HARINGEY

CHILD DEATH REVIEW ARRANGEMENTS

18 June 2019

1. Introduction

1.1 The Act names as statutory child death review partners Local Authorities and CCGs. The Act enables child death review partners for two or more local authority areas to agree that their areas are treated as a single area and for one of them to carry out functions on behalf of the other.

The Council and Haringey CCG are responsible for a) making arrangements for the review of each death of a child normally resident in the area and, if they consider it appropriate, for any non-resident child who has died in their area; b) making arrangements for the analysis of information about deaths reviewed.

The new approach aims to support better learning from child deaths in order to improve care and outcomes, recognising that while the current process has its origin in safeguarding guidance, most preventable child deaths are not connected to safeguarding but largely medical in nature.

In October 2018, guidance was published by the Department of Health and Social Care[1] on the development of child death review systems across England, in large part evolving out of the current CDOP process.

2. New arrangements

2.1 A steering group (the North Central London Child Death Overview Process Transformation steering group (NCL CDOPT steering group)) comprising representatives from the Council, CCG, acute NHS Trusts across North Central London (NCL), LSCBs, Designated Doctors and chaired by the Assistant Director for Public Health in Camden and Islington and supported by the Assistant Directors/Consultants in Public Health from Barnet, Enfield and Haringey was formed to oversee the transition and proposals for the new arrangement.

The NCL CDOPT steering group has focussed on four areas:

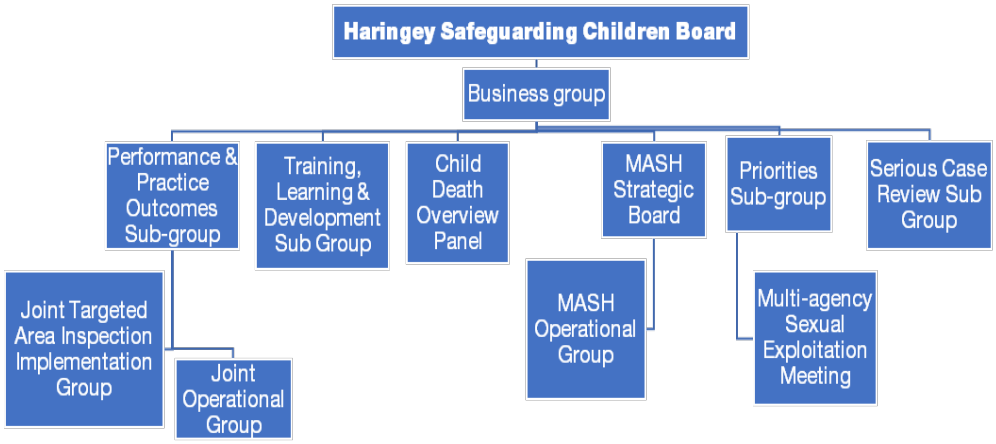
- Completed a review of existing system structures, staffing and resources within the local system.
- Mapped existing assets and their fit with the new statutory requirements
- Completed a 'case for change' for the new arrangements based on the key differences between the current and future systems.
- Supporting the acute NHS Trusts to establish the new system structures and staffing requirements.

2.2 The NCL CDOPT steering group members have agreed there is a need to a) strengthen administrative capacity to support the NCL CDOP, the joint agency response (JAR), the child death review meeting (CDRM) for deaths in settings such as hospice/ home, and support acute NHS Trusts with their CDRM; b) ensure excellent quality key worker and bereavement support for families; c) establish a single point of information

[1]Child Death Review Statutory and Operational Guidance (England), 2018, Department of Health and Social Care

regarding NCL CDOP; d) identify funding for the eCDOP system[2] from April 2020 onwards and e) consider having an Independent Chair of NCL CDOP.

2.3 The current Haringey Child Death Overview Panel (CDOP) arrangement;



Haringey CDOP is a multi-agency sub-committee of the LSCB chaired by the Assistant Director of Public Health. Members include the police, the CCG, the Council's children's services, the LSCB, North Middlesex University NHS Trust and Whittington Health NHS Trust. The group meets four times a year and reports to the LSCB.

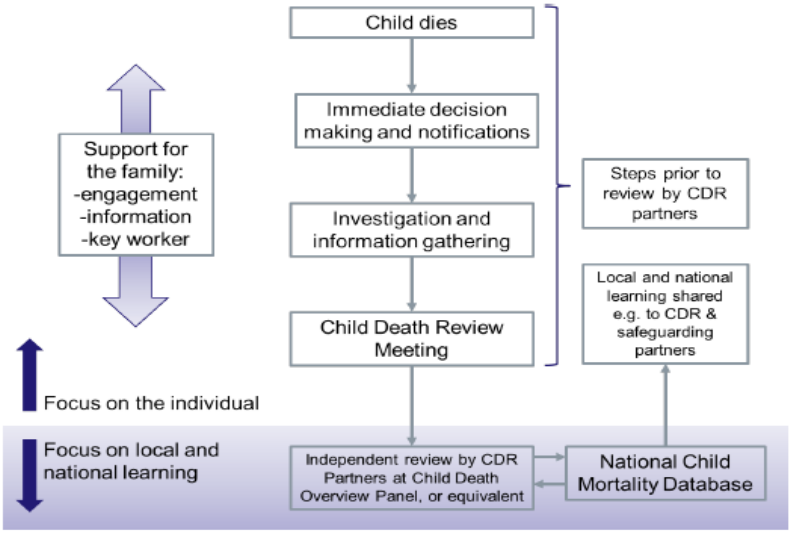
The current CDOP borough process is;

- A child dies, there is immediate decision making and notifications, if the death is from natural causes (expected death) information is collected and the death is reviewed at the CDOP.
- If the death is un-natural (unexpected) a Rapid Response meeting is held, decision making and notifications, information collected followed by the CDOP.

There will be a 4-month grace period for the CDOP (under the LSCB) to complete child death reviews before the new system starts.

[2] The electronic data and information system introduced across London in April 2018 funded for one year by the Healthy London Partnership. In April 2019 the system was funded by NHS England (London Region) for one year.

2.4. The new child death overview process



2.4.1 Geographical Footprint

One of the significant changes is that the geographical and population 'footprint' of child death review partners should cover a child population, such that they typically review at least 60 child deaths per year. This footprint should consider networks of NHS care, and agency and organisational boundaries, in order to reflect the integrated care and social networks of the local area. It must extend to at least one Local Authority area or may overlap with more than one Local Authority area or CCG. Child death review partners should come together to develop clear plans outlining the administrative and logistical processes for these new review arrangements. The NCL CDOPT steering has recommended combining Barnet, Camden, Enfield, Haringey and Islington child death overview panels.

This geographical footprint meets the statutory requirements. Based on the last three years' data the average number of deaths across the five boroughs is 80 (Barnet, 20, Camden 11, Enfield 20, Haringey 20 and Islington 13).

The five areas are increasingly working together. It reflects integrated care and social networks as well and they already use eCDOP so could merge to one electronic system.

2.4.2 Immediate decision making and notifications

Several decisions need to be made by professionals in the hours immediately following the death of a child. This provides a focus on providing good clinical care. It aims to provide the family with compassionate care and support, signposting them to appropriate bereavement support, and ensuring that their voice is heard throughout.

This part of the process includes:

- how best to support the family;
- whether the death meets the criteria for a JAR;
- whether a Medical Certificate of Cause of Death (MCCD) can be issued, or whether a referral to the coroner is required;
- whether the death meets the criteria for a serious incident investigation by any agency.

- A number of notifications must also be made, via the 'Child death notification form' (formally Form A) to the child's GP and other professionals, to the Child Health Information System, the relevant CDOP, and (once operational) the National Child Mortality Database (this will be done automatically by eCDOP).
- Identification of a Key Worker. Supporting and engaging the family who have lost a child is of prime importance throughout the whole child death review process. Recognising the complexity of the process, and the state of total shock that bereavement can bring, families should be given a single, named point of contact (Key Worker) who they can turn to for information on the processes following their child's death, and who can signpost them to sources of support. In addition, they should be provided with a leaflet for parents, families and carers to help understand and navigate the child death review process.

The NCL CDOPT Steering Group has identified that this function can be supported by existing workers across the system, but they recommend that further training be offered for them to meet the responsibilities and competencies required.

2.4.3 Investigating and information gathering

There are no changes to this stage.

Information gathering will be through formal investigations and via a 'child death review form' (formally Form B)

The Key worker will provide overarching coordination alongside any investigation to facilitate the family voice and to keep them informed at all stages.

2.4.4 Child Death Review Meeting (CDRM)

This is a new stage

Although investigations following the death of a child will vary, every child's death should be discussed at a child death review meeting. This is the final multi-professional meeting involving the individuals *who were directly involved* in the case. The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved but has common aims and principles in all cases. The results of the meeting should be captured on a draft 'child death analysis form' (formally Form C) and uploaded to the eCDOP system. This will involve an increase in time commitment from all agencies.

The NCL CDOPT steering group has identified this could be balanced by using existing meetings within the acute NHS Trusts.

2.4.5 Child Death Overview Panel (CDOP)

It is required that all areas hold a multi-agency panel made up of senior professionals *who have had no involvement* in the cases under discussion (this will provide independent scrutiny of each child's death from a multi-agency perspective) and who can identify thematic system changes, in order to learn lessons for the prevention of future child deaths. At this meeting the draft 'child death analysis form' (formally Form C) received from the acute NHS Trusts will be considered, finalised and signed off. The CDOP will review the death of all children normally resident in the area, and where appropriate, the deaths of non-resident children. Local actions to modifiable factors identified will be taken. The frequency of the CDOP is to be confirmed but it is likely to be 3 or 4 times a year. It is recommended that these meetings will be chaired by Public Health or an independent chair. Core membership will be Designated Doctors, local authority Public Health and children's social care, the CCGs, acute NHS Trusts, Designated Doctors for Child Death, and the Coroner's Office. Depending on the theme of the meeting additional experts in that area will be invited.

The new multiagency panel will be the NCL CDOP (covering Barnet, Camden, Enfield, Haringey and Islington).

The proposed new arrangements have been presented in draft to the Council's Corporate Board, the CCG, the 4 Directors of Public Health (covering the 5 boroughs) and the Accountable Officer for NHS NCL CCGs.

In addition to monthly NCL CDOPT steering group meetings, and as part of preparing and consulting stakeholders for the new arrangements, two workshops were held in January 2019 and April 2019 with other leaders across the partnership.

The new arrangement is to be referred to as the 'North Central London Child Death Overview Partners (NCL CDOP). It includes the following:

2.4.6 Leadership and governance

The new arrangement will be led by the NCL CDOP. It is yet to be agreed where in NCL governance will be provided.

The NCL CDOPT steering group wants to see strong links between the new safeguarding partnerships, the CCG Quality and Safety Committees as well as an appropriate NCL group.

Information Governance - Under the data protection legislation, all data sharing and processing requires agreements between those sharing and processing data. Whilst by its nature the key subject of a child death review is not subject to the data protection law as it only applies to the living, the Common Law Duty of Confidentiality will still apply, and where others (e.g. parents, professionals) have their data recorded their information will be subject to the data protection law. There are certain exemptions for safeguarding. There is a North London Information Governance Working Group which was set up to deal with these issues. The NCL CDOPT steering group will request assistance with these information governance issues and arrange for a representative of the group to attend the steering group meetings.

2.4.7 Relevant agencies involved in the new arrangement;

- Local authorities: Barnet, Camden, Enfield, Haringey and Islington
- CCGs: Barnet: Camden, Enfield, Haringey and Islington

- NHS Trusts: North Middlesex University NHS Trust, Whittington Health NHS Trust, Royal Free Group NHS Trust, University College London NHS Trust and Great Ormond Street Hospital.

2.4.8 Geographical area;

- Barnet, Camden, Enfield, Haringey and Islington

2.4.9 Support for bereaved families

The new role of a 'key worker' will give bereaved families a single point of contact for information and support. The need for this role has been identified through national feedback from bereaved families who have requested further support. The NCL CDOPT steering group propose developing an NCL Bereavement Offer, this could be done through goodwill by the acute NHS Trusts. Steering group members from the acute NHS Trusts are addressing this task and are currently updating and sharing their bereavement support contacts.

2.4.10 Functional responsibilities:

Acute NHS Trusts

- Stage one - Immediate decision making and information gathering

At death a discussion and strategy planning session on the appropriate review with notification to relevant multi agency partners. Includes initial case strategy, rapid response and initiation of bereavement support

- Stage two: Investigation and information gathering

Depending on the specific process required. If the death is a sudden unexpected death in infancy or childhood related a joint visit or other process initiation

- Stage Three: Child death review meetings

Multi agency CDRM conducted by the NHS Trust (acute, community or mental health) with care responsibility for the deceased. This aims to establish chronology and causation, submitting local recommendations/actions to CDOP.

The NHS Trusts will need to ensure effective approaches are in place following child deaths, including a) procedures for timely notification of SPOC for child death; b) a process for determining whether to oversee a CDRM or refer for a JAR; c) processes to ensure child death review meetings engage those who have been involved with the care of the child whether they are from other NHS trusts or the community

Trusts will need to ensure they are adequately resourced, that they have confidence in appropriate challenge and that processes are well aligned with other process such as the perinatal mortality review tool, and LeDeR process.

NCL CDOP

- Stage Four: child death overview panel

Considers the CDRM input and identify local or regional learning. Submission to the Department of Health and National Child Mortality Database to inform national identification of trends to enable population-based interventions for the prevention of child deaths.

2.5 The key changes under the new arrangement include:

- In the new system each child's death will be reviewed at a multi-agency CDRM which is to be held by the agency which declares the death (many now will fall into the remit of the acute NHS trusts) as well as the NCL CDOP.
- In the case of unexpected deaths, a JAR is required. This will be similar but within shorter timescale than the current Rapid Response.
- Each family is allocated a Key Worker to act as a single point of contact.
- Across NCL all deaths will be reviewed thematically by independent review by Child Death Review Partners at the CDOP. Currently all deaths are reviewed within each borough at CDOP.
- Submission of data to the National Child Mortality Database (established 1st April 2019). Previously data was submitted to Department of Education.

2.6 Transition timeline

2.6.1 The transition from current LSCB Child Death Overview Panel (CDOP) to the new child death review arrangements began summer 2018 and will be completed by 29th September 2019. The current CDOP will continue until the child death review partner arrangements is in place.

2.6.2 There will be a 4-month grace period for borough based CDOPs (under the LSCB) to complete child death reviews.

2.7 Current position

The NCL CDOPT steering group continues to meet to finalise the requirements in the Act and to support acute NHS Trusts with setting up their new systems and responsibilities.

Glossary of new terminology for the new system

Child Death Review Meeting
The stage of the review process that precedes the independent multi-agency panel arranged by child death review (CDR) partners. This meeting should be a multi-professional meeting where all matters relating to an individual child's death are discussed. The Child Death Review Meeting (CDRM) should be attended by professionals who were directly involved in the care of the child during his or her life, *and* any professionals involved in the investigation into his or her death. The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved and should *not* be limited to medical staff.

For example, the CDRM could take the form of a final case discussion following a Joint Agency Response (JAR), a 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 on a paediatric intensive care unit. These meetings could, as a way of standardising practice nationally, be known as a Child Death Review Meeting.

Outputs from CDRMs (draft Analysis Forms) should be shared with the group set up by CDR partners to conduct reviews, i.e. Child Death Overview Panel (CDOP).

Child Death Overview Panel, or equivalent
A multi-agency panel set up by CDR partners to review the deaths of all children normally resident in their area, and, if appropriate and agreed between CDR partners, the deaths in their area of non-resident children, in order to learn lessons and share any findings for the prevention of future deaths.

In all cases, legal responsibility for ensuring that arrangements are made to review the death of a child lies with the CDR Partners where the child is normally resident.

The CDOP should be informed by a standardised report from the CDRM, and ensures independent, multi-agency scrutiny by senior professionals with *no named responsibility* for the child's care during life. In practice, CDOPs will conduct the independent multi-agency scrutiny on behalf of the local CDR partners responsible for ensuring that the review of deaths of all children normally resident in that area takes place.

Designated doctor for child deaths
A senior paediatrician, appointed by the CDR partners, who will take a lead in co-ordinating responses and health input to the child death review process, across a specified locality or region.

Forms: Notification, Reporting, Analysis
Three standard forms should be used in the child death review process:
• Notification Form (previously "Form A") for initial notification of a death to CDR partners;

• Reporting Form (previously "Form B") for gathering information from agencies or professionals who have information relevant to the case. Reporting forms should be completed by the relevant responsible officer and shared with the relevant CDOP. For certain child deaths, a supplementary Reporting Form should also be completed as required; and

• Analysis Form (previously "Form C") initially drafted at the CDRM and completed at CDOP for evaluating information and identifying lessons to be learned. The Analysis Form is the final output of the child death review process. From 2020 this information should be shared with the National Child Mortality Database, when operational. Specified data to NHS Digital for the transitional period will be notified to Child Death Review Partners separately. The mechanism for collecting, and the content of, this data will evolve as the National Child Mortality Database becomes operational.

All forms and templates to be used for reporting child deaths can be found on GOV.UK. These forms should continue to be used until the introduction of the National Child Mortality Database, in 2019.

Joint Agency Response
A coordinated multi-agency response (on-call health professional, police investigator, duty social worker), should be triggered if a child's death:
• is or could be due to external causes;
• is sudden and there is no immediately apparent cause (including SUDI/C);
• occurs in custody, or where the child was detained under the Mental Health Act;
• where the initial circumstances raise any suspicions that the death may not have been natural; or
• in the case of a stillbirth where no healthcare professional was in attendance.

The full process for a Joint Agency Response is set out in the SUDI/C Guidelines.

Key Worker
A person who acts as a single point of contact for the bereaved family, who they can turn to for information on the child death review process, and who can signpost them to sources of support. This person will usually be a healthcare professional.

Lead health professional
When a JAR is triggered, a lead health professional should be appointed, to coordinate the health response to that death. This person may be a doctor or senior nurse, with appropriate training and expertise. This person will ensure that all health responses are implemented and be responsible for ongoing liaison with the police and other agencies. Where no out-of-hours health rota for a JAR exists in a locality, the role of lead health professional should be taken by the senior attending paediatrician.

Summary of the new Child Death Review Process