Kent and Medway
Child Death Review Partners
Arrangements

June 2019

Contents

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Foreword

We are delighted to publish this document which describes the new Kent and Medway Child Death Review Partners arrangements. These are to be known as the Kent and Medway Child Death Review (Kent and Medway CDR) arrangements. We are steadfast in following good child death review practice at a time when families experience profound loss and bereavement. This loss may also affect professionals involved in caring for the bereaved child. To achieve this and demonstrate best practice, we have designed our review processes to identify key learning and modifiable factors that could be implemented to prevent future deaths.

We recognise that Kent and Medway Clinical Commissioning Groups, Kent County Council and Medway Council, as the Child Death Review Partners, have statutory responsibilities for the child death review arrangements. However, it is necessary to work with relevant bodies named in the Working Together 2018 statutory guidance identified as having specific responsibilities in relation to child death. This is to ensure that our arrangements fit with the statutory requirements and that parents, families and carers receive appropriate and timely support. Our new Kent and Medway CDR arrangements, outlined in this document, describe our revised approach which combines best practice with adherence to statutory requirements.

The Kent and Medway CDR arrangements focus on:

- Combining the geographical areas of the two local authorities by establishing a single approach for undertaking child death reviews. Therefore, the arrangements will cover the deaths of all children that normally live in the Kent and Medway area;
- review and/or analyse matters relating to the death(s) that are relevant to the welfare of children in the area, including factors relating to public health and safety;
- consider whether action and changes to procedures should be taken in relation to any matters identified;
- inform any person or organisation where action should be taken;
- ensure the child death review partner arrangements are effective and continually improve to assist child health and wellbeing in Kent and Medway.

The implementation of the new Kent and Medway CDR arrangements is a strong indication of our intention to provide an effective structure and approach for managing the child death arrangements strictly in accordance with statute. These arrangements also re-affirm our commitment to working collaboratively across local agencies and organisations to better understand thematic learning in order to identify potential safeguarding or local health issues that could be modified to protect children from harm, and ultimately, save lives of children in the area.

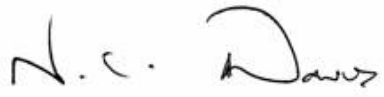
We have a reputation as a national exemplar in the development of eCDOP (electronic child death overview process) and a well-established record of collaborative working and shared learning to inform the prevention of child deaths. Consequently, the Kent and Medway CDR arrangements have been developed from a position of strength. We have also taken on board lessons from other areas that developed and tested new approaches to child death reviews under the National Children's Bureau initiative programme.

In responding to the changes to the Children Act 2004, as amended by the Children Social Work Act 2017, as Child Death Review Partners, we will work with relevant organisations with specific responsibilities in relation to child death. We will regularly review our process to improve our understanding of best practice, learn from national and local experience, and reflect on how we support families. We will critically evaluate our practices, inviting review and challenge from independent national bodies, and venture to deliver the best possible child death review practice across Kent and Medway.

This plan is published on 25 June 2019 and the new arrangements will be implemented on or before 25 September 2019. The new Kent and Medway CDOP arrangements supersede the previous process which operated under the previous Local Safeguarding Children Board.

Glenn Douglas,
Accountable Officer
Kent and Medway CCGs

David Cockburn,
Head of Paid Service
Kent County Council



Neil Davies,
Chief Executive
Medway Council

The child death review process at a glance

The flow chart below sets out the main stages of the child death review process which applies across England.

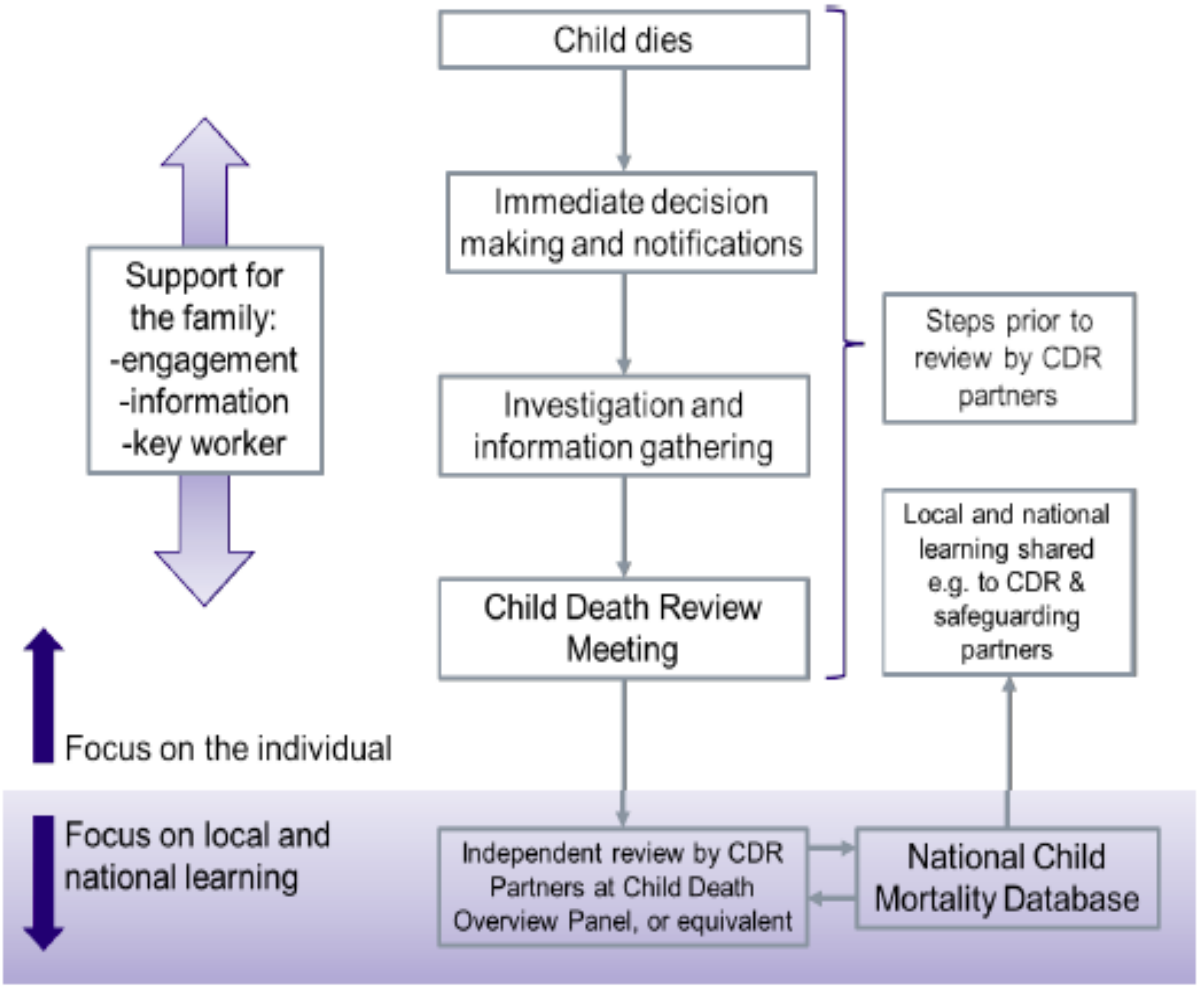


Figure 1 Chart illustrating the full process of a child death review. This includes both the statutory responsibilities of CDR partners to review the deaths of children at an independent multi-agency panel (described here, and throughout, as review at CDOP or equivalent), and the processes that precede or follow this independent review. Further explanation is below.

Extract from Child Death Review Statutory and Operational Guidance (England), October 2018

Section 1: Introduction

Purpose of this document

This document describes the new Kent and Medway Child Death Partners arrangements in fulfilment of the responsibilities set out in the Children Act 2004, as amended by the Children and Social Work Act 2017. The arrangements also comply with the requirements set out in 'Working Together to Safeguard Children 2018'; 'Child Death Review Statutory and Operational Guidance (England) 2018' and the complimentary 'Sudden Unexpected Death in Infancy and Childhood: multi-agency guidelines for care and investigation (SUDI/C Guidelines)'.

The requirements in the above guidance documents underline the fact that carrying out the functions in the child death review process should satisfy specified factors and best practice standards. We will place the concerns of families and carers at the heart of the of the review process. All professionals involved in caring for children must have this consideration in mind in discharging their responsibilities. Similarly, all relevant organisations and agencies across Kent and Medway, should have regard to the objectives and expectations described in this this document which have been developed in order to fulfil the statutory requirements.

Lay out of this document

This document is divided into 7 sections:

- **Section 1** describes purpose of the child death review arrangements including the national and local context;
- **Section 2** describes the high-level governance accountability and outline of the local arrangements agreed by the CDR Partners, including the role of individual officers and how the CDR arrangements fit with other arrangements;
- **Section 3** sets out the details of the responsibilities of the Child Death Review Partners including support for families and carers;
- **Section 4** details the funding arrangements agreed by the CDR Partners;
- **Section 5** describes the responsibilities of specified organisations that have a role in the child death review process;
- **Section 6** details the Kent and Medway CDOP arrangements; and
- **Section 7** describes the local reporting arrangements including the annual review process.

National and local context

Working Together 2018 makes clear that the Child Death Partners in relation to a local authority area as defined in the Children Act 2004, as amended by the Children and Social Work Act 2017) are:

- "the local authority;
- any clinical commissioning group for an area, any part of which falls within the local authority area".

Working Together 2018 further clarifies that, “when a child dies, in any circumstances, it is important for parents and families to understand what has happened and whether there are any lessons to be learned”.

As a result, “child death review partners must make arrangements to review all deaths of children normally resident in the local area and, if they consider it appropriate, for any non-resident child who has died in their area. Furthermore, “child death review partners for two or more local authority areas may combine and agree that their areas be treated as a single area for the purpose of undertaking child death reviews”.

The CDR Partners are required to review and/or analysis information to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety. As described In Working Together 2018, CDR Partners:

“must, at such times as they consider appropriate, prepare and publish reports on:

- what they have done as a result of the child death review arrangements in their area;
- how effective the arrangements have been in practice;
- may request information from a person or organisation for the purposes of enabling or assisting the review and/or analysis process. The person or organisation must comply with the request, and if they do not, the child death review partners may take legal action to seek enforcement; and
- may make payments directly towards expenditure incurred in connection with arrangements made for child death reviews or analysis of information about deaths reviewed, or by contributing to a fund out of which payments may be made; and may provide staff, goods, services, accommodation or other resources to any person for purposes connected with the child death review or analyse process”.

As CDR partners, we have agreed that the two local authority areas will combine and consider our arrangements as a single area for the purpose of undertaking child death review of approximately 120 cases annually, in accordance with the provisions set out in the statutory guidance. We understand that depending on the lessons from specific child death reviews, these arrangements may inform the new local safeguarding children multi-agency arrangements in Kent and Medway.

As CDR partners, we have reviewed our structures and processes, and we have agreed new arrangements which give us a strong basis for meeting the requirements placed on us. The new arrangements also make provision for how we will manage the review of a child who is not normally resident in the Kent and Medway council areas.

Section 2: Governance, Accountability and Outline of the Local Arrangements

Leadership

The CDR Partners' senior executive officers have responsibility for ensuring that the child death review process functions effectively and the good practice is followed, and the arrangements comply with the requirements set out in the relevant statutory guidance.

In Kent and Medway area, the CDR Partners' organisations and the Chief Officers are:

- Kent and Medway Clinical Commissioning Groups – Accountable Officer;
- Kent County Council – Head of Paid Service;
- Medway Council – Chief Executive.

The CDR Partners will co-operate to make local arrangements for the child death review process to improve the experience of bereaved families, as well as professionals, after the death of a child and, to ensure that information from the child death review process is systematically recorded and that relevant learning is identified to inform changes in practice.

The Chief Officers have delegated their functional responsibilities to the following Senior Officers:

- Chief Nurse for the East Kent CCGs and Lead for Kent and Medway CCG's - **Sarah Vaux**;
- Director of Public Health, Kent County Council – **Andrew Scott-Clark**;
- Director of Public Health, Medway Council - **James Williams**.

The CDR Partners' Chief Officers are responsible for the overall assurance that the statutory requirements are being effectively discharged. The Senior Officers who have delegated lead role remain accountable for any actions or decisions taken in their respective organisations. The Senior Officers will provide pro-active assurance to their respective Chief Officers to confirm that the statutory requirements are being fulfilled.

The lead CDR Partner role is assigned to the Kent and Medway Clinical Commissioning Groups.

Outline of the local child death review process

The Kent and Medway child death review process is entirely managed on eCDOP.

Notification, Reporting and Analysis

A death of a child will be recorded on a Notification Form which is completed electronically via a link on eCDOP to notify Kent and Medway Safeguarding Partners and the Kent and Medway Child Death Review (CDR) Team.

The relevant Designated Doctor for child deaths for the local area of the child and the assigned Clinical Commissioning Group for locality is contacted once it is established that the case is identified for intervention. A determination is made as to whether the case is a section 47

Police/Social Care lead or a CDR health lead case. An initial strategy meeting may be held if the case is led by the Police or Social Care where the CDR team is invited.

All bereaved families are given a single, named point of contact who takes on a key worker role with responsibility to inform families about the child death review process, and signpost them to sources of support. It is the responsibility of the organisation where the child was certified dead to identify a key worker for the family. The role could be assigned to a range of practitioners.

The Designated Doctor for child deaths will hold a Joint Agency Review (JAR) if the death requires such a review in conjunction with the CDR Team.

In the event of the death of a Kent and Medway looked-after child who resided outside of the Kent and Medway CDR area, the CDR Team will liaise with the appropriate CDOP and either transfer the case for review by the local team, or if agreed, the Kent and Medway CDR Team will assume lead responsibility for conducting the child death review, including involving other relevant Safeguarding Partnerships with an interest or whose lead agencies had had an involvement.

There is a defined process in place for managing instances where the NHS serious incident criteria are triggered, including the channel of communication between NHS provider organisations, CCGs, JAR and the CDR Team.

On receipt of a notification of a child fitting the Learning Disabilities Mortality Review Programme (LeDeR) criteria, the CDR team will check with the notifying organisation if a LeDeR referral has been made. If unclear, or a LeDeR referral has not been made then this will be completed on the LeDeR site online. Child Deaths that are also part of LeDeR will be identified as LeDeR on eCDOP.

Following a child death, an agency Reporting Form is sent by the CDR Team to each professional or the safeguarding team (e.g. Health, Ambulance Service, Social Care, Police etc) that had been involved with the child or family, either prior to or at the time of death. Professionals/agencies receiving the Reporting Forms will retrieve relevant case records for the child or other family members to complete any information known to them or their organisation and return the form within 7 working days.

A Child Death Review Meeting (CDRM) will be arranged by the CDR Team once all relevant information is received. The review meeting is structured to be flexible and proportionate, and the primary focus is on local learning events. The CDRM is a meeting of professionals without parents to enable full candour and discussion about any difficult issues relating to the care of the child. However, parents will be informed of the meeting by their key worker and they will have an opportunity to contribute information and questions through their key worker or another professional.

The CDRM concludes with a clear description of required follow-up meetings and responsibility for reporting the meeting's conclusions to families.

In all cases the Analysis Form will be completed at the CDRM and sent to the relevant Child Death Overview Panel by the CDR Team.

In the event of an unexpected death, the death will be reported to the Coroner whose jurisdiction covers the area where the death occurred.

Full details about the arrangements are illustrated in the Kent and Medway Child Death Review Process Flowchart (see Appendix A).

Geographical area

The geographical footprint for these arrangements is the Kent County Council and Medway Council local authorities' area. The geographical boundary of the Kent and Medway Clinical Commissioning Groups corresponds to the boundary of the two local authorities.

As permitted by the Children Act 2004, as amended by the Children and Social Work Act 2017, and the related statutory guidance, as CDR Partners we have agreed to combine our areas, therefore, our joint footprint should be treated as a single area for the purpose of discharging our child death review responsibilities in respect of the requirement for a single Child Death Overview Panel (CDOP) to review a minimum of 60 cases annually.

We are also committed to consider where necessary, undertaking child death reviews for children who are not Kent or Medway residents but were physically in the area when a death occurred, after consultation with the responsible CDR Partners. We will also collaborate regarding working arrangements with neighbouring CDR Partners such as London Borough Councils, East Sussex and Surrey County Councils.

Designated Doctors for child deaths

The CDR Partners have appointed Designated Doctors for Child Deaths who lead on co-ordinating the response of the health service into the child death review process for the area. The Designated Doctors for Child Deaths work closely with the CDOP and the role has responsibility for the wider child death review process and advising the CDOP in relation to decisions about which cases might best benefit from review at a themed panel and write summary reports of the key issues arising from the themed meeting.

We expect that the Designated Doctors for Child Deaths will work with specific arms of the police force e.g. the Road Traffic Collision Unit or the British Transport Police. In such situations the Designated Doctors will ensure that there is a co-ordinated approach with other elements of the Joint Agency Response, and any report arising from their investigation informs the wider child death review process.

The following table shows the list of the Designated Doctors for Child Death across the single area at the time of publication. Details of the named Designated Doctors for Child Death may change over time.

Name	Job Title	Organisation
Kent		
Dr Selwyn D'Costa	Consultant Paediatrician	Dartford and Gravesham NHS Trust
Dr Kala Pathy	Consultant Paediatrician	Maidstone and Tunbridge Wells NHS Trust)
Dr Ameen Siddiqui	Consultant Paediatrician	East Kent Hospitals NHS Foundation Trust
Dr Amit Gupta	Consultant Neonatologist	East Kent Hospitals NHS Foundation Trust)
Dr Abhijit Das	Community Consultant Paediatrician	East Kent Hospitals NHS Foundation Trust
Medway		
Dr Helen McElroy	Consultant Neonatologist	Medway NHS Foundation Trust
Dr Asankha Ranasinghe	Consultant Paediatrician	Medway NHS Foundation Trust

How the child death review process fits with other arrangements

The Kent and Medway CDR arrangements have been established against the background of the broader structural changes to the Safeguarding Partners arrangements in Kent and Medway.

In order to ensure that information from the child deaths reviewed is appropriately shared, it is essential that the Kent and Medway CDR arrangements are effective and that there is a close interface with the respective Safeguarding Partners. As a result, learning can be identified and shared with multi-agency partners and appropriate action taken. Similarly, for wider considerations and the need to address strategic issues, the Kent and Medway CDR will link with the respective Health and Wellbeing Boards which sit in the two local authority areas as appropriate.

Section 3: Responsibilities of Child Death Review Partners

The Child Death Review Statutory and Operational Guidance (England) 2018, defines the specific and general responsibilities of several professionals working in health services (across all sectors: acute, maternity, mental health, primary care and community), children's social care services, police, including British Transport Police, and Royal Military Police, coronial services, education, and public health.

Child death review process

Immediate decision making and notification

We have responsibilities as the CDR Partners for ensuring that the local system for making decisions immediately following the death of a child and a number of notifications to the child's GP and other professionals, to the Child Health Information System; and the relevant CDR partners and CDOP work well.

Investigation and information gathering

As CDR Partners we must ensure that clear processes are in place for managing the investigation and information gathering in accordance with the statutory guidance. The range of investigation may include coronial investigation, Joint Agency Response, and NHS Serious Incident Investigation.

Child death review meeting

CDR Partners must ensure that every child's death is discussed at a child death review meeting (CDRM). This is the multi-professional meeting attended by professionals directly involved in the care of that child during life and those involved in the investigation after death. The nature of the meeting will vary according to the circumstances of the child's death and the practitioners involved. As the CDR Partners we will ensure the CDRMs operate in a way that makes it possible to:

- review the background history, treatment, and outcomes of investigations, to determine, as far as is possible, the likely cause of death;
- ascertain contributory and modifiable factors across domains specific to the child, the social and physical environment, and service delivery;
- describe any learning arising from the death and, where appropriate, to identify any actions that should be taken by any of the organisations involved to improve the safety or welfare of children or the child death review process;
- review the support provided to the family and to ensure that the family are provided with the outcomes of any investigation into their child's death;
- a plain English explanation of why their child died (accepting that sometimes this is not possible even after investigations have been undertaken) and any learning from the review meeting.

Child death overview panel

We have responsibilities as CDR partners to establish a system and structure to conduct an independent multi-agency scrutiny using the information provided throughout the early stages of the child death review process. We must ensure that:

- child death reviews are carried out;
- we analyse information from all deaths reviewed to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety;
- consider whether action should be taken in relation to any matters identified;
- prepare and publish annual reports on what has been done as a result of the child death review arrangements and how effective the arrangements have been in practice;
- request information from a person or organisation for the purposes of enabling or assisting the review and/or analysis process - the person or organisation must comply with the request, and if they do not, the child death review partners may take legal action to seek enforcement;
- may make payments directly towards expenditure in connection with CDR arrangements.

Child death review administration

The Kent and Medway CDR Nurse and Administrator will work closely with the Designated Doctors for Child Death in respect of the effective management of CDRMs, as set out in the child death review process.

On behalf of CDR partners, support the request for information from relevant professionals or organisations to provide relevant information for the purposes of enabling or assisting the conduct of the child death review partner's functions.

Support for the families and carers

All relevant professionals have a duty to support and engage with families at all stages in the child death review process. This means that steps will be taken to inform families about the review process, and where appropriate offer them the opportunity to contribute to investigations and meetings. The Kent and Medway CDR process will ensure that families are informed of the outcomes of reviews.

The Kent and Medway CDR process is organised such that every family will have their child's death sensitively reviewed, so that, where possible, identify the cause of death and to ensure that lessons are learnt that may prevent further children's deaths.

The local CDR process should ensure that families should be assured that any information regarding their child's death which they believe might inform the child review meeting would be welcome.

Reviewing deaths of children not normally resident in the area

In the event of the death of a looked-after child (by a different placing authority) in the Kent and Medway CDR area, the Designated Doctor for child death will liaise with the relevant placing authority to identify a clear pathway for the review. Where necessary and following consultation with the responsible CDR Partners we will undertake child death reviews for children who are not Kent residents but were in the area when a death occurred.

Key worker role

As CDR Partners, we recognise that a key worker role is an important resource for families at a difficult time. In line with the Child Death Review Statutory and Operational Guidance 2018, we adhere to the principle that it is the responsibility of the organisation where the child was certified dead to identify a key worker for the family. The key worker serves as

a single, named point of contact for bereaved families. The position can be assigned to a range of practitioners and has the primary responsibility to inform families about the child death review process and signpost them to sources of support. The key worker will be required to work with the coroner's and police family liaison officers in criminal and coronial cases to provide necessary support to the parents in relation to all elements of the investigations by the Coroner or police.

The main responsibilities of the key worker include a requirement to:

- "be a reliable and readily accessible point of contact for the family after the death;
- help co-ordinate meetings between the family and professionals as required;
- be able to provide information on the child death review process and the course of any investigations pertaining to the child, including liaising with the coroner's officer and any police family liaison officer;
- represent the 'voice' of the parents at professional meetings, ensure that their questions are effectively addressed, and to provide feedback to the family afterwards; and
- signpost to expert bereavement support if required".

Section 4: Funding Arrangements

The Children Act 2004, as amended by the Children and Social Work Act 2017, the statutory guidance oblige the CDR Partners to agree how the Kent and Medway CDR arrangements will be funded.

The funding is to enable payments to be made towards expenditure incurred in connection with the arrangements made for child death reviews or analysis of information about deaths reviewed, or by contributing to a fund out of which payments may be made; and may provide staff, goods, services, accommodation or other resources to any person for purposes connected with the child death review or analysis process.

Accordingly, the CDR Partners recognise the necessity to provide suitable funding to the Kent and Medway CDOP arrangements. The agreed funding should be sufficient to cover all elements of the CDR Partners arrangements.

As part of the transition from the existing structure to the new arrangements, the funding agreed in respective of agency funding contribution for 2019/20 financial year will meet the required expenditure to March 2020.

Funding arrangements for 2020/21 and beyond will be subject to further discussions by the CDR Partners following the implementation of the new Kent and Medway CDOP arrangements. A review will be undertaken by January 2020 to determine the respective contribution of the Kent and Medway CDR Partners for 2020/21. This will inform subsequent annual review of funding contribution.

Section 5: Responsibilities of Other Organisations and Agencies

All local organisations or individual practitioners are obliged to have regard to any guidance on child death reviews issued by the government. The relevant statutory guidance set out that all local organisations or individual practitioners that have been involved in a case within the scope of the child death review, should co-operate, as appropriate, in the child death review process carried out by the CDR Partners. The 'Child Death Review Statutory and Operational Guidance (England) 2018', and 'Working Together 2018, should be consulted for further details. The summary of the specific responsibilities is set out in the table below.

Specific responsibilities of relevant bodies in relation to child deaths	
Registrars of Births and Deaths	Requirement on registrars of births and deaths to provide information with the particulars of the death entered in the register in relation to any person who was or may have been under the age of 18 at the time of death
Coroners	Coroner's are under a duty to notify and share information with CDR Partners

Section 6: Child Death Overview Panel

The Child Death Overview Panel (CDOP) is the multi-agency panel set up by CDR partners to review the deaths of all children normally resident in the area, in order to learn lessons and share any findings for the prevention of future deaths. If appropriate, and agreed between CDR partners, the deaths in this area of non-resident children may also be reviewed. As shown earlier, this stage of the review process is known as the CDOP.

The purpose of the Kent and Medway CDOP is to review all child deaths up to the age of 18 years, normally resident in Kent and Medway, irrespective of the place of their death (excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law). The Kent and Medway CDOP will operate in accordance with the statutory guidance: Child Death Review Statutory and Operational Guidance (England) 2018:

Professionals in all agencies have a responsibility to notify the relevant CDR Team of the death of any child of which they become aware. Professionals are also under obligations when they have been involved with the child or family to share information for the purposes of reviewing the child's death, and to participate in Kent and Medway CDR Partners review process.

The Child Death Overview Panel will be chaired alternately by the Directors of Public Health of Kent County Council and Medway Council respectively. As a result of the agreement about chairing CDOP a formal Vice-chair has not been appointed. The Chair has been appointed in accordance with The Child Death Review Statutory and Operational Guidance 2018, which states that "The CDOP should be chaired by someone independent of the key providers (NHS, social services, and police) in the area."

CDOP will oversee the reviews of child deaths that better enable thematic learning in order to identify potential safeguarding or local health issues that could be modified in order to protect children from harm and, preserve lives.

The Kent and Medway CDR Partners have agreed that administrative responsibilities for the CDOP will be managed jointly by the Kent & Medway CDOP Managers, who will liaise closely with the Directors of Public Health in Kent and Medway as appropriate. The administration will support the following functions:

- agreeing the agenda with the Chair two weeks before the meeting;
- sending out the agenda and supporting papers at least one week in advance of the meeting;
- producing and sending out an action log to members no later than one week after the meeting;
- maintaining an up to date list of members and their contact details;
- providing administrative support as necessary for any task and finish groups;
- undertaking research on behalf of the group to enrich and improve local processes and procedures.

Full details about the governance and accountability arrangements, operational responsibilities, membership responsibilities, decision-making and disputes resolution are set out in the terms of reference of the Kent and Medway Child Death Overview Panel Terms of Reference (see Appendix B).

Section 7: Publication of Reports

The Kent and Medway CDR Partners arrangements annual report will be published in September each year about the effectiveness of the new arrangements. The annual report will cover local patterns and trends in child deaths, any lessons learnt, actions taken and the assessment of the effectiveness of the wider child death review process, including the anticipated impact of child death reviews.

In addition, the annual report will also include:

- identified issues in relation to safeguarding and promoting the welfare of children;
- record of how families have been supported in the child death review process;
- relevant lessons from the national review and analysis of child death cases that should be taken on board; and
- evidence of the impact of professional training offered during the year.

The annual report will be approved by the Chief Officers of the Kent and Medway CDR Partners on behalf of the respective organisations. Following such approval, the report will be made available online on the websites of:

- Kent and Medway CCGs;
- Kent County Council;
- Medway Council
- Kent Safeguarding Children Multi-Agency Partnership;
- Medway Safeguarding Children's Partnership.

As part of the facilitation of continuous learning and improvement, a stakeholder's event will be held mid-year where all CDR members/agencies will have the opportunity to discuss the revised way of working and how best to work together collaboratively. Following the implementation in September 2019, a further CDR conference will be held for members to evaluate the early implementation to inform what could be changed or modified as appropriate.

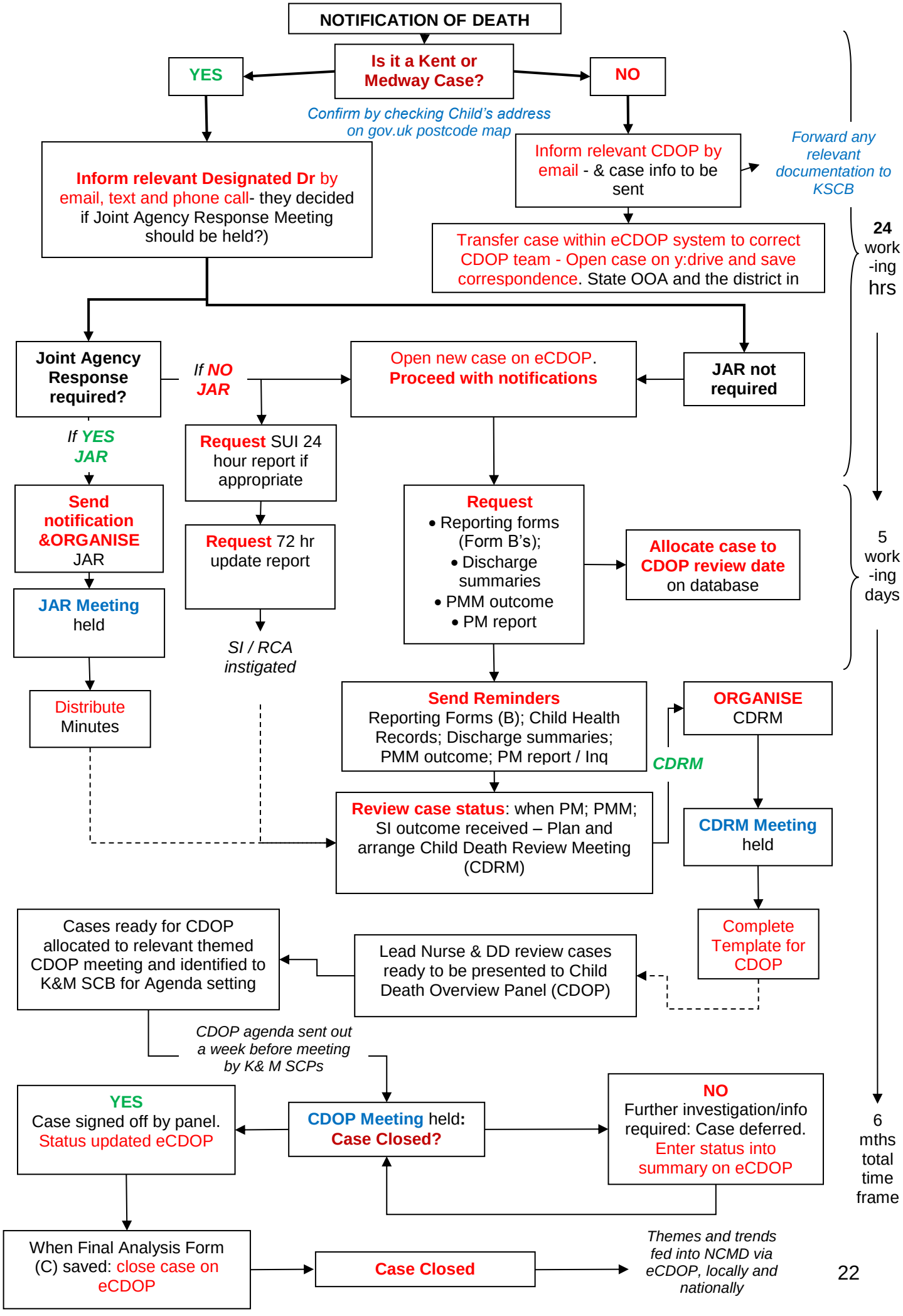
Terminology and abbreviations

The terminology and the abbreviations which are used in this area have specific meaning and to avoid confusing the reader, concise definitions of the key terms are described in the table below.

Term	Definition
Child Death Review (CDR) Partners	This is defined in the Children Act 2004, as amended by the Children and Social Work Act 2017, as the Local Authority and any Clinical Commissioning Group for an area any part of which falls within the local authority area
Child Death Review Process	This refers to the complete process described in this document from the moment of a child's death to the completion of the review by the Child Death Overview Panel (CDOP). *For the avoidance of doubt, it does not include stillbirths, late foetal loss, or terminations of pregnancy (of any gestation) carried out within the law*
Child Death Overview Panel (CDOP)	Is a multi-agency panel set up by CDR partners to review the deaths of all children normally resident in their area, and, if appropriate and agreed between CDR partners, the deaths in their area of non-resident children, in order to learn lessons and share any findings for the prevention of future deaths. This stage of the review process is described as a Child Death Overview Panel (CDOP) in this guidance
Child Death Review Meeting (CDRM)	Is the stage of the review process that precedes the independent multi-agency panel arranged by CDR partners. The nature of the meeting will differ according to the circumstances of the child's death and the practitioners involved and should not be limited to medical staff
Child	A child is defined in the Children Act 2004 as a person under 18 years of age
Chief Officers	In this document, it refers to the Accountable Officer for Kent and Medway Clinical Commissioning Groups (CCGs), the Head of Paid Service of Kent County Council and the Chief Executive of Medway Council
Allied Health Professionals (AHPs)	Professionals with skills, expertise and specialties that work with all age groups in a range of settings including hospitals, people's homes, clinics, surgeries and schools. They are regulated by an independent body
Relevant bodies	Organisations with specific responsibilities in relation to child death as described in the Working Together 2018 statutory guidance
Joint Agency Response (JAR)	A coordinated multi-agency response by health, police, social care which triggered to discuss and reach a decision about whether an investigation should be initiated if, a child's death is or could be due to external causes, is sudden and there is no immediately apparent cause, occurs in custody, or where the child was detained under the Mental Health Act, where the

	initial circumstances raise any suspicions that the death may not have been natural or in the case of a stillbirth where no healthcare professional was in attendance
National Child Mortality Database (NCMD)	A repository of data relating to all children's deaths in England which enable more detailed analysis and interpretation of all data arising from the child death review process, to ensure that lessons are learned following a child's death that learning is widely shared, and that actions are taken, locally and nationally, to reduce child mortality
Sudden Unexpected Death in Infant (SUDI)/ Sudden Unexpected Death in Childhood (SUDC)	A descriptive term used at the death of an infant or child whose death was 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 which led to the death

Appendix A: Kent and Medway Child Death Review Process Flowchart



Terms of Reference

Kent and Medway Child Death Overview Panel

1. Overview and Purpose

The Kent and Medway Child Death Overview Panel (CDOP) has been established, in accordance with the requirements of the Children Act, 2004 and Working Together to Safeguard Children, 2018, by the Kent and Medway Child Death Review (CDR) Partners i.e.: Kent and Medway CCG's; Kent County Council and Medway Council

The purpose of the Kent and Medway CDOP is to review all child deaths intervals up to the age of 18 years, normally resident in Kent and Medway, irrespective of the place of their death (excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law). The Kent and Medway CDOP will operate in accordance with 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.

2. 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 Child Death Review Meeting (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 at the earliest opportunity if 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 the National Child Mortality Database;
- To produce an annual report on local patterns and trends in child deaths, any lessons learned, and actions taken, and the effectiveness of the wider child death review process
- 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.

3. Operational Responsibilities

- Hold meetings at monthly intervals to enable the death of each child to be discussed in a timely manner.
- Hold themed meetings where CDR partners arrange for a single CDOP, or neighbouring CDOPs, to collectively review child deaths from a particular cause/group of causes. Such arrangements allow for the invitation of appropriate experts to inform

discussions, and/or allow easier identification of themes when the number of deaths from a cause is small.

- Ensure that effective 'rapid 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 Kent and Medway's Safeguarding Children's Partnerships respectively so that prompt action can be taken to prevent future such deaths where possible.

4. Governance and Accountability

- The CDOP is accountable to both the Kent and Medway Safeguarding Children's Partnerships respectively.
- The CDOP Chairs will provide a concise summary of the key points from each meeting to the Executive Leads of their respective safeguarding children partnerships.
- The CDOP will provide a report to both the Kent and Medway Safeguarding Children's Partnerships, summarising any recommendations from the reviews of child deaths, as required.

5. Membership

The Child Death Overview Panel will be chaired alternately by the Directors of Public Health in Kent and Medway respectively. This arrangement negates the requirement for a Vice-chair. The Chair should be appointed in accordance with The Child Death Review Statutory & Operational Guidance, which states*: "The CDOP should be chaired by someone independent of the key providers (NHS, social services, and police) in the area."* The core membership of Kent and Medway CDOP is detailed below:

- Public Health, Medway Council
- Public Health, Kent County Council
- Designated Doctor for child deaths *(and a hospital clinician if the Designated Doctor is a community doctor or vice versa)*
- Social services
- Police
- Safeguarding (Designated Doctor or Nurse)
- Lead Nurse for Child Deaths
- Primary care (GP or health visitor)
- Nursing and/or midwifery
- Lay representation
- Coroner's office
- Health & Wellbeing Board
- Ambulance Services
- CDOP Manager, Medway Safeguarding Children's Partnership
- CDOP Manager, Kent Safeguarding Children Multi-Agency Partnership (KSCMAP)
- Representative from KSCMAP Health Group

In addition to the core membership, relevant experts from health and other agencies will be invited as necessary to inform discussions, i.e.:

- Education
- Hospice
- Housing
- Council

Quoracy

The CDOP will be quorate if there are five or more core members present at the meeting. These must include representation, from Health, Kent County Council and Medway Council.

Responsibilities of Panel Members

Panel members should be familiar with their responsibilities and ensure that they read all relevant material in advance of panel meetings.

Decisions and Disputes

Decisions will normally be reached by consensus. In the event of a disagreement, a vote of members will be taken. In the event of a failure to resolve the issue, the Chair will have the casting vote or discuss with the CDOP Managers resolution of outstanding issues.

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 Overview Panel is STRICTLY CONFIDENTIAL and must not be disclosed to third parties, without discussion and agreement of the Chair.

8. Administrative Support

This will be provided alternatively by the Kent and Medway Safeguarding Children Partnerships, as appropriate, and will include:

- Agreeing the agenda with the Chair two weeks before the meeting
- Sending out the agenda and supporting papers at least one week in advance of the meeting
- Producing and sending out an action log to members no later than one week after the meeting
- Maintaining an up to date list of members and their contact details
- Providing administrative support as necessary for any task and finish groups
- Undertaking research on behalf of the group to enrich and improve local processes and procedures.

9. Publication

The Kent and Medway CDR arrangements will be published on the respective websites of:

- Kent and Medway's CCGs

- Kent County Council
- Medway Council
- Kent Safeguarding Children Multi-Agency Partnership
- Medway Safeguarding Children's Partnership

10. Review Date and Next Review Date

The terms of reference of the Kent and Medway CDOP will be subject to annual review, or more frequently, if required:

- Date of next review is March 2020