



Black Country Child Death Overview Panel (CDOP)

CDOP Arrangements for Publication by 29th June, 2019

Overview

The Black Country Strategic CDOP has been set up by Child Death Review (CDR) Partners:

- City of Wolverhampton Council
- Dudley CCG
- Dudley Metropolitan Borough Council
- Sandwell and West Birmingham CCG
- Sandwell Metropolitan Borough Council
- Walsall CCG
- Walsall Metropolitan Borough Council
- Wolverhampton CCG

to oversee the review of deaths of children under the requirements of the Children Act, 2004 and Working Together to Safeguard Children, 2018.

Purpose

The purpose of the Black Country CDOP is to ensure that a review of all child deaths (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) up to the age of 18 years, normally resident in Black Country, irrespective of the place of their death. The Black Country CDOP will adhere to the statutory guidance: Child Death Review Statutory and Operational Guidance (England) 2018: <https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england>.

CDOP Responsibilities

- To collect and collate information about each child death, seeking relevant information from professionals and, where appropriate, family members;
- To analyse the information obtained, including the report from the CDRM, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths;
- To make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children;
- To notify the Child Safeguarding Practice Review Panel and local Safeguarding Partners when it suspects that a child may have been abused or neglected;
- To notify the Medical Examiner (once introduced) and the doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction;
- To provide specified data to NHS Digital and then, once established, to the National Child Mortality Database;



- To produce an annual report for CDR partners on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process; and
- To contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.

Operational Responsibilities

- Hold meetings at intervals to enable the death of each child to be discussed in a timely manner. Meetings will be held six-monthly.
- Hold themed meetings where CDR partners arrange for a single CDOP, or neighbouring CDOPs, to collectively review child deaths from a particular cause or group of causes. Such arrangements allow appropriate professional experts to be present at the panel to inform discussions, and/or allow easier identification of themes when the number of deaths from a particular cause is small.
- Ensure that effective Joint Agency Response arrangements are in place, to enable key professionals to come together to undertake enquiries into and evaluating each unexpected death of a child.
- Review the appropriateness of agency responses to each death of a child.
- Review relevant environmental, social, health and cultural aspects of each death, to ensure a thorough consideration of how such deaths might be prevented in the future.
- Determine whether each death had modifiable factors.
- Make appropriate recommendations to the Local Health and Wellbeing Boards and Local Safeguarding Partnerships, in order that prompt action can be taken to prevent future such deaths where possible.

Governance and Accountability

- The Child Death Review Panel is accountable to the Child Death Review (CDR) Partners (above) through a Memorandum of Understanding
- A concise summary of the key points from each meeting will be provided to the Health and Wellbeing Boards and other strategic partnerships including the local Safeguarding Children's and Community Safety Partnerships, where relevant.
- The Child Death Review Panel will provide a report to the Child Death Review (CDR) Partners (above), summarising any recommendations from the reviews of child deaths.

The memorandum of understanding attached to this document

Conflict of Interest

Panel members must declare any conflict of interest at the outset of each meeting and panel members should not lead discussions if they are the named professional with responsibility for the care of the child.



Confidentiality

All information discussed at The Child Death Review Panel is STRICTLY CONFIDENTIAL and must not be disclosed to third parties, without discussion and agreement of the Chair.

Publication

The Black Country Child Death Overview Panel (CDOP) arrangements will be published on the Statutory partner websites. The arrangements will also be published on the Safeguarding Children Partnership websites across the Black Country.

Review Date and Next Review Date

The terms of reference of Black Country CDOP will be subject to annual review, or more frequently, if required.

Last Reviewed: 5th June, 2019

Next Review Scheduled: 30th June, 2020