COVENTRY, WARWICKSHIRE AND SOLIHULL

STATUTORY CHILD DEATH REVIEW ARRANGEMENTS

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Foreword

The death of a child is a devastating loss that profoundly affects all those involved. A sensitive approach is critical in meeting the needs of those parents, siblings, families, friends and professionals involved in caring for the child.

The child death review process seeks to respect the rights of the child and their family with the intention of learning what happened and why, and whether there are any lessons to be learned, with the aim of preventing future child deaths.

The clinical commissioning groups in Coventry, Warwickshire and Solihull (Coventry and Rugby CCG, South Warwickshire CCG, Warwickshire North CCG and Birmingham & Solihull CCG), together with the three local authorities (Coventry, Warwickshire and Solihull), as statutory partners, are committed to working together to support learning from child deaths in a compassionate and empathetic way to improve the learning from child deaths both locally and nationally and, ultimately, reduce child deaths in the future.

During the next few months we will transition from our current to our future arrangements. This document outlines how our arrangements will change during that period to ensure we meet the revised statutory guidance issued through 'Working Together 2018' and the associated 'Child Death Review: Statutory and Operational Guidance (England)', published in September 2018.

These arrangements, plus the operational procedures that underpin them, will be published on the websites of the four CCGs, three Local Authorities and three Local Children's Safeguarding Partnerships.

1. Background

1.1. *Working Together to Safeguard Children*' *2018* (https://www.gov.uk/government/publications/working-together-to-safeguard-children--2) is the statutory guidance which helps all agencies to know what the law says they, *and others, must do in order to provide a coordinated approach to safeguarding and promoting* the welfare of children. Whilst the majority of deaths in England arise from medical causes sadly, some deaths are the result of a failure to appropriately safeguard children.

1.2. Chapter 5 of '*Working Together'* sets out the legislative framework for the review of child deaths and guidance on how to meet the statutory requirements. Alongside this, the Child Death Review Statutory Guidance (https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england) sets out in detail the processes to be followed to meet the statutory requirements. Child death review partners should have 'regard' to the guidance to assist in their understanding of the steps taken by others before the child death reviews and analysis they carry out.

1.3. The Child Death Review Statutory and Operational Guidance (England), published in September 2018, sets out the key features of what a good child death review process should look like, combining best practice with the statutory requirements that must be followed. This statutory guidance seeks to ensure that outputs from child death reviews are standardised as far as possible and are of a uniform quality to enable effective learning from reviews: specific learning at a local level; thematic learning at a national level.

1.4. The responsibility for ensuring child death reviews are carried out is held by 'child death review partners' who, in relation to a local authority area in England, are defined as the local authority area for that child and any clinical commissioning groups operating in the local authority area. Child Death Review partners must make arrangements to review deaths of all children normally resident in the local area and, if they consider it appropriate, for any non-resident child who has died in their area. Child death review partners may combine and agree that their areas be treated as a single area for the purpose of undertaking child death reviews.

1.5. Child death review partners must make arrangements for the analysis of all information from all deaths reviews in order to identify any matters relating to the death(s) 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. If child death review partners find action should be taken by a person or organisation they must inform them.

1.6. The child death review process covers children: a child is defined in the Children Act 2004 and the Children and Social Work Act 2017 as a person under the age of 18 years.

2. Purpose of this document

2.1. This document sets out the future local arrangements in Coventry, Warwickshire and Solihull for Child Death Reviews. It should be noted that given the change in statutory guidance, we will transition to our new arrangements during the next six months, i.e. by 29 January 2020, the national date of implementation.

The Accountable Officers for Child Death Reviews are:

Andrea Green – Chief Officer, NHS Coventry & Rugby/NHS Warwickshire North CCGs
Gillian Entwistle – Chief Officer, NHS South Warwickshire CCG
Paul Jennings – Chief Officer, NHS Birmingham and Solihull CCG
Nick Page – Chief Executive, Solihull Council
Martin Reeves – Chief Executive, Coventry City Council
Monica Fogarty – Chief Executive, Warwickshire County Council.

3. Requirements of the New Guidance

3.1. The new statutory guidance sets out a number of changes to the previous guidance, as detailed below:

- Death review is extended to the death of any live-born baby where there is a death certificate.
- Enhanced clarity on the role of the designated doctor for child deaths.
- Perinatal Mortality Review Tool (PRMT) in standard use from 22 weeks to 28 days after birth.
- Updated guidance for Sudden Unexpected Deaths in Childhood responses.
- Hospital duty to undertake child death reviews prior to CDOP reviews.
- Thematic CDOP meetings.
- Notifications to CDOP (Designated Doctor for Child Deaths) within 24 hours.
- Investigations and child death review meeting findings should be shared with CDOP via the new reporting form during the investigation and information gathering stage.
- Joint Agency Response (JAR) and Sudden Unexpected Deaths in Childhood (SUDIC) protocols – CDOP should be informed within 24 hours.
- CDOP must be informed of serious incident reviews along with outcomes and reports within 20 calendar days.
- CDOP combining into a single area.
- CDOP must review at least 60 deaths per year for the purpose of theming reviews.
- Specified CDOP quorum and membership.
- Panel chair should be independent of delivery of child services.
- Conflicts of interest need to be specified and the named professional, or those who had caring responsibilities, should not lead the discussion.
- Designated Doctor has a responsibility to advise CDOP in relation to themed panels.

- 6 weeks between coroner or hospital child death review meeting until review by CDOP.
- Themed panels can/should involve professionals from different areas or regions and should occur within 12 months of death. Designated doctors should work together to decide which cases fit which theme.
- All information at panel must be redacted.
- An annual report must be published 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.
- A regular (annual) review of the CDOP meeting.
- The CDR partners in Coventry, Warwickshire and Solihull have agreed to share the annual CDOP report with the CCGs' Governing Bodies (through their Clinical Quality and Governance Committees), the Safeguarding Children's Board and the Health and Wellbeing Board.

3.2. A number of these components relate to the operational implementation of child death arrangements within NHS providers or other commissioned providers of healthcare. In this regard, the CCGs or local authorities will be formally writing to their providers to seek assurance on their compliance with the new arrangements.

3.3. In respect of those elements relating to the CDOP process specifically, our arrangements are detailed later in this document.

4. Strengths, Weaknesses, Opportunities and Threats (SWOT)

4.1. In devising our new arrangements we have undertaken a SWOT analysis on our current arrangements: the aim being to retain what we are doing well (where it is compliant with the new guidance); but also to use the revised guidance as an opportunity to build on our strengths and achieve compliance in the most effective way.

Strengths	**Weakness**
• Excellent collaborative working between Coventry, Warwickshire and Solihull through a joint CDOP management team • Panels chaired by the Directors of Public Health, who are considered independent of delivery of child services • Excellent commitment to attendance at panel	• 3 separate panels in Coventry, Warwickshire and Solihull (CW&S) are too small (<60 cases per year each) • Difficult to achieve themed panels when considering just CW&S cases • Designated Doctor for Deaths arrangements lack robustness and roles are not in line with new guidance • SUDIC arrangements lack robustness in Warwickshire • Arrangements are not necessarily as cost effective as they could be • Child death review process not strongly linked into overall mortality review processes within Health • Insufficient local cases to support themed reviews in all categories, such as cardiac and learning disability deaths
Opportunities	**Threats**
• A move to a single panel would create volume in numbers, supporting themed reviews and better cost effectiveness • Changes in clinical, managerial and administrative personnel could create opportunities to revise arrangements • Link to a broader CCG footprint with Birmingham for some themed panels, e.g. cardiac panels	• Loss of existing child death related clinical, managerial and administrative posts could introduce instability • Failure of providers to appropriately engage and support the new arrangements (although mitigated by this being statutory guidance)

5. Proposed Arrangements

5.1. Geographical Footprint and Child Death Review Partners

5.1.1. Our geographical footprint will cover the local authority boundaries of Coventry, Warwickshire and Solihull. CCGs within this footprint will be Coventry and Rugby CCG, South Warwickshire CCG, Warwickshire North CCG and the Solihull element of Birmingham and Solihull CCG. This is in line with our former Child Death Overview Panels' (CDOP) footprint.

5.1.2. This CDOP area will be responsible for completing approximately 75-85 reviews each year.

5.1.3. We will hold single CDOP panels across our footprint, i.e. child deaths from Coventry, Warwickshire and Solihull will be reviewed at a single panel with cross-footprint representation, depending on the cases to be considered.

5.1.4. CDOP notifications should be made to cdopcsw@warwickshire.gov.uk until July 2019 and then following this date should be made online via the ECDOP reporting site at https://www.ecdop.co.uk/CSW/Live/Public The CDOP Team will then process cases as per their procedures, taking into account the need for a child death review meeting prior to the CDOP panel. An overview of this process is detailed at Appendix 1.

5.1.5. Notifications of child deaths meeting the LeDeR criteria (i.e. children with a learning disability) should be made by to the LeDeR Local Area Contacts:

Deidre Giacomin (for South Warwickshire CCG)
Mary Mansfield (for Warwickshire North and Coventry and Rugby CCGs)
Joseph Martin (for Solihull CCG)

5.2. **Nature and Frequency of Panels**

5.2.1. We have reviewed the nature of the cases we have had during the past 5 years and our panels will likely reflect the frequency detailed in Table 1 below. That said, given the role of the Designated Doctor for Child Deaths to theme cases, these frequencies may change. The volume of panels is broadly in line with the volume of panels delivered under the previous arrangements but the theming of cases onto panels will create a specific focus which aids learning.

5.2.2. Given the low number of cardiac and learning disability cases within our area we will seek to combine our themed panels in these areas with Birmingham, particularly given our patient flows to Birmingham Children's Hospital.

Table 1

Panel Type	Frequency	Panels per year	Number of cases
General	One panel every 3 months	4	12
Neonates	One panel every 3 months	4	50 cases
Suicides/Self Harms	One panel annually	1	6 cases
Road Traffic/SUDIC	One panel every 6 months	2	12 cases
Life Limiting Illness	One panel annually	1	6
Total		**12**	**86**

5.3. **Panel Membership**

5.3.1. The statutory guidance outlines the required core membership, as well as proposed membership of each themed panel (see 5.3.4). Core members are: public health, Designated Doctor for Child Deaths (and a hospital clinician if the Designated Doctor is a community doctor or vice versa), social services, police, safeguarding (designated doctor or nurse), primary care (GP or health visitor), nursing and/or midwifery and lay representation.

5.3.2. The panel will be chaired by an individual independent of key providers (NHS, social care and police). This role will initially be shared by the Directors of Public Health or their representative(s) but will be reviewed over time.

5.3.3. Our arrangements will take an approach of 'right professional, right time' to panel attendance so that the professionals attending shall not only be able to provide appropriate expertise but shall be independent of the case. All professionals likely to be invited to panel will be provided with a schedule of dates at the beginning of each year to ensure they have time allocated to attend, as required.

5.3.4. The tables below identify the membership likely to be required for the different panels. Additional professionals will be invited on a case by case basis, for

example, coroner's office, education, housing, council services, ambulance service or hospices.

Neonatal panel:	Cardiac panel:
Designated doctor	Designated doctor
CDOP manager	CDOP manager
Neonatal network lead (if neonatologist also need neonatal nurse and vice versa)	Cardiac network lead
Midwife	Cardiologist
Health visitor	Cardiac surgeon
Obstetrician	Cardiac liaison nurse
Pathologist	Pathologist
Transport team	Transport team
Lay representative	Lay representative

SUDI/C panel:	Trauma panel:
Designated doctor	Designated doctor
CDOP manager	CDOP manager
SUDI/C paediatrician	Trauma network lead
Midwife/Health visitor	Neurosurgeon/trauma surgeon
Police	Transport team
Social worker	Police
Pathologist	Social worker
Emergency Department representative	Emergency Department representative
Lay representative	Lay representative

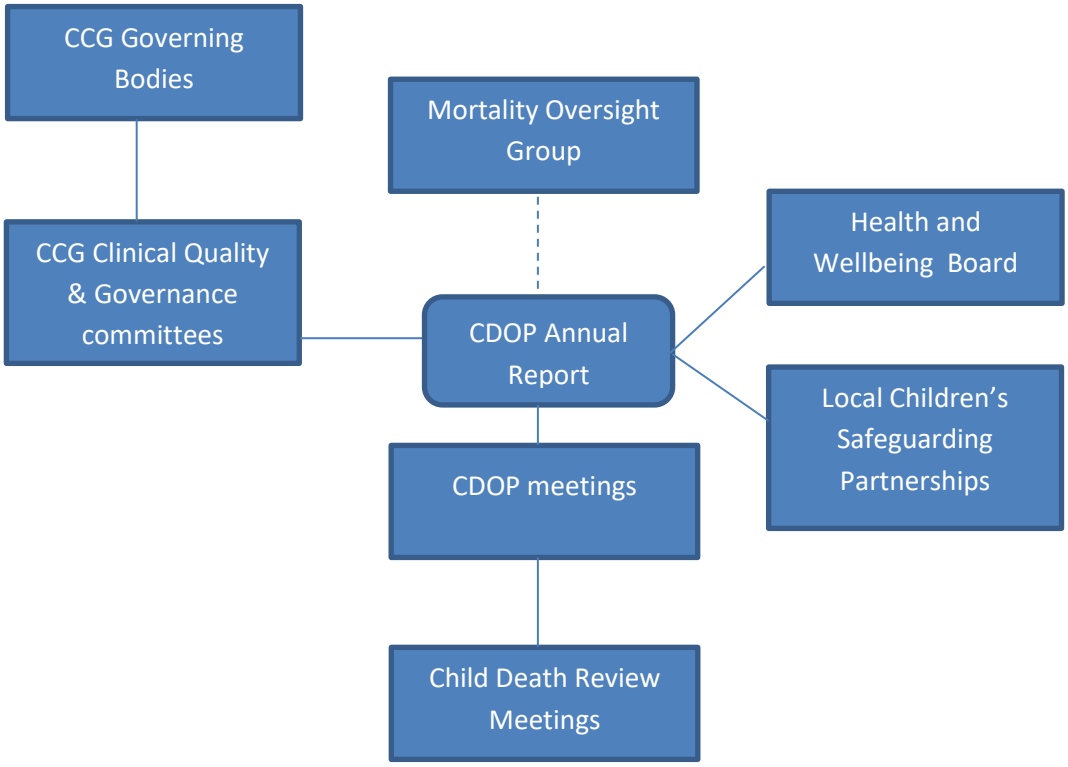
Suicide panel:	Learning disability panel:
Designated doctor	Designated doctor
CDOP manager	CDOP manager
Lay representative	LeDeR reviewer
Child psychiatrist	Learning Disabilities Nurse
GP	Social worker/safeguarding
Social Worker	Relevant medical professional (e.g. neurologist, respiratory)
Education representative	Transitions lead
Youth justice representative	Lay representative
Police	

5.3.5. The statutory guidance outlines the specific roles of individuals at panels. As we move through our transition period the CCGs and LAs will seek to update the specifications within relevant NHS or other provider contracts in respect of child death review to ensure those personnel involved in panels are clear about their roles.

5.3.6. Similarly, we will review and ensure job descriptions for current and future CDOP clinical, managerial and administrative roles accurately reflect the updated guidance.

6. Governance

6.1. The governance structure within which CDOP will report is detailed below.



CCG Governing Bodies and Local Authorities are ultimately accountable for ensuring CDR partner statutory responsibilities are fulfilled. This assurance will be achieved through regular mortality reports, plus the CDOP annual reports, presented to CCG committees and the Health and Wellbeing Boards respectively. Paragraphs 6.2, 6.3 and 6.4 provide additional information in this regard.

6.2. The oversight and key learning from child deaths will be reported through the CDOP Annual Report to the CCGs' Clinical Quality and Governance Committees, as well as to the Health and Wellbeing and Local Children's Safeguarding Partnerships.

6.3. In addition, the Coventry and Warwickshire system has recently established a Mortality Oversight Group, attended by CCG, NHS Provider and Public Health Clinical Leads (Medical, Nursing and Public Health Directors), as well as NHSI and LA Social Care representatives, which will receive the annual CDOP report for review and action, as appropriate.

6.4. Whilst the Child Death Overview Panel is no longer accountable to the Children's Safeguarding Boards the Local Children's Safeguarding Partnerships will continue to receive a copy of the annual report, and/or details of deaths and learning, where shortfalls in safeguarding have been identified so as to inform their work programmes.

7. Designated Doctor for Child Death

7.1. The CCGs currently commission Designated Doctors for Child Death through a number of NHS providers. There are currently three such doctors: for Coventry, Warwickshire and Solihull respectively.

7.2. The new statutory guidance places a greater emphasis on the integration of the Designated Doctor for Child Deaths within CDOP arrangements with the thematic allocation of cases for panel being a key element of their role. There is an expectation that the Designated Doctor for Child Deaths will be a practising paediatrician with allocated hours to complete the element of the child death review process.

7.3. On that basis, during the transition period the CCGs in Coventry and Warwickshire will jointly re-commission their Designated Doctor for Child Deaths post through the development of a revised service specification for delivery by a NHS provider. The service specification will ensure clarity regarding the new role, the hours and cover arrangements during times of leave, so as to ensure robustness of the new role.

7.4. Solihull has its own Designated Doctor for Safeguarding Children and lead paediatrician for rapid response who remains the Child Death Partners' Overview member for Solihull cases. As we work through implementation plans, any changes to the models in Coventry, Warwickshire and Solihull will be undertaken collaboratively. The Designated Doctor for Coventry and Warwickshire will provide the input into the CW&S CDOP meetings but will liaise closely with the Birmingham and Solihull designated doctor(s) in relation to the theming of Solihull cases.

8. Learning

8.1. A core element of the child death overview panel process is to ensure learning, with the aim of preventing future deaths. As previously described, thematic panels will help support this process by identifying learning themes at a local and national level.

8.2. All child deaths will undergo a CDOP review within a year of the Child Death Review meeting (CDRM) if it is subject to thematic categorisation by the Designated Doctor Child Deaths. The aim will be to achieve a review of non-themed CDOP cases within a maximum of 6 weeks of the CDRM.

8.3. A CDRM, undertaken by a multi-disciplinary/agency review team, ensures that local learning is rapidly identified and an action plan developed for implementation within 6 weeks of the death of the child.

8.4. Cases reviewed by CDOP, either through a general or themed panel, may identify additional learning which will then be disseminated both locally and nationally. It has been agreed locally that learning from CDOP panel will be disseminated within 2 weeks of the panel meeting. Appendix 1 identifies the CDOP process at a high level.

All CDOP cases will be redacted and therefore anonymised for the purpose of the review.

8.5. Appendix 3 details the single points of contact through which information will be gained and learning disseminated.

9. ECDOP and the National Mortality Database

9.1. The Child Death partners have funded the ECDOP platform to support efficient collation and dissemination of information, including statistics to inform the annual report. It is anticipated this software will be fully operational prior to the 'go live' date for the new arrangements. The ECDOP system will enable direct reporting of information into the National Mortality database which was launched on 1 April 2019.

10. Managerial Arrangements

10.1. The CW&S CDOP is currently supported by a full time manager and full-time administrator; both employed by Warwickshire Local Authority (see Section 16 for CDOP Manager contact details). CDR partners will keep under review current arrangements and consider better integrating the CDOP team and Designated Doctor for Child Deaths, under the hosting of a lead CCG. Skill-mix will be considered as part of this review. This would improve efficiency and communications, particularly with the introduction of the new ECDOP system.

11. Funding Arrangements

11.1. The following funding arrangements are currently in place:

- The CCGs fund the Designated Doctors for Child Death and SUDIC response protocols through their contracts with commissioned providers;
- All seven partner organisations currently fund the CDOP managerial/administration arrangements.

11.2. Changes to the commissioning of Designated Doctors, SUDIC response protocols and managerial/administration arrangements provide an opportunity to review of both the overall costs and costs to individual organisations; the aim being to drive cost efficiency.

12. Operational Elements

12.1. Partner organisations in the NHS, Local Authority and Police have a statutory duty to deliver many of the operational elements of the child death review process. The arrangements detailed in this document do not go into this detail, except where current arrangements are identified as a current weakness to the overall Child Death Overview

process. Local CDOP procedures will be updated to reflect the new statutory guidance and published before the 'go-live' date of 29 September 2019.

12.2. During the transition period we will seek written assurance from our partner organisations that they meet the operational elements of the statutory guidance.

12.3. **SUDIC rapid response protocols**

12.3.1. The Coventry and Warwickshire CCGs commission their providers to provide SUDIC rapid response protocols. We know however, that at times, we have been unable to deliver these protocols, potentially compromising the joint agency response (JAR), child death review process or, potentially, the safeguarding of children and young people in a household. Existing SUDIC protocols are medically-led and, in view of the challenges in paediatric manpower locally, are unsustainable in the longer term from both from a workforce and financial perspective.

12.3.2. During the transition period the Coventry and Warwickshire will re-commission a nurse-led SUDIC service that operates across the whole of Coventry and Warwickshire, interfacing with our Health providers, as appropriate. This will introduce robustness to the model during times of leave and equity of cover across our CDOP footprint. The SUDIC protocol for Solihull will be implemented as per Birmingham and Solihull's arrangement.

12.4. **Single Points of Contact**

12.4.1. The CDOP process relies heavily on good single point of contact (SPOCs) networks for both the receipt and dissemination of information. A single point of contact network is being established for the new arrangements, with identified individuals within each agency/organisation. These single points of contact will also be utilised to support the dissemination of learning within their agencies/organisations after CDOP reviews.

13. Implementation Timeline

13.1. This guidance applies across England from 29 June 2018. The final expiry date is 29 September 2020. From 29 June 2018, local authority areas must begin their transition from LSCBs to safeguarding partner and child death review partner arrangements. **The transition must be completed by 29 September 2019**. After new safeguarding partner and child death review partner arrangements are set up, LSCBs in the area have a statutory 'grace' period of up to 12 months to complete and publish outstanding SCRs and of up to four months to complete outstanding child death reviews. They should, however, seek to complete these reviews as soon as possible and in the case of outstanding SCRs, no later than six months from the date of the decision to initiate a review. LSCBs must complete all child death reviews by 29 January 2020 and all SCRs by 29 September 2020 at the latest. This guidance remains applicable in any

local area in England until the new arrangements are in place, and during the grace periods, where relevant.

13.2. The 'go-live' date for the new arrangements is 29 September 2019. The implementation plan below details the key milestones and dates to ensure we are ready for implementation of our new arrangements by that date. It is worth noting that 29th September is not an 'end point' in itself, and we will review and revise our arrangements on an on-going basis to ensure fitness for purpose and full compliance with the statutory guidance.

13.3. The child death review partners have created an executive group that meets regularly to progress the implementation of our plan and manage the associated risks.

13.4. Given our desire to re-commission aspects of our current provision it is likely that we will evolve our arrangements during a period of transition that goes beyond the implementation date of 29 September 2019. That said, whilst we will be unable to fully address our current weaknesses during that period, particularly in respect of the efficiency of our arrangements, we are confident we will be compliant with the statutory guidance.

Action	**Lead**	**Timescale**
Purchase ECDOP	CDOP manager	Achieved
Seek provider organisation assurance that they have appropriate mechanisms and staff in place to fulfil their statutory responsibilities under the guidance	Heads of Safeguarding	By end July 2019
Identify single points of contact in each organisation	CDOP Manager	By end September 2019
Update CDOP procedures and publish on CCG/LA/Safeguarding Board websites	CDOP Manager	By end September 2019
Re-commission the Designated Doctor for Child Deaths role for C,W&S	C&W CCG Chief Nurses	By end March 2020
Re-design and re-commission the SUDIC model for C,W&S	C&W CCG Chief Nurses	By end March 2020
Review/redesign the managerial/administrative support, as appropriate	C&W Chief Nurses with DPH input	As appropriate
Review current and future funding arrangements upon completion of any changes in team structure	Chief Nurses and DsPH – CW&S	As appropriate

14. Risks

14.1. The risks, ratings and mitigations associated with the change in arrangements are detailed below. During our transition phase we will actively monitor and manage our risks with the view to closing them.

Risks	Risk Rating	Risk Mitigation
Loss of existing managerial staff during transition period	Medium to High	Secure the input of interim managers and specialist expertise of substantive CCG safeguarding staff should this arise
Failure to successfully re-commission the Designated Doctor role	Medium	Continuation of current arrangements until this is resolved
Failure to successfully re-commission the nurse-led SUDIC model	Medium	Continuation of current arrangements until this is resolved
ECDOP system fails to work	Low	Continue with manual systems until this is addressed

15. Benefits

15.1 The benefits of the new arrangements are as follows:

- Ability to achieve more robust learning from themed reviews both at a local and national level, with the ability to influence local practice and national policy/guidance.
- More timely feedback on learning locally to influence practice.
- Enhanced communication routes through single points of access.
- Better support for families through a key worker approach in provider organisations.
- More efficient arrangements through the re-commissioning of the Designated Doctor and SUDIC roles, the use of ECDOP and the potential future redesign of the managerial/administrative support to CDOP.
- Greater independence/scrutiny of individual cases.

16. Contacts

Key contacts in respect of child deaths in Coventry, Warwickshire and Solihull are:

CDOP Manager – Caroline Lamming-Chowen, Warwickshire County Council

Designated Nurse Child Protection (Coventry) – Jayne Phelps, NHS Coventry and Rugby CCG - 02476 246019:CRCCG.safeguarding@nhs.net

Designated Nurse Child Protection (Warwickshire) – Jackie Channell, NHS Warwickshire North CCG – 07909686106: jackie.channell@nhs.net

Designated Doctor Child Deaths (Coventry) – Dr Brian Shields, University Hospitals Coventry and Warwickshire NHS Trust – 02476 964000 via switchboard

Designated Doctor Child Deaths (Warwickshire) – Dr Vaishali Desai, South Warwickshire Foundation NHS Trust - 01926 495321 via switchboard

Birmingham and Solihull Safeguarding Designated Professionals (including the Designated Doctor and Nurse, Child Deaths): Floor 1, Woodcock Street, Birmingham, B7 4DJ. 0121 203 3300 (option 2). Email: nhsbsolccg.safeguarding@nhs.net

Coventry MASH - (024) 7678 8555

Warwickshire MASH - 01926 414144

Solihull MASH - 0121 788 4300

Communications of child deaths should be sent to: cdopcsw@warwickshire.gov.uk until July 2019 and then following this date should be made online via the ECDOP reporting site at https://www.ecdop.co.uk/CSW/Live/Public

17. Appendix 1

The flow chart below sets out the main stages of the child death review process.

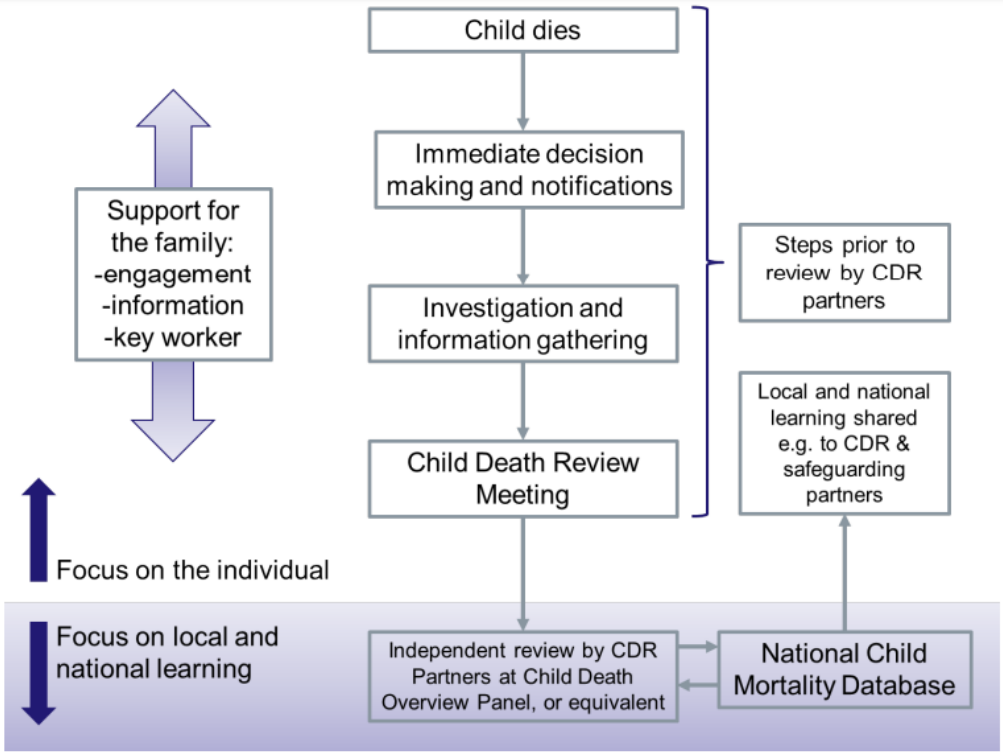


Figure 1 Chart illustrating the full process of a child death review. This includes both the statutory responsibilities of CDR partners to review the deaths of children at an independent multi-agency panel (described here, and throughout, as review at CDOP or equivalent), and the processes that precede or follow this independent review. Further explanation is below.

Statutory Partners