NCMD

National Child Mortality Database

Knowledge, understanding and learning to improve young lives

Implementing Working Together to Safeguard Children Changes

Tuesday 14th October 2025

11.30am to 12.45am

Implementing Working Together to Safeguard Children Changes

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14 October 2025

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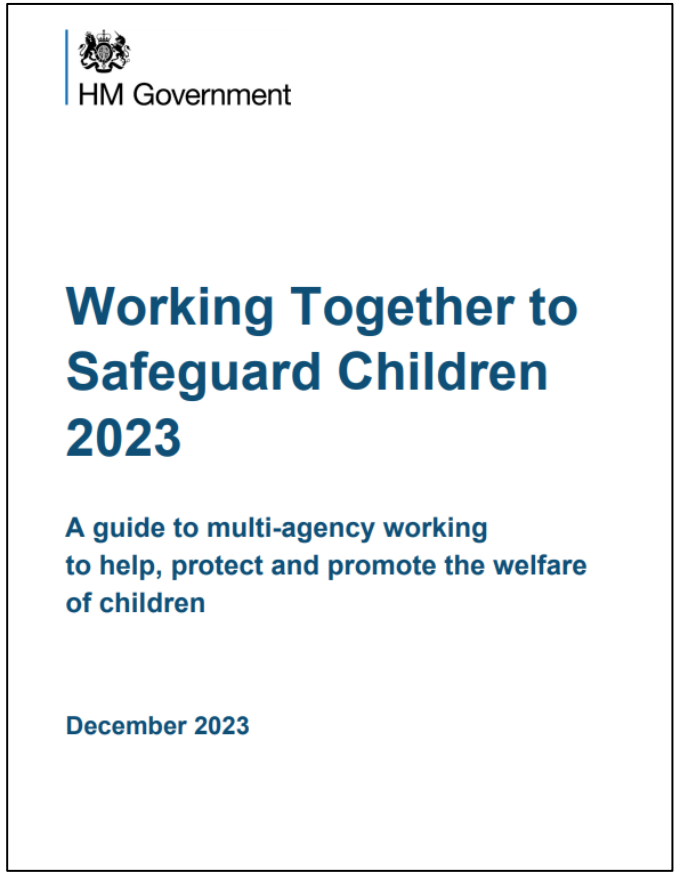
Knowledge, understanding and learning to improve young lives

What will this webinar cover?

- Re-cap of WT changes
- ICB changes to funding
- Walk through of changes to eCDOP system
- What to do if you are not using eCDOP
- Power BI reports
- Guidance for CDOPs (scenarios)
- Questions and discussion

Summary of Updates to Working Together

- 'Child death review partners' are defined as the local authority and any Integrated Care Boards (ICBs) operating in the local authority area.
- The term 'Child Death Overview Panel (CDOP) framework' has been replaced with **Child Death Review Statutory and Operational Guidance (2018)**
- The language describing the responsibility of 'child death review partners' towards the review of deaths of non-resident children who have died in their area on behalf of their CDR partners has been strengthened ('*if they consider it appropriate'* to '*as indicated'*).
- It reflects new guidance requiring coroners to send post-mortem reports to CDOPs for relevant child death reviews.
- It reflects changes of name by removing independent review by 'child death review partners' and replacing with 'child death overview panel'.
- The language around the responsibility to inform relevant safeguarding partners and the Child Safeguarding Practice Review Panel where there has been evidence of abuse or neglect has been strengthened to include all professionals.



Requirements of the Children Act 2004

- Section 16(M) of the Act makes provision for CDOPs to review the deaths of both resident and non-resident children
- The purposes of a review or 'analysis of information' under this section of the Act are:
  - 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**, and
  - to consider whether it would be appropriate for anyone to take action in relation to any matters identified

Review of non-resident deaths by CDOP

- In the previous version of Working Together the language used contributed to inconsistencies amongst CDOPs in the review of deaths of children not-normally resident in their area
- There are two broad groups of non-resident children.
- Group 1: Those children who are normally resident in England and die in England but outside of their area of normal residence
- Group 2: Those children who are normally resident in one of the devolved nations and die in England
- Group 3: Those children who are normally resident in another country and die in England
- The purpose of child death review is to learn from deaths in order to reduce the number of children who die. It is therefore important that all deaths are learned from.
- The Children Act requires that CDOPs must make arrangements for the analysis of information of **deaths of children in their area** so they can be satisfied that they have learned from all deaths and that any possible themes or patterns are picked up on
- To avoid duplication of effort, in every case, there must be agreement between CDOPs concerning which CDOP will conduct the review.

ICB Funding Changes

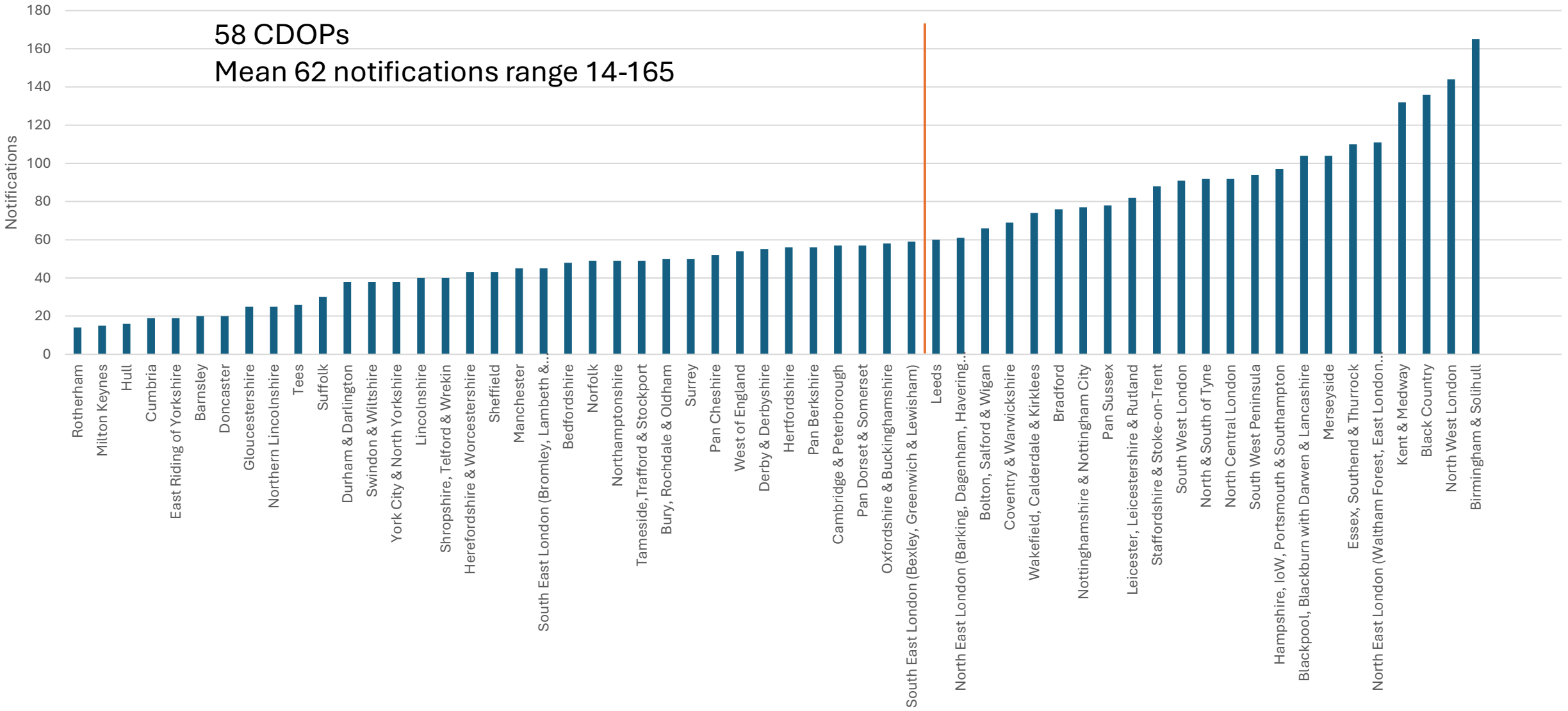
- ‘Clustering’ of ICBs – potential CDOP mergers and reduced funding
- 5.1.2 CDR statutory operational guidance
- CDR partner footprints should be locally agreed; they should be aligned to existing networks of NHS care and other child services and should take account of agency and organisational boundaries. They should cover a child population such that they typically review at least 60 child deaths each year. Reviewing at least 60 deaths each year will 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, ultimately, save lives.
- ICB funding and clustering not yet known – but CDR remains core ICB function

Thirlwall Inquiry

- Local CDOP not aware of deaths of non-resident babies
- Unable to identify potential concerns ‘not full picture’

- Lack of clarity over starting JAR/SUDIC when collapse occurs in hospital
- Update to CDR guidance and Kennedy/SUDIC guidelines should address this

Notifications by CDOP 2024



Challenge – Local vs Regional Learning

- Local learning should be identified by robust Child Death Review Meetings
  - These are held by organisation where most learning is likely to be identified – no change
  - CDOPs should not redo Child Death Review Meetings
- Larger CDOPs are better able to identify themes or unusual cases, or make comparison between different trusts – so identify local themes
- Larger CDOPs still need good local connections
- CDOP mergers may reduce inequity – but need to avoid a ‘race to the bottom’

Live Walk-Through of changes to eCDOP

What to do if one CDOP does not use eCDOP

- If you are a CDOP not using eCDOP who has an out of area death, you should contact the CDOP in the area of death via email to arrange how you are going to work together and who will “own” the case
- Things to agree:

- Who will review the death? Whichever CDOP this is will be the one responsible for creating the case (either in the NCMD portal or eCDOP)
- Which reporting form requests will be sent out by which CDOP? Will each CDOP request their local forms? All forms should be sent back to the CDOP reviewing the death
- How will feedback from the CDOP review be provided to the non-reviewing CDOP?

- If you are a CDOP that uses eCDOP and you have a death that occurs in an area where the CDOP does not use eCDOP, you should also follow the above process

NCMD Reporting Tool

Deaths by hospital trust

NCMD Reporting – Deaths by hospital trust

NCMD have developed a new report which will provide each CDOP with the **total** number of deaths that **occurred in a hospital within their footprint.**

Aim: to provide the total number of deaths (resident and non-resident) by Trust/Hospital/Place of death/Age group, as a way for CDOPs to have oversight on deaths that occurred in a hospital trust in their area.

The report will also provide information on which CDOP is reviewing these deaths.

Format: online interactive report developed in PowerBI. Each user will only see the data for deaths in trusts that are within their CDOP footprint (i.e. you will not see all hospital trusts across England). To do this, we developed a mapping of all hospital trusts to CDOPs.

NCMD Reporting – Deaths by hospital trust

- The report does cover:
  - All deaths that occurred in a hospital located within the CDOP footprint (both deaths of residents and non-residents).
  - By age group, trust/hospital, place (e.g., NICU/PICU).
  - The CDOPs responsible for the child death review.

- The report does not cover:
  - Deaths where the place of death is **not** recorded as 'hospital' (e.g., deaths that occur in the community).
  - Deaths that occurred in a hospital trust outside of England.
  - Rates of death.
  - Deaths that your CDOP are reviewing that occurred in a hospital trust located outside the geographical footprint of the CDOP. However, this is provided in the quarterly Data Quality and Monitoring Report.

This report is a starting point.

Walk-Through of NCMD reporting tool

Hospital trusts and CDOPs have been anonymised for the purposes of this demonstration

What to consider when deciding which CDOP should review a death (Statutory Guidance 5.5.1 & 2)

- While in all cases, the CDR partners in the area where the child is normally resident is responsible for ensuring that a CDOP review takes place , legislation allows for CDR partners to make pragmatic arrangements for the review of a death in their area of a child not normally resident there
- This should be guided by which area is likely to derive the most learning in each type of death

Type of death	Suggested CDOP to review
Trauma deaths occurring in a public place (e.g. drowning, road traffic collision)	CDOP in the area of the accident
SUDIC, suicide or homicide	CDOP in the area of residence (shared learning vital)
'Looked after' child	CDOP in the area of death (WT, 2023)
Neonatal deaths and deaths of children under specialist care (e.g. cardiac or oncology)	CDOP in the area where the majority of **recent** clinical care has been given. This might include babies who have been born and died in a tertiary hospital where antenatal care has been given there
Children with chronic or life-limiting conditions on complex, regional care pathways	CDOP in the area of residence

Other sources of information for CDOPs

- In order to comply with the Children's Act requirements, CDOPs should have knowledge of the numbers and causes of deaths within their area.
- CDOPs can obtain information on deaths in their area which they have not reviewed from a number of different sources
  - NCMD Power BI reports
  - 'Outlier reports':
    - PICAnet data dashboard shows data on paediatric intensive care admissions in the UK - https://www.picanet.org.uk/data-collection/picanet-data-dashboard/
    - PMRT standardised real-time mortality trend analysis data; 'Reading the Signals' Neonatal outcome working group
  - Coroner's regulation 28 reports to prevent future deaths can be accessed here - https://www.judiciary.uk/courts-and-tribunals/coroners-courts/reports-to-prevent-future-deaths/

Scenario 1

Hospital A: DGH with level 2 neonatal unit

Case: 28-week gestation non-resident baby. Now 4 weeks old. Died post aspiration event

Q. Which CDOP should be reviewing this case?

Q. If CDOP co-located with the DGH reviews this case, how should they set about it?

Scenario 2

Hospital B: Tertiary children's hospital with large cardiac surgical program

Case: 4-week gestation non-resident baby. Died post arterial switch operation.

Q. Which CDOP should be reviewing this case?

Q. If CDOP co-located with the tertiary children's hospital reviews this case, how should they set about it?

Scenario 3

Hospital C: Tertiary children's hospital with major trauma centre

Case: 15-year-old non-resident child. Involved in RTA 120 miles away. Pre-hospital care->DGH-> tertiary hospital. Died in PICU.

Q. Which CDOP should be reviewing this case?

Q. If CDOP co-located with the accident reviews this case, how should they set about it?

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Questions and Discussion