

Child Death Reviews For Shropshire and Telford & Wrekin

1. Child Death Reviews

Under the Children Act 2004 there is a statutory requirement that all child deaths are independently reviewed.

The Child Death Review Statutory and Operational Guidance (England) (2018) sets out the key features of robust child death review process and apply to all organisations involved with child death review:

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

The Children Act 2004 requires statutory partners to make arrangements to carry out child death reviews. These arrangements should result in the establishment of a Child Death Overview Panel (CDOP), or equivalent, to review the deaths of all children normally resident in the relevant local authority area, and if they consider it appropriate the deaths in that area of non-resident children. The review should be carried out by a Child Death Overview Panel (CDOP), on behalf of the partners, and should be conducted in accordance with this guidance and Working Together

The child death review process covers children; a child is defined in the Children Act 1989 as a person under 18 years of age. A child death review must be carried out for all children regardless of the cause of death. This includes the death of any live-born baby where a death certificate has been issued.

The purpose of a child death review is 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 action should be taken in relation to any matters identified. Where it is found that action should be taken by a person or organisation, they will be informed.

2. Child Death Review Partners

The child death review partners are defined as the local authority for that area and any clinical commissioning groups operating in the local authority area as set out in the Children Act 2004 (the Act), as amended by the Children and Social Work Act 2017.

For Shropshire and Telford & Wrekin the following key agencies and partners are:

- Shropshire Local Authority
- Telford local Authority
- Shropshire and Telford & Wrekin Clinical Commissioning Groups
- Shropshire Public Health
- Telford & Wrekin Public Health
- West Mercia Police force.

The Partners will work together to ensure that arrangements are in place to review all deaths of children normally resident in the counties of Shropshire and Telford & Wrekin kin.

Note: where it is considered appropriate, for any non-resident child who dies in either local authority area a review will also be conducted.

3. Responsibilities of the Partners

It is the responsibility of the Partners to ensure local processes are in place to provide a robust response to the review of local child deaths. Notifications, initial decision making and the initial child death review processes will continue to be implemented at a local level by operational staff.

The geographical and population 'footprint' has been locally agreed and covers a child population across both Telford & Wrekin and Shropshire. The CDOP will typically review around 24-60 child deaths per year. This footprint also takes into account and reflects NHS and Police boundaries.

The Partners have established a designated doctor for child deaths, who is a senior paediatrician. The designated doctors represent Shropshire Community Trust. A senior paediatric clinician from the local Acute hospitals that of Princess Royal Hospital and the Royal Shrewsbury Hospital will also support the panel along with other clinicians invited as required.

The Partners will choose to review the death of a child in their local area even if that child is not normally resident there. Potential 'out of area cases' will be brought to the attention of the designated doctor for child deaths and the CDOP Chair who will decide whether it is useful for CDOP to review an out of area case.

The Partners will publish information on the arrangements for child death reviews on the respective websites.

In addition, the Partners will prepare and publish a joint annual report 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.

4. Responsibilities of other Organisations/Agencies

The Partners will request information from a person or organisation for the purposes of enabling or assisting the review and/or analysis process. Requests for information must be complied with and if they are not, the Partners will consider legal action to seek enforcement.

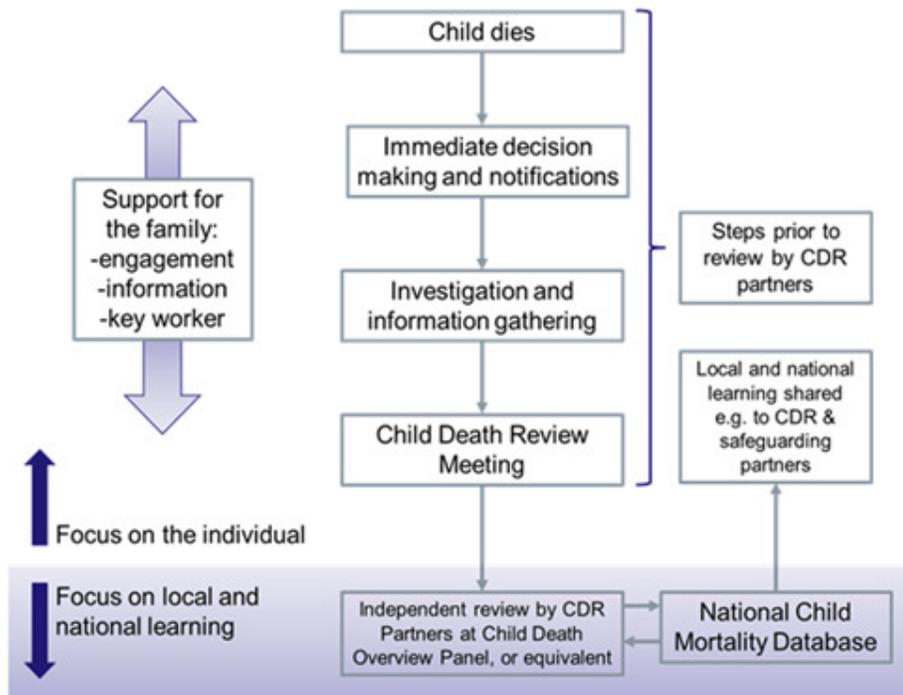
All local organisations or individual practitioners that have had involvement in the case will be required, as appropriate, to participate in the child death review process and should also have regard to any guidance on child death reviews issued by the government. Information will need to be provided on the appropriate template.

There are specific requirements on registrars of births and deaths to supply the relevant Partners with the particulars of children who have died or where an entry in the register is corrected. The registrar must also notify child death review partners if they issue a Certificate of No Liability to Register (where a death is not required by law to be registered in England or Wales) where it appears that the deceased was or may have been under the age of 18 at the time of death. Information must be provided to the relevant Partners (which cover the sub-district in which the register is kept) no later than seven days from either the date the death was registered, the date the correction was made or the date the certificate was issued.

The Coroners have a duty to notify the relevant Partners within three working days of deciding to investigate a death or commission a post-mortem, and they have a duty to share information with the relevant Partners.

5. Responding to the death of a child: the Child Death Review process (focus on the individual child)

In accordance with statutory guidance the following process will be followed when a child dies:



The steps that precede the Partners' independent review (completed by the Child Death Overview Panel) commence in the immediate aftermath of a child's death. These include the immediate decisions, notifications and parallel investigations, and the local case review by those directly involved with the care of the child or involved in the investigation after death, at the Child Death Review Meeting.

These processes will continue to be implemented locally by designated professionals.

The following decisions will be made by the designated professionals in the hours immediately following the death of a child. These include:

- Who will be the keyworker and provide support to the family;
- Whether the death meets the criteria for a Joint Agency Response (i.e. because it is sudden or unexpected);
- What format the child death review meeting should take;
- Whether the death meets the criteria for a health serious incident investigation.

The relevant designated professionals for each local area will work together to in order to:

- Establish, as far as is possible, the cause of the child's death;

- Identify any modifiable contributory factors;
- Provide ongoing support to the family;
- Learn lessons in order to reduce the risk of future child deaths and promote the health, safety and wellbeing of other children;
- Ensure that all statutory obligations are met.

The Partners anticipate that child death review meetings will be held in respect of all child deaths, however these will be flexible and proportionate, and focused on local learning. It has been agreed that in certain circumstances it may be appropriate for the review to be quite brief or for the meeting to discuss several children.

The Child Death Review Meeting will be chaired by a lead health professional within the organisation where death was declared, or the lead health professional in a Joint Agency Response.

The meeting will take place as soon as is practically possible, ideally within three months, although serious incident investigations and the length of time it takes to receive the final post-mortem report may cause delay. The CDRM should occur before any coroner's inquest, and before the CDOP meets.

The CDRM is a meeting for professionals, however, the Partners anticipate that parents will be informed of the meeting by their key worker and have an opportunity to contribute information and questions through their key worker or another professional. At the meeting's conclusion, there should be a clear description of what follow-up meetings have already occurred with the parents, and who is responsible for reporting the meeting's conclusions to the family.

6. The independent review: Child Death Overview Panel (focus on local and national learning)

Shropshire and Telford & Wrekin Mortality Records will operate a joint Child Death Overview Panel to undertake the independent review of all child deaths in the county. The joint CDOP will be independently chaired by non provider.

The functions of CDOP include:

- 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 CDRM, 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 notify the Medical Examiner and the doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction;
- To provide specified data 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; and
- To 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.

CDOP will have a core representation which will include:

- Public Health;
- The Designated Doctor for child deaths;
- Sudden Unexpected Death In Childhood (SUDIC) Co-ordinator;
- CDOP Named nurse
- Admin support
- Children's Social Care;
- Police;
- Education representative;
- The Designated doctor for safeguarding;
- The Designated nurse for safeguarding;
- Primary Care (GP or health visitor);
- Midwifery;

- Lay representation;
- Voluntary sector representation;
- Child Death administrator

and will include other professionals co-opted onto the Panel for specific individual cases or themed case reviews where they bring a particular expertise to the subject.

Quoracy will require attendance of Lead Professionals from Health and the Local Authority for the area where the child normally resides. CDOP will meet at least quarterly and will aim to review child deaths within 6 weeks of receiving the report from the Child Death Review Meeting.

Where appropriate, CDOP administrators will liaise with counterparts from other Child Death Review areas to consider the review of non-resident children. CDOP will consider undertaking a review of a non-resident child where the majority of learning is in Shropshire and Telford & Wrekin.

CDOP Managers will liaise with the designated paediatricians and lead nurses to identify opportunities for 'themed' meetings to collectively review child deaths from a particular cause or group of causes.

The key worker for the family should inform them of the CDOP meeting and its purpose. The family should be advised that it will not be possible to give case specific feedback.

The CDOP panel in Shropshire and Telford & Wrekin will meet with their counterpart in Hereford and Worcester as agreed for a collaborative exploration of matters of common concern including themes and trends analysis

7. National Child Mortality Database

From 1 April 2019 the National Child Mortality Database (NCMD) is the repository for data relating to all children's deaths in England. It will enable more detailed analysis and interpretation of all data arising from the child death review process, to ensure that lessons are learned following a child's death that learning is widely shared, and that actions are taken, locally and nationally, to reduce child mortality.

The Child Death Overview Panel will submit copies of all completed forms associated with the child death review process and the analysis of information about the deaths reviewed to the National Child Mortality Database as required.

8. Acknowledgment

With acknowledgment and thanks to Hereford and Worcester Child death overview panel.

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