



Memorandum of Understanding between:

- **Bournemouth, Christchurch and Poole Council**
- **Dorset Clinical Commissioning Group**
- **Dorset Council**
- **Somerset Clinical Commissioning Group,**
- **Somerset County Council**

Author	Version	Created: June 2019
Dr S. Abdollahian	1.0	Review date: June 2020

1. Joint Statement

- 1.1 Bournemouth, Christchurch and Poole (BCP), Dorset Council, Dorset Clinical Commissioning Group, Dorset Council, Somerset Clinical Commissioning Group and Somerset County Council (hereafter referred to as the partners) share a common goal to support the Child Death Review Process across the partners' geographical footprint.
- 1.2 Following the publication of Working Together in 2018 and further child death guidance, a requirement for a child death review footprint of 60 deaths per annum was recommended.
- 1.3 Through this Memorandum of Understanding the partners agree to work together to provide high standard child death reviews.
- 1.4 This will benefit our communities by providing key learning from cases locally as well as reporting into the national child mortality database to identify themes of learning and thus potential advances in service delivery.
- 1.5 This document is not legally binding and cannot constrain any organisation in exercising their respective roles and responsibilities as directed by the Secretary of State.

2. Roles and Responsibilities

- 2.1 The partners, as set out in the Children's Act 2004, as amended in the Children's and Social work act 2017 will work together to ensure their statutory requirements are met.
- 2.2 Local Death Reviews remain the responsibility of the individual county, for example, the local review for a child death of a Somerset child will be the responsibility of the Somerset CCG and Somerset County Council. Out of area deaths will be reviewed on a case by case basis by the individual county. This will result in either a joint review between the county the child died and the county the child resided, or individually, depending on where potential learning lies. Standardised documentation will be used in both Dorset and Somerset using the eCDOP IT System which has been jointly procured.
- 2.3 The child death review partners will jointly provide the business support in each county to facilitate the child death review process. This will be in the form of Child Death Administrators (with specialised training), supported by their Business Managers using the eCDOP case management system. The business support arrangements will be reviewed annually to ensure it provides efficient and high quality support.
- 2.4 The child death partners have agreed to work together to provide and joint host Child Death Overview Panels as per the 'Terms of Reference' Document 'Appendix A' which is in keeping with national guidance.

3. Shared Purpose

- 3.1 Our shared purpose is to provide high standard child death reviews and ensure maximum impact of learning, which is shared in line with agreed governance structures with the safeguarding partnerships.

- 3.2 We will work together to professionally scrutinise every child death within Dorset and Somerset. We will ensure the voice of the family is heard in the reviews and key learning shared and recommendations made in line with local policy. We will also feed into national networks to share data and help identify potential themes which can only be identified at scale.

4. Our approach to joint working

- 4.1 The partners commit to transparent and open communication between our organisations to oversee joint working.

a) Ways of Working:

- Strategic - the organisations will work together to support each other in meeting our respective requirements around child death.
- Operational - the organisations will develop clear approaches to operational matters around the child death overview panels. Working efficiently and effectively to review deaths in line with guidance.
- Cultural – the organisations will seek to promote common values, creating a panel which provides respect for colleagues and a forum for open professional challenge to provide thorough death reviews.

b) The overarching approach to joint working will be characterised by:

- Openness and honesty.
- Transparency.
- Understanding of respective statutory roles, duties and powers, recognising the need to work collaboratively as well as individually.
- Engagement on issues of mutual interest and importance, including joint learning and development.
- Early and pro-active information sharing at a local, regional and national level.
- Trust in each other, providing and being open to professional challenge.
- Ambitious for our family and children involved in reviews to focus on the best possible reviews and creating impact from learning.

c) Delivering Joint Priorities

- To maintain an effective working relationship, the child death partners will ensure regular contact and close working. We will ensure the business support and administrative function for CDOP work together and this is reviewed annually to ensure it is working effectively.
- The Chair will work with the vice chair to ensure the combined panel is functioning in line with its quoracy arrangement and terms of reference (appendix a)
- It is expected each county will provide either the chair or the vice chair. Professionals in these roles will work together to ensure reports are submitted as per local safeguarding partnership governance arrangements and data fed into the national mortality database.
- Each county will agree to provide professionals as per the terms of reference to provide robust reviews.

- The partners will agree to host the CDOP panels central to each county border to minimise travel times.

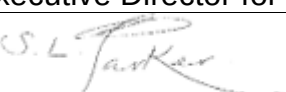
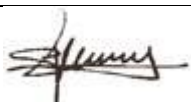
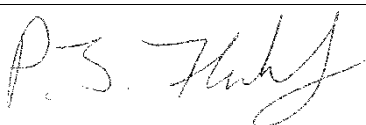
5. Reviewing the agreement

- 5.1 The terms of reference for the child death overview panel will be reviewed yearly.
- 5.2 This memorandum of Understanding will be reviewed annually but may be revised sooner if agreed by all parties.

6. Publication

- 6.1 The new Pan Dorset and Somerset Child Death arrangements will be published by the partners through the publication of this Memorandum of Understanding and the Pan Dorset and Somerset CDOP Terms of reference using their own websites as appropriate.

7. Signatories

Dorset	Bournemouth, Christchurch and Poole Council	Name: Judith Ramsden
		Job Title: Corporate Director Children's Services
		Signature: 
		Date: 14 June 2019
	Dorset Council	Name: Sarah Parker
		Job Title: Executive Director for People - Children
		Signature: 
		Date: 14 June 2019
	Dorset Clinical Commissioning Group	Name: Vanessa Read
		Job Title: Director of Nursing and Quality
		Signature: 
		Date: 14 June 2019
Somerset	Somerset Clinical Commissioning Group	Name: Sandra Corry
		Job Title: Director of Nursing
		Signature: 
		Date: 13/06/19
	Somerset County Council	Name: Pat Flaherty
		Job Title: Chief Executive
		Signature: 
		Date: 19 June 2019

APPENDIX A

DORSET AND SOMERSET CHILD DEATH OVERVIEW PANEL - TERMS OF REFERENCE

1. AUTHORITY AND PURPOSE

- 1.1 The Dorset and Somerset Child Death Overview Panel (CDOP) has been established following the publication of Working Together in 2018 and will be accountable to the Local Safeguarding Partnerships (LSPs) arrangements to be finalised in both Dorset and Somerset.
- 1.2 The combined numbers of deaths reviewed at the joint panel will ensure the recommendations in the child death guidance published as part of Working Together 2018 are met.

The purpose of CDOP is to review all the child deaths of children normally resident or registered with a GP in Dorset and Somerset, following the process defined in child death guidance;

- To progress local prevention agenda in respect of child death,
- To review the deaths of children and young people aged 0-17years,
- To ensure a coordinated response to unexpected child deaths,
- To collect and analyse information about child deaths in order to identify opportunities for the prevention of harm and child deaths that can be addressed locally, regionally and nationally.
- To professionally challenge to improve child outcomes
- To report data nationally as required to inform the national policy agenda
- Link with local LeDeR process for children with a formal diagnosis above four years of age

2.0 FUNCTIONS

- 2.1 CDOP will review, collect and analyse information about each child death and review each case to classify the cause of death, identify any modifiable factors associated with the case and decide on the preventability of each death.
- 2.2 The review will also identify any matters of concern affecting the safety and welfare of children, wider public health or safety concerns arising from a particular death or pattern of deaths.
- 2.3 Where a case indicates the need for a Serious Case Review, CDOP will make appropriate recommendations to the LSPs where further action is required.
- 2.4 The appropriateness of the response of professionals to the unexpected death of a child will be reviewed.
- 2.5 Contribute to neonatal network learning by sharing Form C's on our children
- 2.6 CDOP to lead review of children with learning difficulties and share learning with LeDeR process and where required ensure attendance of LeDeR reviewer to local review
- 2.7 The eCDOP system will be used to collect and collate an agreed minimum data set to support identification of any trends in local data and facilitate co-operation with regional and national initiatives to prevent unexpected child deaths.

- 2.8 The panel will ensure information is conveyed appropriately to families by all professionals and agencies involved. This will include clarity on the purpose of the child death review and its interdependency with any other concurrent investigations such as; criminal proceedings, coroner's inquest, serious incident, mortality review, safeguarding enquiries and serious case reviews.
- 2.9 A key function of CDOP is to identify lessons learned from the cases reviewed and to share with the appropriate agencies. This can include;
- Sharing any immediate lessons for health and social care providers or relevant agencies,
 - Make recommendations for consideration of care pathway or commissioned service reviews,
 - Liaise with Local Safeguarding partnerships in respect of any training requirements,
 - Consider wider sharing through health, education and care systems, designated professional network, CDOP chairs and Safeguarding Partnerships.
- 2.8 Provide an annual report to the Local Safeguarding Partnerships and relevant Mortality groups in Dorset and Somerset.

3.0 MEMBERSHIP

- 3.1 CDOP membership will be constituted by the following roles:

Panel Member Role	Organisation represented
Lay Member	TBD year 2
Designated Doctor for Child Death – Acute Paediatrician (each panel 1 rep)	Dorset Provider
Designated Doctor for Child Death – Acute Paediatrician (each panel 1 rep)	Somerset Provider
Designated Doctor for Child Death – Community Paediatrician (each panel 1 rep)	Dorset Provider
Designated Doctor for Child Death – Community Paediatrician (each panel 1 rep)	Somerset Provider
Children's Social Care representative	Dorset Council
Children's Social Care representative	Somerset County Council
Police Representative	Dorset Police
Police Representative	Avon and Somerset Police
Designated Professional for Child Safeguarding or CCG representative – 1 rep rotating between Dorset CCG and Somerset CCG	Dorset CCG
	Somerset CCG
Public Health representative –1 rep rotating between PH Dorset and PH Somerset	PH Dorset
	PH Somerset
Primary Care representative –1 rep rotating between Dorset and Somerset	Dorset
	Somerset
Nursing representative	Dorset Provider or CCG
Nursing representative	Somerset Provider or CCG
Ambulance Service representative	Ambulance Provider
Co-opted members	
Education rep	Somerset

Neonatal Panel:

Neonatal reviews need to link with perinatal mortality review group meeting in the case of a baby who dies in a neonatal unit, or a hospital-based mortality meeting following the death of a child in a paediatric intensive care unit. The neonatal unit where the baby died should lead the review but link with other health and care providers who have been involved with the child or family Supported by the use of the Perinatal Mortality Review Tool (PMRT) The learning from these twice yearly themed panels will be fed back into the south west neonatal network, for Somerset and Thames Valley and Wessex neonatal network.

Membership:

Designated Dr from each county

Midwifery representative from different provider to that represented by designated Dr

Obstetric representative from one of the Somerset Providers (Taunton when meeting in Yeovil, Yeovil when meeting in Dorchester)

Social care representative from each county

Health Visitor rep

? neonatal network link

Business Support representative

3.2 Co-opted members will be drawn from the following, and otherwise as deemed appropriate by the Panel chair;

- Appropriate clinicians and managers from secondary care disciplines for example Obstetrician, Neonatologist, Child Psychiatrist,
- Tertiary care specialists,
- Police specialist investigations unit
- Patient Safety Manager,
- Local Area Contact for Learning Disability Mortality Reviews (LeDeR),
- Coroner's Officer,
- Other statutory bodies.

3.3 All panel members and co-opted members will have signed a confidentiality statement annually. Observers are welcome to attend the panel following the agreement of the Chair and will sign a confidentiality agreement prior to the start of the meeting.

4.0 QUORACY

4.1 The CDOP meeting will be considered quorate when the following core members or their agreed deputies are present;

- Designated Doctors for child death (1 attending for each county and preferably one acute and one community paediatrician),
- Social Care representatives (2 Local / Unitary Authority representatives 1 for each county),
- Police Force representatives (1 each from Dorset and Avon and Somerset)
- Child Safeguarding representative
- Public Health representative
- Primary Care representative

4.2 The quorum should include one representative each for Dorset and Somerset Clinical Commissioning Group (CCG). Core members may represent two or more roles.

- 4.3 The Chair and Vice Chair will be selected from the core membership of the panel and each meeting will be administratively supported by one of the Dorset and Somerset CDOP administrators.

5.0 FREQUENCY OF MEETINGS

- 5.1 CDOP will meet a minimum of 8 times a year to include 6 panels and 2 neonatal panels.
- 5.2 Panels will be held equally in Dorset and Somerset with Yeovil and Dorchester being the preferred locations and will have a balanced representation of Dorset and Somerset panel members.
- 5.3 The dates of meetings will be set for a year in advance with core member required to attend or send an agreed deputy.
- 5.4 The anonymised and collated information on the cases to be discussed at each panel will be sent to all panel members and co-opted members two weeks in advance of the CDOP, so that they can be read in advance of the meeting.

6.0 FREQUENCY OF REVIEW

- 6.1 The Terms of Reference will be reviewed annually to reflect the planning cycles of the Local Safeguarding Partnerships.

These TORs are for one year, after which process will be evaluated.

Version: 1.0

Date Agreed: 23.05.2019

Review Date: 23.05.2020