Agenda item 3

DERBYSHIRE HEALTH AND WELLBEING BOARD

New Arrangements for the Child Death Review Partners and the Child Death Overview Panel

Report of the Director of Public Health and the Designated Nurse for Safeguarding Children

1. Purpose of the Report

- To update the Board on the new arrangements for the review of all children's deaths in Derbyshire County and Derby City.
- Discuss any pertinent issues in relation to the new national requirements for the Child Death Review Partners (CDRP) and the Child Death Overview Panel (CDOP).
- To approve new reporting arrangements for CDRP and CDOP that includes the Board receiving regular updates from the CDRP and CDOP.

2. Information and Analysis

The Children Act (2004), as amended by the Children and Social Work Act (2017), strengthens an already important relationship by placing new duties on key agencies in a local area. Specifically the Police, Clinical Commissioning Groups (CCG's) and the Local Authority are under a duty to make arrangements to work together, and with other partners locally, to safeguard and promote the welfare of all children in their area (Working Together 2018).

The arrangements to review child deaths have been amended as part of Working Together (2018) in Chapter 5 – Child Death Reviews. The key features of what a good child death review process should look like is detailed in the Child Death Review Statutory and Operational Guidance (2018).The processes in these two documents combines best practice with statutory requirements that must be followed.

The responsibility for ensuring child death reviews are carried out is held by the Child Death Review Partners, who are defined as the Local Authority for an area and any Clinical Commissioning Groups operating within the local authority area (Working Together 2018). Within the new arrangements the Child Death Review Partners will be the Local Authorities for Derbyshire and Derby City and the Derbyshire CCG's. This information and the local context is covered in more detail in the full local position paper attached to this covering report.

3. Recommendation

- That the Board acknowledges the information and local implications covered within the attached paper.

- That the Board acknowledges the progress to date and also the local challenges in having all required functions in place by the requisite deadline.

- That the Board agrees to form part of the new governance arrangements for the Child Death Review Partners and Child Death Overview Panel, this will be alongside the role of the Childrens Safeguarding Board.

Dean Wallace, Director of Public Health, Derbyshire County Council

Juanita Murray, Designated Nurse Safeguarding Children and Chair of CDOP, NHS Derby and Derbyshire CCG

New Arrangements for the Child Death Review Partners and the Child Death Overview Panel – CDOP

Derbyshire and Derby City

Position Paper

Purpose of the Paper

The purpose of this paper is to outline the changes required for the review of all children's deaths in Derbyshire and Derby City in line with Working Together to Safeguard Children (2018) and the Child Death Review Statutory and Operational Guidance (2018). This paper gives a summary of the changes required and the current position of the Child Death Overview Panel (CDOP). The paper outlines an analysis of the gaps in provision that will need to be supported to ensure a seamless transition from the current arrangements to the Child Death Review Partners which need to be in place by 29th September 2019.

Introduction and Background

The Children Act (2004), as amended by the Children and Social Work Act (2017), strengthens an already important relationship by placing new duties on key agencies in a local area. Specifically the Police, Clinical Commissioning Groups (CCG's) and the Local Authority are under a duty to make arrangements to work together, and with other partners locally, to safeguard and promote the welfare of all children in their area (Working Together 2018).

The arrangements to review child deaths have been amended as part of Working Together (2018) in Chapter 5 – Child Death Reviews. The key features of what a good child death review process should look like is detailed in the Child Death Review Statutory and Operational Guidance (2018).The processes in these two documents combines best practice with statutory requirements that must be followed.

The responsibility for ensuring child death reviews are carried out is held by the Child Death Review Partners, who are defined as the Local Authority for an area and any Clinical Commissioning Groups operating within the local authority area (Working Together 2018). Within the new arrangements the Child Death Review Partners will be the Local Authorities for Derbyshire and Derby City and the Derbyshire CCG's.

The statutory guidance requires the partners to review all births where there are signs of life until a child's 18th birthday. Working Together (2018) describes the purpose of a review and analysis of a child's death, is to identify any matters relating to the death, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters which will include the assurance that families are receiving appropriate bereavement support.

There is a requirement that the Child Death Review Partners should publicise information on the arrangements for child death reviews in their area and formally notify NHS England. The

aim is to align the timing of the new arrangements to the new local multi-agency safeguarding arrangements.

The arrangements should include:-

- Which Local Authority and Clinical Commissioning Group partners are identified

- Who the accountable officials are (the Local Authority Chief Executive and the Accountable Officer/ Chief Executive Officer of the Clinical Commissioning Group)
- What geographical area is covered.
- Information on the Designated Doctor for Child Deaths.

Transition Period

From the 29th June 2018, Local Authority areas must begin their transition from Local Safeguarding Children Boards (LSCB) to Child Death Review Partner arrangements. The transition must be completed by 29 September 2019.

- LSCBs must continue to ensure that the review of each death of a child normally resident in the LSCB area is undertaken by the established CDOP until the point at which the new child death review partner arrangements are in place.
- Following the commencement of the new child death review partner arrangements, LSCBs in the area have a statutory 'grace' period of up to 4 months to complete any outstanding child death reviews. Any CDOP set up under LSCB arrangements may not undertake any new child death reviews during this 4-month period.
- The latest date for completion of any review of a death that occurred before the 29th September 2019 is the 29th January 2020.

Current Position

CDOP was established in 2008 and is a joint arrangement between Derbyshire and Derby City. The administration for CDOP is hosted and managed by Derbyshire Healthcare FT (DHCFT) and currently funded by the CCG. CDOP is a sub group of Derbyshire and Derby City's Safeguarding Children's Boards.

The new Child Death Review Statutory and Operational Guidance (2018) suggests that CDOPs should work together and review at least 60 deaths per year. Derbyshire and Derby City have already established a joint CDOP and meet this requirement. (See table 1 below)

The CDOP arrangements have met the current requirement of reviewing the deaths of all resident children in the Derbyshire and Derby City area. This can be evidence in the CDOP annual reports that have been submitted to both Safeguarding Children Boards over the years. The new statutory guidance is more explicit in the requirements and responsibilities of CDOP. The Child Death Overview Panel will be the last point of review of all child deaths. There is a greater role for the health providers to ensure that a robust Child Death Review Meeting takes place. There is a requirement to have a robust arrangement in place to extract the learning from child deaths and to ensure that this is shared locally and nationally through the new National Child Mortality Database.

The current input from Paediatricians to CDOP is:-

- 1 session from Chesterfield Royal Hospital Foundation Trust
- 1 session from Community Paediatrics Derbyshire Healthcare Foundation Trust
- Neonatologists attends a themed panel 4 times a year from the University Hospitals of Derby and Burton Foundation Trust year

- Consultant Paediatrician from the University Hospitals of Derby and Burton Foundation Trust

Currently all four Paediatricians prepare the cases and present at CDOP

Table 1

Numbers of child deaths over the last 5 years in Derbyshire and Derby City

Year	1 and under	2-17	Total
2013-14	46	22	68
2014-15	36	18	54
2015-16	40	22	62
2016-17	33	17	50
2017-18	61	10	71
Total	**216**	**89**	**305**

Table 2

Current position of open cases up to 1st March 2019 in Derbyshire and Derby City

Children

Year of Death	Number of cases outstanding for CDOP
2017	4
2018	25
2019	6

The Current total of deaths of children to be reviewed by CDOP is 35

Table 3

Neonates

Year of Death	Number of cases outstanding for CDOP
2018	9
2019	7

Current total number of neonatal deaths to be reviewed by CDOP is 16

Number of deaths awaiting Inquest and cannot be reviewed is 14

Total number of deaths to be reviewed and closed is 51

Analysis

The Child Death Overview Panel has been functioning for a number of years with a strong engagement from a wide range of partners who are committed to ensuring that any learning from child death is utilised and shared within the partnership locally and nationally.

There are currently 7 CDOP meetings arranged between March and September 2019. During this period there will be additional new deaths to review. Those deaths that occur before September 2019 will be reviewed under the current arrangements and any deaths that occur from the 29th September 2019 will be reviewed under the new arrangement.

Two of the planned meetings are neonatal themed panels which leaves 5 panels to review all other deaths. This is approximately seven deaths per panel not taking into account those new deaths that occur between now and September.

Plan for completion of cases

There has been a considerable amount of work and data cleansing to ensure that CDOP have a clear picture of the position of cases and what needs to be achieved before the new arrangements commence.

The CDOP task and finish group are formulating a plan for the completion of cases within the limiting parameters of Inquests and Safeguarding Practice Reviews. The priority will be to hear the older cases first, this will form part of the task and finish group action plan. Each panel will have to be fully utilised and there may be a requirement of extra panels to complete the work within the statutory timescales.

In regard to the neonatal themed panels there are smaller numbers of cases however there are only two panels before September 2019 to discuss these cases it will be a challenge to close all of these cases before the end of September 2019.

The progress of the cases being reviewed will be reported quarterly to the Child Death Review Partners and to the Safeguarding Children Boards and any concerns in not completing case discussions will be highlighted accordingly.

Inquests

At present there are fourteen cases to be heard at inquest. The timeframe for these cases are unknown and in the new statutory guidance these cases should not be heard at CDOP until completion of the inquest. CDOP has no influence on the coroner's processes or when cases are set to be heard.

The Chair of CDOP, one of the Paediatricians and the Police lead for CDOP have met with the coroner and discussed the Child Death Review Process. The coroner is aware of the statutory requirements around timeliness of the CDOP review and informed us he has increased resources and capacity within the coronial system.

Gap Analysis of Statutory Guidance and Case for Change

The new Child Death Review Statutory and Operational guidance was published in October 2018, however plans for change have been in motion since the publication of Working Together (2018). In order to progress and implement the new statutory CDOP arrangements

the Chair of CDOP has set up a task and finish group which consists of Paediatricians, Public Health, Police, Social Care and the CDOP Coordinator. There are seven work streams addressing a number of areas that need to be progressed.

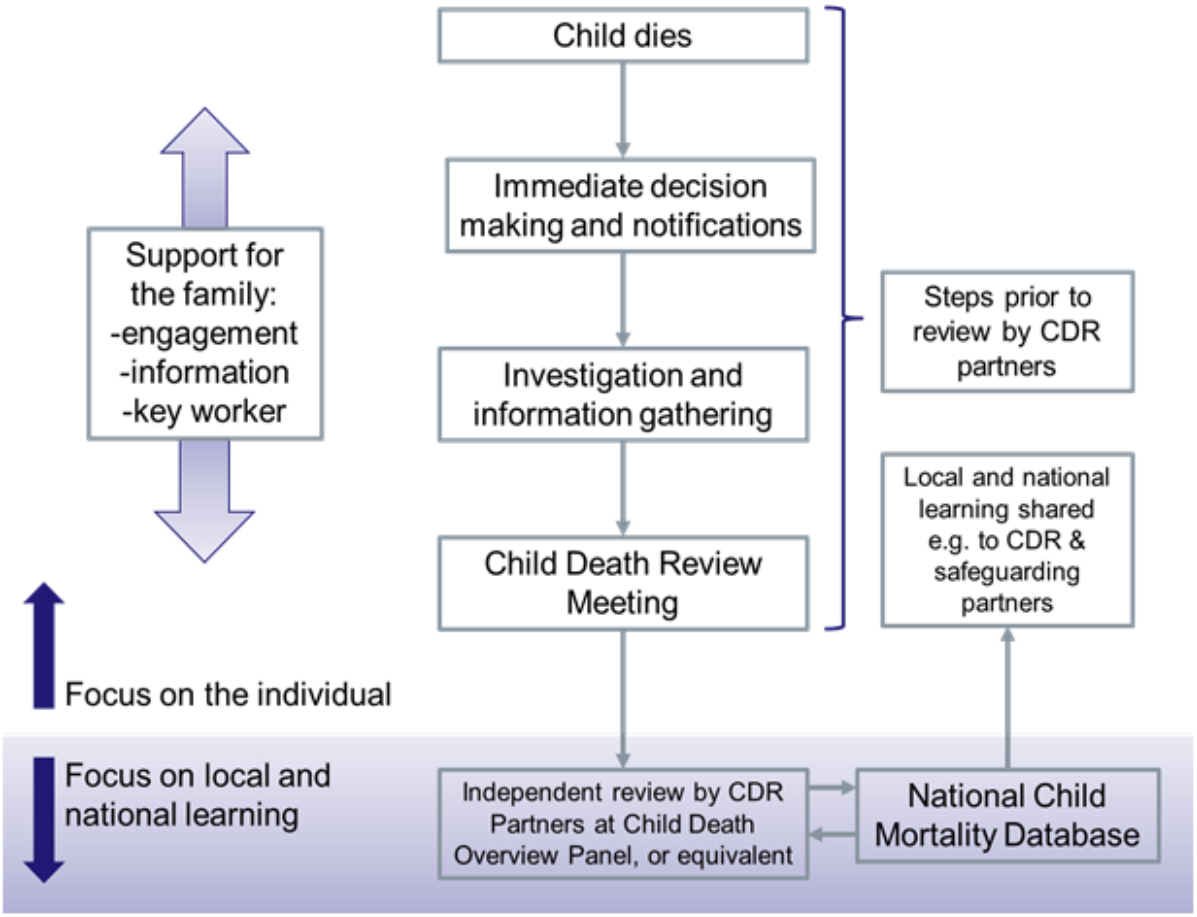
The main purpose of the CDOP task and finish group and work streams is to review what processes and resources are currently in place and how CDOP will meet the requirements of

the new arrangements. The group will have an understanding of what needs to reviewed, changed, implemented and resourced.

The time line for these changes to be progressed can be seen in appendix 1

The table below depicts the processes that need to take place prior to the Child Death Overview Panel reviewing a child's death:

Table 4



Gaps Identified:

In reviewing the statutory guidance the fundamental gaps for Derbyshire and Derby City Child Death Review Partners are:-

- Designated Doctor for Child Death
- Link/Key worker to liaise with families, relevant partners and health providers around the child death review process

- The establishment of consistent Child Death Review Meetings within the health provider organisation where a child has received their care or has died
- Pathways linking with other processes for example the Safeguarding Practice Reviews and the Learning Disabilities Mortality Review (LeDeR) process

Task and Finish Group and Action Plan

A task and finish Group has been established and several work streams are ongoing and changes are being made to the CDOP processes as required. A great deal of work has been achieved by the group within a short time period.

Table 5

Work Stream	Progress up to March 2019
Role of Designated Doctor	Business Case submitted awaiting decision from Child Death Review Partners.
Link/Key Worker role	Business Case submitted awaiting decision from Child Death Review Partners.
Pathways	SCR and LeDeR pathways being developed with partners. Pathway between CCG/Providers and CDOP concerning Serious Incident Reporting will be developed.
Process	Business Case for *e CDOP* (end to end case management system) has been agreed by the Child Death Review Partners awaiting formal agreement of funding.
Child Death Review Meeting	Paediatricians have been working in their own provider organisations to develop these meetings with no additional resource. This will be part of the role of the Link/Key Worker.
Terms of Reference	Now completed, see attached in appendices.
Review of the SUDIC Procedures	Review and update complete, the document will go to Policy and Procedure sub group of the LSCB for agreement in May 2019.
Links with the Coroner	Visit made to the coroner by the Chair and members of CDOP to discuss inquests and the Child Death Review Process.

The progress of the action plan and the work of the task and finish will be reported to the Child Death Review Partners quarterly, to the Safeguarding Children Board and to the Derbyshire CCG's Quality & Performance Committee.

Commissioning and/or funding requests that are identified will need to progress through the Local Authorities and Derbyshire CCG's processes.

Benefits of implementing the statutory changes

- The Child Death Partners will meet the statutory requirements as set in the child Death Overview and Operational Statutory Guidance (2018).
- The establishment of the new arrangements will enable a more thorough and robust process for reviewing all children's deaths.
- The learning from child death cases will be formalised and be available promptly to the partnership.
- The timeliness of reviewing cases will be within the timescale of 6 months for child deaths and 12 months for neonates and any exceptions in not meeting the timescales will be reported quarterly to the Child Death Review Partners with clear reasoning for the delay.
- Families will have a specialist health professional who will be a contact point who is a clinician and will have the responsibility to help families navigate the child death process.
- There will be assurance that families are offered or are receiving bereavement support in a timely way to meet their individual needs.
- The Child Death Review Meetings will have a consistent approach and a framework to feed into the Child Death Overview Panel process.

- There will be increased assurance to the Child Death Review Partners that CDOP and the child death process is efficient and meeting the statutory requirements. Any problems or concerns will be identified at an early point and a plan for mitigating or managing any risk will be put in place.
- CDOP will identify any learning points or themes that may influence service improvement and development both locally and nationally.
- *e CDOP* will provide a safe and secure electronic end to end case management system for all child deaths. This will automatically feed into the National Child Mortality Database.
- Reporting all deaths through the National Child Mortality Database is a statutory requirement from the 1st April 2019. Themes and trends will be identified.

Options Appraisal

There has been very little financial resource allocated or aligned into the Derbyshire and Derby City CDOP from the current Safeguarding Children Boards. The current identifiable resource from Derbyshire CCG is;

- 1 session of Consultant Paediatrician at Chesterfield Royal Hospital Foundation Trust (CRHFT) funded by the Derbyshire CCG's.
- 1 session of Consultant Community Paediatrician from Derbyshire Healthcare Foundation Trust (DHCFT) this is part of the Community Paediatrician Service and aligned to the SUDIC statutory requirement. The Community Paediatric Service Specification is being reviewed by Derbyshire CCG's Children's Commissioners.
- 3 days a week CDOP Coordinator Band 4 hosted by Derbyshire Healthcare Foundation Trust (DHCFT)

There is also work completed for CDOP by a Neonatologist and a Hospital Paediatrician which is not currently funded but agreed as part of the safeguarding partnership working arrangements.

Child Death Review Meeting

There is an expectation in the statutory guidance that the preparation for CDOP such as the Child Death Mortality Meetings will be completed by the health provider where the child has died. The Child Death Review Meeting brings together all professionals that have known and worked with the child and family both from the hospital setting and within the community. This is an opportunity to gather information and to start to make an analysis of this information which will help populate the CDOP analysis form. There is an opportunity to ensure that any learning is identified early and to be assured that families are receiving

appropriate bereavement support that meets their needs. Work will need to be completed by the Designated Doctor for Child Death and/or the Link/Key worker to work together to support the health providers to ensure this happens with a consistent approach across the Derbyshire and Derby City footprint. Without these meetings taking place the cases cannot be heard at CDOP which may create further delay.

In order to implement the above and required changes below there are a number of options put forward on ways that the key partners can look to meet the requirements of the new CDOP statutory arrangements:

Option 1 – Advised Option (amended from 1st Positions Paper)

- *e CDOP* (electronic management system to ensure the secure and efficient management of the child death review process and CDOP)
- Sessions allocated for the CDOP Coordinator to remain unchanged.
- 2 sessions of Designated Doctor Child Death formalised with a Job Description and Service Level Agreement between the Derbyshire CCG and health provider (s)
- Fulltime band 7 Lead Nurse for Child Death Review Process for the Derbyshire/ Derby City footprint managed in the Derbyshire CCG's Safeguarding Children Team

Option 2

No further resource is allocated. This option will not meet new statutory requirements and will not meet the required changes needed to the Child Death Review Process. This will be a risk to the Child Death Review Partners.

Governance and Reporting Arrangements

At present CDOP is a sub group of the Derby and Derbyshire Safeguarding Children's Boards and reports quarterly to the Boards and also presents a CDOP Annual Report. Going forwards there will be oversight of the child death review arrangements within the new Safeguarding Partnership.

The Local Authority partner and representative have been identified by Derbyshire County Council and Derby City Council. The lead will be taken by Public Health. The two Directors of Public Health and the Chair of CDOP have met for preliminary discussions on the resourcing arrangements and the governance and reporting requirements for the Child Death Review Process.

The CCG Partner will be the Director of Quality/Chief Nurse of the Derby and Derbyshire CCG.

The partners will meet with the Chair of CDOP to have further discussions and to formalise the governance and reporting mechanisms.

The reporting will include the timeliness of cases, quality of information from the Child Death Review Meetings and learning gained from the reviews. Exceptions, risk and concerns from cases will also be highlighted as part of the reporting processes.

There will also need to be a process established in gaining and sharing Information from local and national networks and sharing of the data from the National Child Mortality Database.

Conclusions

1. The Local Authorities (Derby City and Derbyshire) have identified the two Directors of Public Health as the representation of the Child Death Review Partnership to work alongside the Derby and Derbyshire Clinical Commissioning Group to progress and implement the new statutory arrangements.
2. The new arrangements will require a financial commitment from the Child Death Review Partners and this will need to be agreed.
3. Two business cases have been written regarding the resourcing of the statutory arrangements. These have been shared with the CCG and the two Local Authority partners.

4. *e CDOP* has been agreed, the funding needs to be confirmed and then the system implemented as a priority as reporting into the National Child Mortality Database commences on 1st April 2019.
5. The Chair of CDOP will need to be in a position to publish the new Child Death Review Partnership Arrangements to the DOH and NHSE by June 2019.

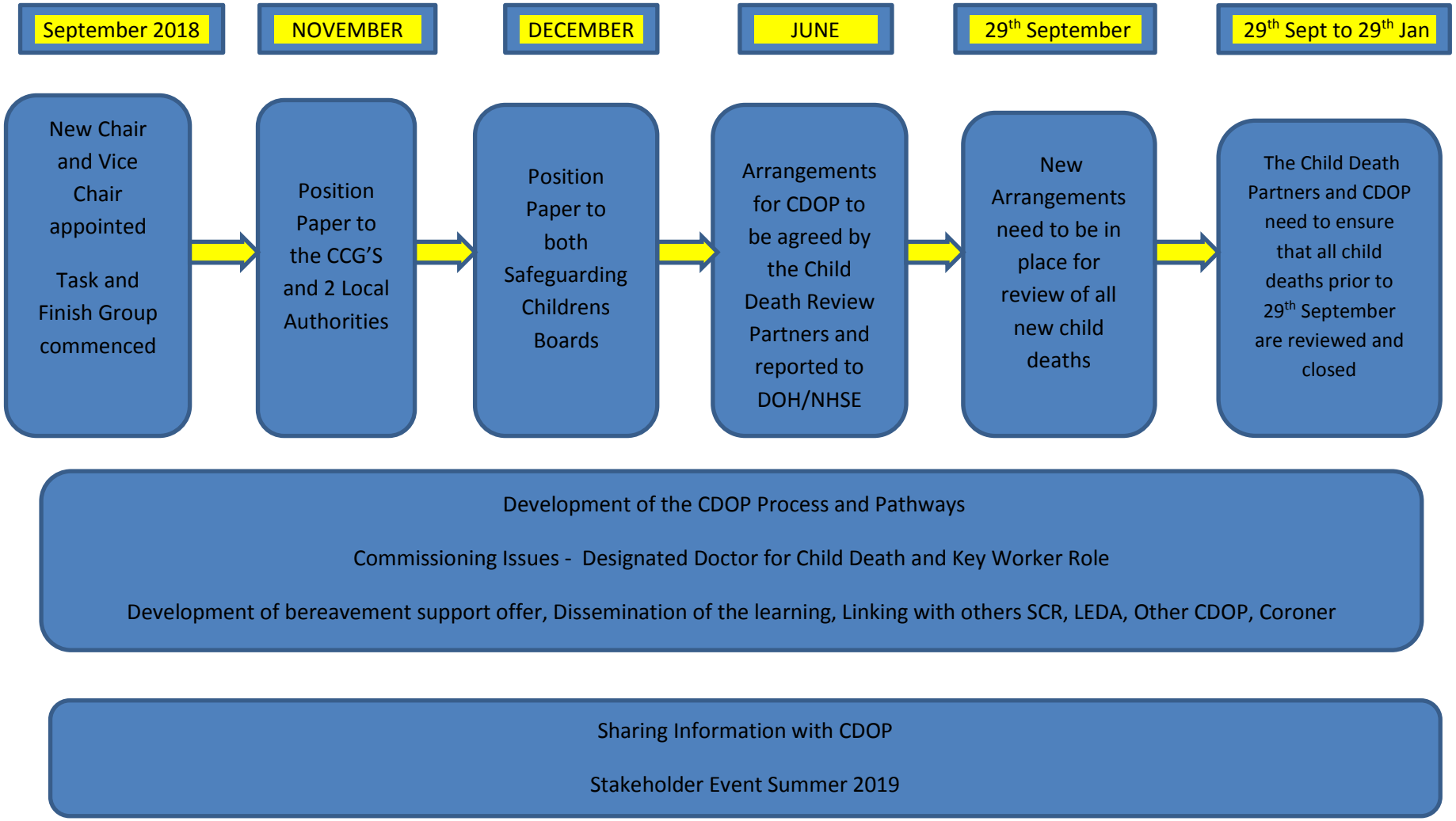
Juanita Murray – Designated Nurse Safeguarding Children and Chair of CDOP

Appendices

Appendix 1:

Timeline for Child Death Partners and CDOP Arrangements in line with Working Together 2018

CDOP Statutory Guidance published October 2018



NHS

North Derbyshire Clinical Commissioning Group
Erewash Clinical Commissioning Group
Hardwick Clinical Commissioning Group
Southern Derbyshire Clinical Commissioning Group

Integrating Children and Young People's Services
Building for a brighter future

Derbyshire Safeguarding Children Board

Safeguarding Children
Everybody's Business

Derbyshire and Derby City Child Death Review Partners

Child Death Overview Panel

Terms of Reference

Statutory Requirements

The Children Act 2004 requires Child Death Review Partners (CDR) to make arrangements to carry out all child death reviews. These arrangements should result in the establishment of a Child Death Overview Panel (CDOP) in line with Working Together 2018.

CDR partners have a legal responsibility and must make arrangements to review all the 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 in agreement with the CDOP area the child would normally reside in.

A child is defined as any live birth and any child up to their 18th birthday.

The Child Death Review Partners are the two Local Authorities and Clinical Commissioning Groups for Derbyshire and Derby City.

The reviews of all children's deaths should be carried out by CDOP in accordance with the Child Death Review Statutory and Operational Guidance (2018) and Working Together to Safeguard Children - Chapter 5 (2018).

Overarching requirements and responsibility of CDOP

CDOP will conduct the independent multi-agency scrutiny of all child deaths on behalf of the CDR partners.

Review and make an analysis of any matters relating to the death of a child which maybe relevant to the welfare and safety of children within Derbyshire and Derby City taking into account the public health considerations.

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.

Share and disseminate any learning including any themes or trends locally, regionally and nationally as appropriate.

Panel Responsibilities and Functions

- 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, 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 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
- To contribute to local, regional and national initiatives to improve learning from child death reviews

Panel Membership

The CDOP is a multi-professional panel whose core membership should include senior representatives from the following agencies or roles:

CDOP is only quorate if there is attendance by the lead professionals from health and the Local Authority.

- Public health
- Designated Doctor for Child Deaths
- Hospital Paediatrician if Designated Doctor is a Community Paediatrician and vice versa
- Social Care representation from the City and County
- Police
- Safeguarding (Designated Doctor or Nurse)
- Primary care
- 0-19 Service representative from the City and County
- Paediatric Nursing
- Lay Representation

In addition to the core membership relevant experts from health and other agencies should be invited as necessary to inform discussion on a case by case basis or for themed panels.

CDOP should be chaired by someone independent of the key providers. The chair will be responsible for ensuring that this process of CDOP operates effectively.

Members are responsible to ensure that if they cannot attend a person with the same level of responsibility attends in their place.

Quarterly Neonatal Themed Panel

The membership of the themed panel needs to be considered in line with the statutory guidance. The membership would be as above with the exception of the police. Additional members

- Neonatologist
- Midwifery
- Obstetrician (input from if not attending)
- Neonatal Specialist Nurse

Other Themed Panels will be considered in line with Statutory Guidance and local need.

Expectations of panel members

All panel members should read and agree with the confidentiality agreement

All conflicts of interest should be declared prior to the case discussions

All panel members are expected to read the case information and consider any learning points prior to panel

All panel members should take a lead within their professional group to disseminate any learning that is derived from the panel

All cases tabled for CDOP should have had a Child Death Review Meeting and a summary of the meeting should form part of the analysis form (Form C). This will be completed by the provider responsible for the child's care

All other investigations or reviews should be made available to CDOP to be considered as part of the CDOP process including the pathway to share information from Child Practice Reviews and the LeDeR process.

CDOP is the final review of a child's death and all information should have been reviewed prior to CDOP or be made available to the panel for discussion

Timeframe

The aim of CDOP is to review all child deaths within 6 months and within 12 months if the death is discussed in a themed panel

Deaths awaiting inquests or those associated with a criminal investigation will be delayed in being reviewed by CDOP until the coroner has completed the inquest or the investigation has been concluded

If there are any reasons for delay these will be reported to the Child Death Partners as an exception report

Involvement of family or carers

Parents should be informed by their key worker that the review of CDOP will happen and the purpose of the meeting should be explained

Parents should be informed of the anonymous nature of CDOP review and that it is not possible to give them case specific feedback.

Parents should feel empowered to share any information about their child's death which they feel will inform the meeting.

CDOP should be assured that there is evidence that the needs of the family in terms of follow up and bereavement support have been met and any concerns about care or service provision has been shared with the appropriate organisations.

Reporting and accountability

CDOP is accountable and will report directly to the Child Death Review partners, the process for this needs to be agreed.

CDOP need to be assured that confidentiality and information sharing arrangements are followed as per local policy and procedures including the safe storage of records.

Production of an Annual Report to the CDR partners and the Safeguarding Children Partnership.

Any risks associated with care or gaps in service provision will be escalated to the appropriate organisation by the Designated Doctor or Chair of CDOP.

All forms and analysis will be provided to the Child Death Mortality Database by CDOP.

Learning, thematic trends and safety issues should be shared throughout the partnership and with local and national CDOP networks.

Meeting Arrangements

CDOP will meet monthly with the themed neonatal panel meeting quarterly.

If the meeting is not quorate the meeting will be cancelled by the chair and this will be escalated to the CDR partners.

There needs to be agreement from the chair for anyone wishing to observe CDOP.

Terms of Reference to be reviewed in annually.

Agreed March 2019, to be reviewed by April 2020.