

## SWINDON LSCB BOARD MEETING – REPORT

<b>Meeting Date</b>	19 March 2019	<b>Agenda Item No</b>	
<b>Agenda Item Title</b>	Child Death Review (CDR) Process		

### 1. Summary of key points in the report

This report provides detail of the Child Death Review process for Swindon in line with the principles for child death review set out in Chapter 5 of *Working Together 2018*.

On 15<sup>th</sup> October 2018 new national statutory and operational guidance for child death reviews was published by the Department of Health. This guidance lays out how CDOPs should operate going forward and can be viewed via the following link.

<https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england>

This guidance has been produced following the recommendations of the Wood Review <https://www.gov.uk/government/publications/wood-review-of-local-safeguarding-children-boards> and the consultation that took place to revise Working Together to Safeguard Children, specifically Chapter 5, relating to the child death review process.

<https://www.gov.uk/government/consultations/working-together-to-safeguard-children-revisions-to-statutory-guidance>

The new national guidance for child death reviews asks CDOPs (Child Death Overview Panels) to consider whether they need to reconfigure or merge with another CDOP such that they cover a footprint sufficient to review a minimum of 60 child deaths per year. The Wiltshire and Swindon CDOP reviews on average 44 deaths a year.

Appendix one outlines a summary of the Child Death Review process guidelines following publication of the new national guidance.

The statutory partners with responsibility for the Child Death Review process in this region are:

- Swindon CCG
- Wiltshire CCG
- Swindon Borough Council
- Wiltshire Council

### 2. What are the identified actions?

Discussions have taken place with all the CDR partners;

- The current CDOP arrangements are considered to be effective
- Swindon is part of the NHS Wiltshire, Swindon and B&NES STP footprint – B&NES average only 6 child deaths a year and they are already part of the larger West of England CDOP.
- Agreement to continue with the current Wiltshire and Swindon CDOP arrangements.
- Explore further the opportunity to link up annually with West of England CDOP. This could include a workshop scenario looking at cases, sharing learning and best practice.
- The West of England CDOP includes Bristol, North Somerset, South Gloucestershire and Bath and North East Somerset (B&NES) and reviews on average just over 100 deaths a year.
- Agreement to extend for a further year (2019-2020) the contract with the University of

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Bristol to deliver the Child Death service on behalf of Wiltshire and Swindon

### 3. What improvements have been made for children and young people?

The learning from all child death reviews will be shared with the new National Child Mortality Database, once operational, which may in addition take into account information from other reviews in order to identify any trends or similarities with deaths. Information from the database may be able to inform systematic or local changes to prevent future deaths.

### 4. What evidence has been provided to support the stated improvements?

The Wiltshire and Swindon CDOP currently conforms to the requirements of Working Together 2018 and the operational guidance. It considers all modifiable factors that are evident in all the cases that it reviews and identifies any actions that may inform or improve services and outcomes for children and young people. The Wiltshire and Swindon CDOP annual report outlines these actions identified over the year.

The Wiltshire and Swindon CDOP news bulletin (published twice a year) looks at the common themes that have been identified and is available for all LSCB partner agencies to circulate to their staff.

### 5. What further action is planned?

Follow up discussion with the Designated Doctor for the West of England CDOP to determine how we might consider an annual event to share learning and best practice across a wider footprint.

The transition guidance attached to Working Together 2018 states:

*From 29 June 2018, child death review partners have **up to 12 months** to agree arrangements for the review of each death of a child normally resident in their area, including arrangements for the analysis of information about deaths reviewed.*

*Child death review partners should publish their arrangements, and should notify NHS England when they have done so, at [England.cypalignment@nhs.net](mailto:England.cypalignment@nhs.net). At the end of the **12-month period**, or at any time before, child death review partners have **up to three months** to implement the arrangements.*

The Swindon & Wiltshire CDR partners intend to align their notification and implementation process with that of the new safeguarding arrangements namely to publish the CDR arrangements on 29<sup>th</sup> April 2019 and implement them on July 29<sup>th</sup> 2019.

### 6. Key issues for Board focus

Note the future child death review process and intention to continue with the Wiltshire and Swindon CDOP.

<b>Author</b>	Cherry Jones	<b>Date</b>	11 March 2019
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I confirm that this report has been endorsed by the relevant Manager/ Head of Service (single agency reports only)

<b>Manager</b>		<b>Date</b>	
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## Appendix One

### **Child Death Review process following publication of new national guidance**

#### **SECTION 1: INTRODUCTION AND BACKGROUND:**

On 15<sup>th</sup> October 2018 new national statutory and operational guidance for child death reviews was published by the Department of Health. This guidance lays out how CDOPs should operate going forward and can be viewed via the following link.

<https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england>

This guidance has been produced following the recommendations of the Wood Review

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The new national guidance for child death reviews asks CDOPs to consider whether they need to reconfigure or merge with another CDOP such that they cover a footprint sufficient to review a minimum of 60 child deaths per year.

Swindon & Wiltshire CDOP have reviewed the following numbers of deaths in the last 5 years

	<b>2013-14</b>	<b>2014-15</b>	<b>2015-16</b>	<b>2016-17</b>	<b>2017-18</b>
Swindon	14	17	13	17	13
Wiltshire	50	34	25	25	15
<b>TOTAL</b>	<b>64</b>	<b>51</b>	<b>38</b>	<b>42</b>	<b>28</b>

This shows that for this panel, the number of deaths reviewed is consistently under 60 with the exception of 2013-14, when additional meetings took place to deal with a backlog of cases that had built up.

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No additional funding has been made available to help with the implementation of the new guidance and the deadline for implementation is September 2019.

Locally there has been no formal review of the current provision of this service for the Swindon and Wiltshire region since work began in 2008. The publication of the new guidance and the requirements it will place on Child Death Review Partners (CDR Partners) (Clinical Commissioning Groups and Local Authorities) therefore represents a good opportunity for all partners in the child death review process to review their current arrangements and consider alternatives.

The CDR Partners in this region are:

- Swindon CCG
- Wiltshire CCG
- Swindon Borough Council
- Wiltshire Council

## **SECTION 2: REQUIREMENTS OF WORKING TOGETHER (WT) 2018 and THE OPERATIONAL GUIDANCE**

The following section details what **must** be done by CDR partners to fulfil their obligations under WT. The CDOP service can be commissioned by any of the CDR Partners on behalf of the whole group.

- Make arrangements to review all deaths of children normally resident in the local area (including if they die overseas) and, if they consider it appropriate, for any non-resident child who has died in their area e.g. for the deaths of looked-after children in their area who were not normally resident there. Consideration should also be given to where the most learning can take place. CDR Partners for the area where the child is normally resident should decide which area conducts the review and retains the responsibility for ensuring the review has been carried out.
- Make arrangements for the analysis of information from all deaths reviewed
- Must prepare and publish reports on what they have done as a result of the child death review arrangements in their area, and how effective the arrangements have been in practice
- Consider the core representation of their CDOP. WT suggests that this would ideally include: public health; the designated doctor for child deaths; social services; police; the designated doctor or nurse for safeguarding; primary care (GP or health visitor); nursing and/or midwifery; lay representation; and any other professionals they consider appropriate
- Ensure that a designated doctor for child deaths is appointed to their CDOP. This should be a senior paediatrician who can take a lead role in the review process.
- Ensure a process is in place whereby the designated doctor for child deaths is notified of each child death and is sent relevant information
- Publicise information on the arrangements for child death reviews in their area. This should include who the accountable officials are (the local authority chief executive and the accountable officer of the clinical commissioning group), which local authority and

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clinical commissioning group partners are involved, what geographical area is covered and who the designated doctor for child deaths is.

- Share the learning from all child death reviews with the National Child Mortality Database (NCMD) once operational

The detailed description of the processes that should be followed when responding to, investigating, and reviewing all child deaths is set out in the Operational Guidance, which requires the following:

- Chief Executives of clinical commissioning groups (CCGs) and local authorities should ensure that all of their staff who are involved in the child death review process read and follow the operational guidance.
- When a child dies, immediate decision making takes place and notification of the death to relevant agencies including the CDR partners via the local CDOP administrator.
- Families should be given a single, named point of contact, the “key worker”, for information on the processes following their child's death, and who can signpost them to sources of support.
- Report deaths of children with learning disabilities or suspected learning disabilities to the Learning Disabilities Mortality Review Programme (LEDER).
- Joint agency response (JAR) (previously known as rapid response) should be considered for the deaths of all children. A JAR is a multi-agency response involving police and health professionals. A lead health professional should be assigned. This person may be a doctor, senior nurse or health visitor with appropriate training and expertise. In WOE the lead health professionals are currently community paediatricians, although elsewhere in the country both health visitor and nurse led rotas are in place. The response can include elements such as a joint health/police interview with the family, examining the body and taking relevant samples, conducting a home/scene visit, convening a strategy meeting, liaising with other agencies to obtain background information. Effective cross-agency working is key to the investigation of such deaths and to supporting the family.
- Collection of information from all professionals who had contact with the child throughout their life. In the case of neonatal deaths this also includes professionals who had contact with the mother during her pregnancy. This is done using the statutory reporting form and supplementary reporting forms (previously known as Form B and supplementary Form Bs)
- Collection of information from other sources including:
  - Post Mortem Reports
  - Serious Incident Investigations
  - Root Cause Analysis Reports
  - Health Safety Investigation Branch
  - Serious Case Reviews
- Conduct a local child death review meeting for every child. This is a multi-professional meeting attended by professionals directly involved in the care of that child during life and their investigation after death. The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved. It would, for example, take the form of a case discussion following a Joint Agency Response, a

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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. It has common aims and principles in all cases.

- 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
- Discussion of each child normally resident in their area at a CDOP meeting. If appropriate, and agreed between CDR partners, the CDOP can also review the deaths of children not normally resident in their area but who have died there.
- Provision of CDOPs final case record to the NCMD, once operational.
- Produce an annual report on local patterns and trends in child deaths, any lessons learnt, and actions taken, and the effectiveness of the wider child death review process
- 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

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