydon Sutton Merton Wandsworth Richmond Kingston
Number of deaths reviewed in total in the 2018/19 year in the areas listed above	Approximately 110

Section 3: Requirements of Working Together to Safeguard Children 2018 and the Child Death Review Statutory and Operational Guidance.

Requirement WT1: To make arrangements to review the deaths of children normally resident in the local area (including if they die overseas) and, if they consider it appropriate, for any non-resident child who has died in the area
Q1.1 Please give an overview of your local arrangements for reviewing child deaths. *This should include details of the administrative and logistical processes and should give details of the local arrangements for the notification process, information gathering, child death review meetings, frequency of CDOP meetings*
All children who are residents of Croydon when they die will have their deaths reviewed at the SWL CDOP. Prior to this they will have a joint agency response if the criteria is met, followed by a child death review meeting. The joint agency response is the responsibility of the designated doctor for child death reviews, who will also chair the subsequent CDRM. CDRM will be chaired by paediatricians in the hospital Croydon uses eCDOP an electronic solution through which information will be shared. This is used from notification of the death all the way through to SWL CDOP. There remains in post the previous single point of contact who will continue to administer the process locally
Q1.2 Please describe the process that will be followed when a child not resident in your area dies in your area. *This should include how the CDOP in the area of residence will be notified, how decisions will be made about who conducts the review and retains responsibility for the case.*
The CDRM is the responsibility of the organisation where the death is declared. If the child is from another area, there will be discussion with the child's borough of residence to ascertain who is best placed to undertake this meeting.
Q1.3 Please describe how you will engage with hospitals in your area to ensure good communication and sharing of information when a child dies. *This should include consideration of the notification process, completion of reporting forms and supplementary reporting forms, and whether you support arrangements for child death review meetings through provision of agency reporting forms*

eCDOP is used by most of the London boroughs, so notification will take place electronically for most children. The administrator will ensure that other boroughs are notified of deaths of children from their areas
Requirement WT2: To make arrangements for the analysis of information from all deaths reviewed

Q2.1 National analysis of information from deaths reviewed will be undertaken by NCMD, and there is a statutory duty to provide data to NCMD for this purpose. Please describe how you will provide information to NCMD. *This should include details of how you submit data to NCMD securely and details of any other local analysis you plan to undertake*
eCDOP will send information to SWL CDOP which will upload data to NCMD. The plan is to review Croydon data on a quarterly basis to ensure that we capture and disseminate local learning
Requirement WT3: At such times as are considered appropriate, prepare and publish reports on what you have done as a result of the child death review arrangements in your area, and how effective the arrangements have been in practice
Q3.1 Please describe your plans for publication of reports related to this requirement. *This should include details of what reports you plan to publish (if appropriate) and where they will be published*
An annual report will be published. It will be on the CCG, Local Authority and Croydon Safeguarding Children Partnership (CSCP) websites
Requirement WT4: To consider the core representation of your CDOP (or equivalent)
Q4.1 Please give details of the agencies and job roles of the individuals on your CDOP. *This should include details of core members and any members that are co-opted for specific discussions / themed panel meetings*

This is still being discussed, however the following will be core members

- *Independent chair – Public Health.*
- *Designated Doctors for child death reviews*
- *Designated Nurses for Safeguarding Children*
- *Children's social care - head of service level*
- *Local Single Point of Contact*
- *Police*
- *Representation from Maternity services*
- *Lay member*

Q4.1 Please give details of the agencies and job roles of the individuals on your CDOP. *This should include details of core members and any members that are co-opted for specific discussions / themed panel meetings*

Q5.1 Please give details of this role in your local area. *This should include which organisation the role is employed within and the number of working hours for the post. Please also include a job description if available.*

The role description are being developed for the lay member

All other job roles are in existing job descriptions

Q5.2 Please describe the process for notifying the Designated Doctor for Child Deaths when a death occurs. *This should include details of who is responsible for carrying out the notification and how this occurs (e.g. email / telephone via the CDOP admin team).*

The administrator for child death reviews will email the designated doctor

Requirement WT6: Publicise information on the arrangements for child death reviews in your area.

Q6.1 Please give details on where the information for child death reviews in your area can be publicly accessed. *The information publicly available should include who the accountable officials are (the local authority chief executive and the accountable officer of the clinical commissioning group),*

which local authority and clinical commissioning group partners are involved, what geographical area is covered and who the designated doctor for child deaths is
It will be available on the CCG and local authority and Croydon Safeguarding Children Partnership (CSCP) websites
Requirement WT7: Child death review partners should agree locally how the child death review process will be funded in their area.
Q7.1. **Please give details on how the CDR process in your area is being funded?** *This might include mention of funding coming from LA, CCG and Health Care Trusts.*
The funding for the process included funding from the CCG, Croydon Local Authority and Croydon Health Services NHS Trust (CHS) (integrated community and acute trust). Despite no additional funding being made available, CHS has provided funding for additional programmed activity time for to paediatricians (one general and one neonatology) to lead the CDR meetings. The CCG will fund the keyworker and administration support will be provided from the local authority support already in place (SPOC). All these will be monitored closely to ensure the demand on any one is not too great or creating delays at any point of the process.

Section 4: Requirements of the Child Death Review Statutory and Operational Guidance

Requirement OG1: Chief Executives of clinical commissioning groups (CCGs) and local authorities should ensure that all of their staff who are involved in the child death review process read and follow the operational guidance.
Q1.1 Please describe how you have ensured that all staff within the child death review process have read and follow the operational guidance. This should include methods of dissemination of the guidance and any training / awareness raising sessions that have been provided
The guidance has been shared at strategic and operational levels in all organisations Healthy London Partnership organised awareness raising sessions Training needs for staff are being assessed, in order to provide relevant training In CHS this has been disseminated by the Medical Director to all staff immediately involved in this new process.
Requirement OG2: Families should be given a single, named point of contact, the "key worker", for information on the processes following their child's death, and who can signpost them to sources of support.
Q2.1 Please describe your process for assuring that relevant organisations have appointed a key worker in the event of a child death. *This should include details of the responsibilities of that post*
The CCG is funding the "key worker" who will be employed within CHS. There is ongoing discussion about how best to deliver this requirement, but it is proposed that it will be based within the existing Children's Hospital at Home team in order to ensure that there is always someone available to be allocated. The details of the post include: • A reliable and readily accessible point of contact for the family after the death • Co-ordination of meetings between the family and professionals as required • Providing information on the child death review process and the course of any investigations pertaining to the child • Liaising as required with the coroner's officer and police family liaison officer • Representing the 'voice' of the parents at professional meetings, ensuring that their questions are effectively addressed • Providing feedback to the family afterwards • Signposting to expert bereavement support if required
Requirement OG3: To report deaths of children with learning disabilities or suspected learning disabilities to the Learning Disabilities Mortality Review Programme (LEDER).

Q3.1 Please describe your process for notifying LEDER of the death of a child with a learning disability. *This should include details of who is responsible for making the notification and how it occurs (e.g. telephone / email)*
The child death administrator working with the designated doctor for child death reviews will notify LEDER. The process is already in place.
Requirement OG4: A Joint Agency Response (JAR) should be considered if certain criteria, set out in the guidance are met.

Q4.1 Please describe your model for JAR. *This should include details of who the lead health professional will be (e.g. nurse / health visitor / paediatrician), details of who attends when a home visit is required and the times between which the JAR is available e.g. is there an on-call element? Please also include details of the estimated number of deaths requiring a JAR in your area each year.*
The lead health professional will be the designated doctor for Child Death Reviews (consultant in charge when death is confirmed will take on the role until it is handed over to the designated doctor). The home visit will be undertaken by the police The estimate is 10-12 deaths
Requirement OG5: Conduct a child death review meeting for every child

Q5.1 Please describe how the child death review meeting will be convened for the following groups:

- Children who die in hospitals in your area
- Neonatal deaths in hospitals in your area (this should include use of the Perinatal Mortality Review Tool (PMRT)
- Children who die in the community in your area
- **Children whose deaths trigger a joint agency response**

The child death review meeting for children who die at Croydon Health Services/Croydon University Hospital will be convened by acute hospital paediatricians

Child death review meetings for neonatal deaths at Croydon Health Services/Croydon University Hospital will be convened by hospital neonatologists/paediatricians

Child death review meetings for those who die in the community will be discussed and decided on who will be best placed to convene the meeting.

If there has been a joint agency response, the child death review meeting will be convened by the designated doctor for child death reviews.

Requirement OG6: Produce an annual report on local patterns and trends in child deaths, any lessons learnt, and actions taken, and the effectiveness of the wider child death review process

Q6.1 Please give details of when you will produce your annual report and where it will be published

The annual report will be completed by SWL CDOP in the first quarter of the following year.

It will be published on the websites of Croydon CCG, London Borough of Croydon and Croydon Safeguarding Children Partnership