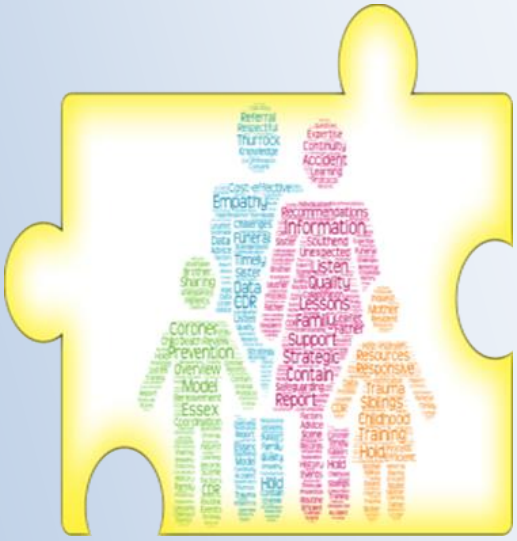
Southend Essex and Thurrock Child Death Review Partners



Essex County Council

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NHS
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Clinical Commissioning Group

NHS
Southend
Clinical Commissioning Group

NHS
Basildon & Brentwood
Clinical Commissioning Group

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West Essex
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Mid Essex
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Castle Point and Rochford
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Thurrock
Clinical Commissioning Group

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Executive Summary

This report provides an outline of the new Child Death Review Arrangements to be implemented across Southend, Essex and Thurrock in response to the Children and Social Work Act 2017 and Working Together to Safeguarding Children 2018.

The legislation introduces new Child Death Review Partners, consisting of the Local Authority and Clinical Commissioning Groups (CCGs), to oversee all child deaths in their area. The Child Death Review Arrangements are to become operational from 29th September 2019.

Child Death Review Partners

			Designated Dr for Child Death
Basildon and Brentwood CCG	**Accountable Officer**	**Lisa Allen**	**Dr K. Puvanendran**
Castle Point & Rochford CCG	**Accountable Officer**	**Terry Huff**	**Dr Azaz Khalil**
Mid Essex CCG	**Accountable Officer**	**Caroline Rassell**	**Dr Manas Datta**
North East Essex CCG	**Chief Officer**	**Dr Ed Garrett**	**Dr Joakim Anderson**
Southend CCG	**Accountable Officer**	**Terry Huff**	**Dr Azaz Khalil**
Thurrock CCG	**Accountable Officer**	**Mandy Ansell**	**Dr K. Puvanendran**
West Essex CCG	**Chief Officer**	**Andrew Geldard**	**Dr Than Soe**
Essex County Council	**Chief Executive**	**Gavin Jones**	
Southend-on Sea Borough Council	**Chief Executive**	**Alison Griffin**	
Thurrock Council	**Chief Executive**	**Lyn Carpenter**	

Introduction

'*The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity'* (HM Gov., 2018:10). Sensitivity, empathy and compassionate care are fundamental to the support offered to all families. It is also vital for parents and families to understand what has happened to their child and whether there are any lessons to be learned. The process for reviewing child deaths needs to be grounded in a deep respect for the rights of children and their families, with the intention of preventing future deaths.

Background

Following the amendment of the Children Act 2004 by the Children and Social Work Act 2017, new Child Death Review arrangements have been introduced which are scheduled to take place from September 2019. The new legislation introduced 'child death review partners', to oversee all child deaths in their area. The child death review partners are expected to publish their arrangements by 29 June 2019, and become operational from 29th September 2019.

Historic arrangements

On 1st April 2008, the Children Act 2004 and Regulation 6 of the Local Safeguarding Children Board Regulations (LSCB) 2005 introduced responsibilities in relation to the review of and response to the deaths of children and young people from birth until their 18th birthday (excluding still births). The legislation required LSCBs to have in place arrangements to review all child deaths within their area, including a rapid response for each unexpected death of a child.

In response, the Safeguarding Children Boards of Southend, Essex and Thurrock established a joint strategy with oversight provided by the Strategic Child Death Overview Panel (SCDOP) and local Child Death Review Panels.

These arrangements will remain in place until 29th September 2019, when the new legislation is enacted.

The Children and Social Work Act 2017

The Children and Social Work Act 2017, which came into effect on 29th June 2018, moved the statutory responsibility for undertaking a review of each death of a child or young person under 18 years of age, from the Local Safeguarding Children Board to the 'Child death review partners'. The child death review partners consist of the Local Authority and Clinical Commissioning Groups for an area in which the child is normally resident.

This followed recommendations from The Wood Report, undertaken by Sir Alan Wood CBE, previously the Director of Children's Services in Hackney, that the governance for child death reviews be transferred from the Department for Education to the Department of Health. It was recognised that only 4% of deaths are safeguarding related whilst the vast majority are medical or health related.

The **Children and Social Work Act 2017** has also introduced:

- Child death review partners to make arrangements to review **all** deaths of children normally resident in the local area, and if they consider it appropriate, for those not normally resident in the area.
- Child death review partners may model the current child death review structures and processes including the existing Child Death Review Overview Panel (CDOP) framework.
- Places greater emphasis on learning from what happened and why, and identifying modifiable factors, which could prevent future deaths.
- Established the National Child Mortality Database to provide a repository of learning.
- Child death review partners should agree locally how the child death review process will be funded in their area.
- They should cover a child population such that they typically review at least 60 child deaths per year.
- Child death review partners should ensure that a designated doctor for child deaths is available for any multi-agency panel and that a process is in place whereby the designated doctor for child deaths is notified of each child death and is sent relevant information.

Significant changes proposed to the Child Death Review Process

Whereas historically only unexpected deaths of infants and children, until their 18th birthday, were subject to a Rapid Response (to be termed a Joint Agency Response (JAR) in the new procedures) and required a multi-agency meeting, the updated Child Death Review Statutory and Operational Guidance (October 2018) requires all child deaths to have a Child Death Review Meeting.

As outlined within the guidance, a Joint Agency Response (JAR) will be convened when the 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;
- occurs where the initial circumstances raise any suspicions that the death may not have been natural;
- occurs in the case of a stillbirth where no healthcare professional was in attendance.

Other key changes to operational arrangements are outlined below:

- Introduces a Lead professional role;
- Requires the provision of bereavement support for families;
- Recommends the introduction of themed child death reviews, e.g. neonatal, cardiac etc.
- Includes the death of any live-born baby where a death certificate has been issued.
- Completion of Analysis Form at Child Death Review Meeting.

Current position across Southend, Essex and Thurrock (SET)

In 2018-19 there were 100 notifications of child deaths across SET, of which 32 met the criteria for a Rapid Response – this is where the death was not anticipated as a significant possibility for example, 24 hours before; or where there has been an unexpected collapse or incident leading to or

precipitating the events which lead to the death (HM Gov., 2015). Moving forward it is anticipated the unexpected deaths will meet the criteria for a Joint Agency Response (JAR).

Southend, Essex and Thurrock (SET) are already compliant with the Lead Professional role for unexpected child deaths, with the function fulfilled by the Nurse-led Child Death Review Health Team. In addition, bereavement support is offered to all of these families either by the team or the most appropriate professional already in contact with the family.

However, the current process does not include arrangements to facilitate a Child Death Review Meeting for child deaths that do not meet the criteria for a JAR or provide the offer of support for those families. The guidance suggests utilising existing Mortality Review Panels for neonatal/ child deaths in hospitals. Applying this model, the forum would need to have the appropriate expertise, capacity and wider knowledge of the child and family to review the circumstances prior to and surrounding the death. As several deaths may be reviewed within one session, it would require significant preparation to ensure relevant health, education and local authority colleagues are available to attend, and that sufficient information is available to effectively complete the CDR Analysis Form.

The guidance also states that the Child Death Review Meeting should be chaired by the lead professional with designated time assigned for this within their job plan.

The new arrangements will therefore ensure the function and capacity of the existing Nurse-led Child Death Review Health Team is expanded to incorporate this role.

The Nurse-led Health Child Death Review Team working across SET

The Nurse-led Health Child Death Review Team will have oversight of all child deaths until their 18th birthday. This will include:

- Coordinating the arrangements for the review of all child deaths (see Appendix 1);
- Facilitating/ Chairing the Child Death Review Meeting as required (for a JAR this will be the Designated Dr for Child Deaths);
- Identifying the most appropriate professional to offer on-going bereavement support to the family;
- Ensuring the CDR Analysis Form is completed robustly identifying modifiable factors, learning points and issues ascertained in the review. A local work plan should be developed, with actions allocated to the relevant department or agency responsible, and include a timeline for completion. The new Supplementary Information Forms will also be completed at the Child Death Review meeting.

Using data from 2018/19, it is approximated that 60 – 70 deaths per year will meet this additional requirement across SET.

The Nurse-led CDR Team will continue to complete the Learning Disabilities Mortality Review requirements (LeDeR), as part of the national programme, for children aged 4-17+ years meeting the criteria http://www.bristol.ac.uk/sps/leder/.

It is anticipated that the new structure will provide a consistent approach for all child deaths across SET, placing bereaved families at the centre of support and interventions offered.

The centralised team will be able to provide quality assurance regarding data gathering and information sharing, and ensure modifiable factors and learning are identified from a multi-agency perspective.

The nurse-led approach for reviewing child deaths, alongside the Designated Doctors, has been recognised regionally and nationally as an innovative and prestigious model of service development. The amalgamation of expertise has proved an invaluable resource, with training offered by team members across the SET multi-agency partnership.

Relocation of the CDR Manager

The role of the CDR Manager, which has been facilitated by the Essex Safeguarding Children Board, will be re-located to sit within the CDR Nurse-led Health Team.

As the single point of contact for all child deaths within Southend, Essex and Thurrock, this should support a seamless transition and facilitate an immediate coordinated response to all new notifications.

A further advantage of this model is the facility to offer peer support for staff members, particularly in view of sensitivity of such matters, and to provide more robust arrangements for planned and unplanned leave.

eCDOP

eCDOP is a secure electronic software programme which was developed by Kent Safeguarding Children Board (LSCB) in 2015 and has since been adopted by 57 LSCBs, including all London. The software facilitates the notification of child deaths within the LSCB area and the collation of data from professionals via the Data Gathering Forms, which are completed on-line. The software has been shown to be efficient, reducing administration time from 2 days to 2 hours, and provides a uniform approach nationally for the collation of information. Furthermore, connectivity with the National Child Mortality Database avoids duplication, so the information will only be inputted once.

eCDOP has now been adopted and is in the process of being implemented across Southend, Essex and Thurrock.

Changes to the Strategic Child Death Overview Panel (SCDOP) and Child Death Overview Panels (CDOP)

Prior to 1st April 2019, five local Child Death Review Panels met quarterly (20 meetings per year) to review cases of children resident within their own area. This reflected the 5 Essex CCG areas with the inclusion of Southend and Thurrock.

From 1st April 2019 the local CDR Panels merged to form a single Child Death Overview Panel (see Appendix 2). The Child Death Overview Panel (CDOP) meeting is held once a month (12 meetings per year). The panel meetings will review and consider cases that are ready for discussion, regardless of

which area the child was resident in. This will provide greater assurance that there is independent multi-agency scrutiny by senior professionals with no named responsibility for the child's care during life.

The CDOP will conduct an anonymised secondary review of each case. This will be informed by the draft Analysis Form from the Child Death Review Meeting, the Supplementary Information Form and the fully anonymised composite record, to determine any contributory factors and identify wider learning. The Analysis Form will be finalised at this meeting.

The current SCDOP will be re-named the Strategic Child Death Review Committee and will continue to provide strategic oversight of the CDR process, agree recommendations and actions for learning.

Conclusion

As reiterated in Working Together to Safeguard Children (HM Gov, 2018a: 94), '*the death of a child is a devastating loss that profoundly affects all those involved'.* Whilst it is recognised that the majority of child deaths are from a medical cause, the new arrangements ensure that both effective bereavement support is available to all families, and robust and coordinated processes are in place to review the circumstances. Identifying modifiable factors should inform learning and ultimately, influence national policy to prevent future child deaths.

Relevant Organisations

Essex County Council Public Health
Essex Police including British Transport Police, and Royal Military Police;
Essex Coronial Service
Children Social Care
Adult Social Care
Basildon & Thurrock University Hospitals NHS Foundation Trust (BTUH)
Mid Essex Hospital Services NHS Trust (MEHT)
Southend Hospital University NHS Foundation Trust (SHUFT)
East Suffolk and North Essex NHS Foundation Trust (ESNEFT)
North East London NHS Foundation Trust (NELFT)
Princess Alexandra Hospital (PAH)
Essex Child and Family Well-being Service (ECFWS)
Anglian Community Enterprise Community Interest Company (ACE)
Emotional Well-Being and Mental Health Service (EWMHS)
Essex Partnership University NHS Foundation Trust (EPUT)
East of England Ambulance Service NHS Trust (EEAST)
Provide
All Primary Education Establishments including maintained nursery schools All Secondary Education Establishments
All Special Schools
All Pupil Referral Units and Alternative Provision Providers
All Further Education Colleges
Early Years Settings
Voluntary Sector
Essex Fire and Rescue Services

References

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HM Gov (2015) *Working Together to Safeguard Children A guide to interagency working to safeguard and promote the welfare of children*. March 2015. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf

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HM Gov (2018b) *Child Death Review Statutory Guidance and Operational Guidance (England).* October 2018. Available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

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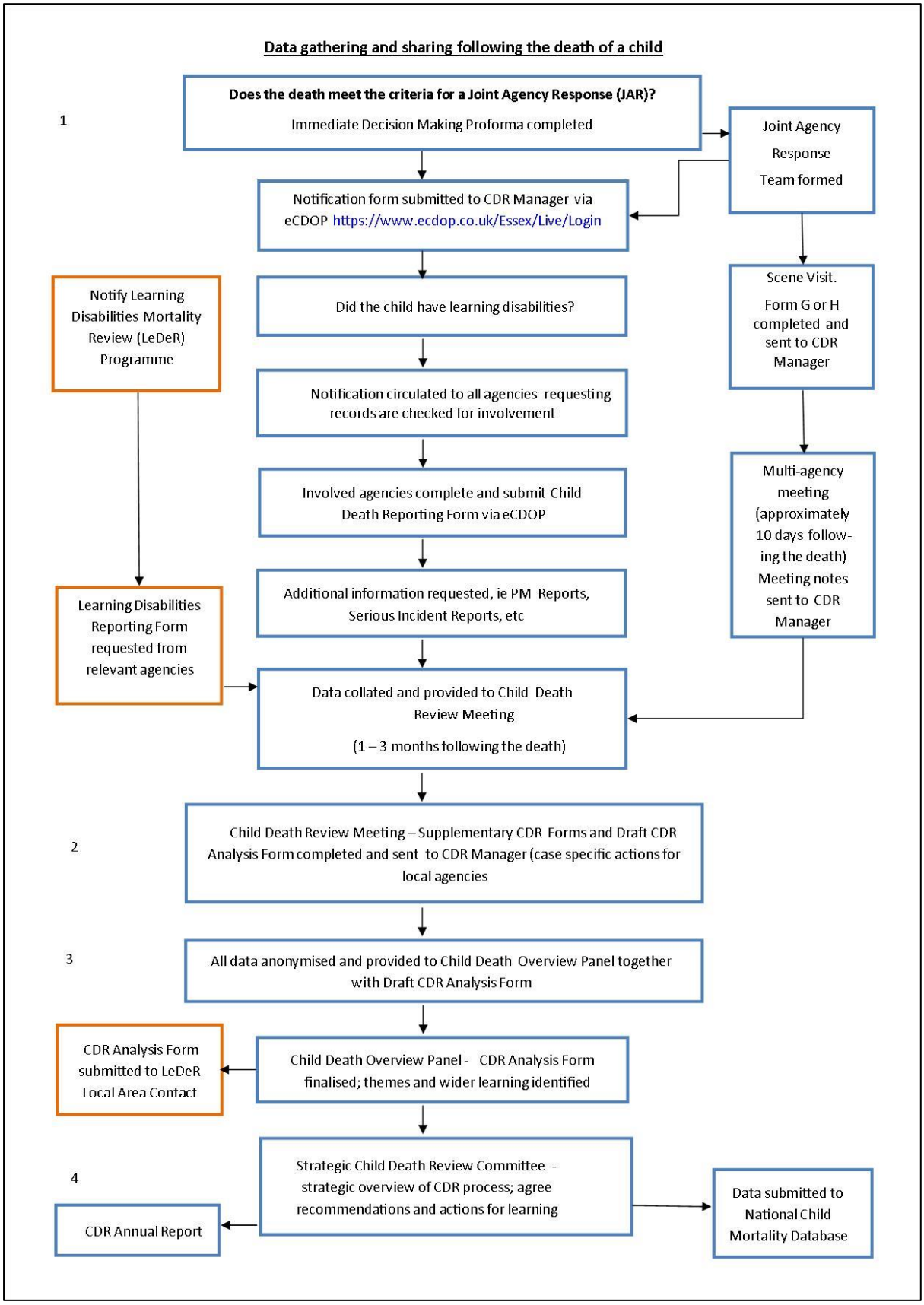
Appendix 1


Data gathering and sharing following the death of a child
1
Does the death meet the criteria for a Joint Agency Response (JAR)?
Immediate Decision Making Proforma completed
Joint Agency Response Team formed
Notification form submitted to CDR Manager via eCDOP https://www.ecdop.co.uk/Essex/Live/Login
Notify Learning Disabilities Mortality Review (LeDeR) Programme
Did the child have learning disabilities?
Scene Visit. Form G or H completed and sent to CDR Manager
Notification circulated to all agencies requesting records are checked for involvement
Involved agencies complete and submit Child Death Reporting Form via eCDOP
Multi-agency meeting (approximately 10 days following the death) Meeting notes sent to CDR Manager
Learning Disabilities Reporting Form requested from relevant agencies
Additional information requested, ie PM Reports, Serious Incident Reports, etc
Data collated and provided to Child Death Review Meeting
(1 – 3 months following the death)
2
Child Death Review Meeting – Supplementary CDR Forms and Draft CDR Analysis Form completed and sent to CDR Manager (case specific actions for local agencies
3
All data anonymised and provided to Child Death Overview Panel together with Draft CDR Analysis Form
CDR Analysis Form submitted to LeDeR Local Area Contact
Child Death Overview Panel - CDR Analysis Form finalised; themes and wider learning identified
4
Strategic Child Death Review Committee - strategic overview of CDR process; agree recommendations and actions for learning
CDR Annual Report
Data submitted to National Child Mortality Database

Glossary

[1] **Joint Agency Response** – Previously Rapid Response. To be undertaken in the case of a death due to external causes, or sudden with no apparent cause, or in custody, or suspicious circumstances, or stillbirth with no healthcare professional in attendance.

[2] **Child Death Review Meeting** – **Every** child death will have a multi-agency ***Child Death Review*** *meeting.* This is a multi-agency meeting of professionals directly involved in the care of the child during life and their investigation after death. This meeting will take place in a setting where most professionals can attend, as soon as all information has been collated and a draft Analysis Form will be completed. This meeting will enable case specific actions for local agencies to be identified and actioned.

The meeting will be chaired by the Child Death Review Health Response Team, except where a case has been subject to a JAR when the meeting will be chaired by a Designated Doctor or by the Children Social Care.

[3] **Child Death Overview Panel** – Previously Local Child Death Review Panel. This is a multi-agency panel which will conduct an independent anonymous scrutiny of each child death. These meetings will be held monthly and will be chaired by a Public Health representative.

[4] **Strategic Child Death Review Committee** – Previously Strategic Child Death Overview Panel.

Appendix 2

From 1st April 2019:-

- The Local CDR Panels will be merged to a single **Child Death Overview Panel**.

- A Child Death Overview Panel meeting will be held once a month (12 meetings per year). The panel meetings will review and consider cases that are ready for discussion, regardless of which area the child was resident in.

- **Every** child death will have a multi-agency ***Child Death Review*** *meeting.* This is a multi-agency meeting of professionals directly involved in the care of the child during life and their investigation after death. This meeting will take place in a setting where most professionals can attend, as soon as all information has been collated and a draft Analysis Form will be completed. This meeting will enable case specific actions for local agencies to be identified and actioned.

- The **Child Death Review Overview Panel** will then conduct an independent multi-agency scrutiny by senior professionals with no named responsibility for the child's care during life.

  They will conduct an anonymised secondary review of each case, informed by the draft Analysis Form from the child death review meeting, together with full anonymised information, to determine any contributory factors and identify any wider learning. The Analysis Form will be finalised at this meeting.

- The venues for the monthly Child Death Overview Panels will be rotated across the SET area and agencies will be asked to nominate senior representatives to attend.

Membership:

The panel to be chaired by a Public Health representative and to have the following core membership:-

- A Designated Paediatrician for Unexpected Deaths in Childhood
- A Designated Nurse Safeguarding Children
- A senior representative of Public Health (Chair)
- A representative from the Nurse Led Child Death Review Team
- A senior representative of children's social care
- A senior representative of the Police Child Abuse Investigation Unit
- A senior midwifery representative

Attendance at each meeting to be determined by the core membership agencies. Meeting venues will be rotated and representatives from each of the SET areas will be invited to attend all of the meetings. Representatives from Southend and Thurrock areas may choose to attend only those meetings in locations closest to their area.

Attendance will be required by at least one Designated Doctor at each meeting.

Additional members may be invited to attend panels on a standing or ad hoc basis.

Quoracy
The meeting will be quorate if lead professionals from health and the local authority are in attendance.

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 escalate to the Strategic Child Death Review Committee for 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 Review Panel is STRICTLY CONFIDENTIAL and must not be disclosed to third parties, without discussion and agreement of the Chair.

Review Date and Next Review Date
The terms of reference of the SET CDOP will be subject to annual review, or more frequently, if required.
Last Reviewed: 31 March 2019
Next Review Scheduled: 31 March 2020

Strategic Child Death Overview Panel

The current SCDOP will be re-named the **Strategic Child Death Review Committee** and will continue to provide a strategic overview of the CDR process, agree recommendations and actions for learning.