Black Country Child Death Overview Panel Arrangements: Briefing Paper for CDOP and Strategic Partners – Sept 19

Purpose:
The purpose of this briefing paper is to:

- Outline changes to child death review processes across the Black Country
- Update Health and Wellbeing Board partners on progress towards establishing a Black Country Strategic Child Death Overview Panel
- Clarify the actions that have been agreed
- Outline some of the challenges that remain
- Make recommendations

Background:
Following the publication of the Child Death Review Statutory and Operational guidance 2018 in October last year, the responsibility for Child Death Reviews (CDRs) at national level passed from the Department for Education to the Department of Health and Social Care. This followed a review of Children's Safeguarding arrangements known as the Wood[1] Review which concluded that: *"Over 80% of child deaths have medical or public health causation. For babies and infants the cause is often related to congenital factors and in the early teenage/ adolescent age range the causation is related often to injury. Clinicians estimate that only 4% of child deaths relate to safeguarding or require an SCR to be carried out."* [1]

Until June this year, Local Children's Safeguarding Boards (LSCBs) have held the statutory responsibility for reviewing child deaths through locally organised Child Death Overview Panels. Over the last 12 months, Black Country strategic partners have been involved in the development of Child Death Review processes as part of the Department for Education's Early Adopter programme for changes in the Children's Safeguarding Legislation. These developments have been overseen by a multi-agency steering group, which has now been disbanded (4/9/19) on the premise that a new Black Country Strategic CDOP is established to reduce the risk of future deaths or harm to children and:

- Ensure that there is a strategic influence from child death reviews to reduce risk of death and future harm to children, within a changing environment
- Provide oversight and assurance of the whole Child Death Review (CDR) and Sudden Unexpected Deaths in Children (SUDC) processes in accordance with the national child death review statutory and operational guidance 2018 and local child death review policies across black country, to ensure consistency and quality.
- Consider what if any action should be taken in relation to any modifiable factors identified, and make recommendations to multi-agency safeguarding arrangements, health and wellbeing boards and other relevant strategic partnerships.

The proposals have been approved by the statutory partners through a Memorandum of Understanding (MOU), and which clarifies that the Black Country Strategic CDOP will:

[1] Wood Report: Review of the role and functions of Local Safeguarding Children Boards, 2016

- ***be accountable to the Statutory Partners and will report to bi-annually and annually to Health and Wellbeing Boards, and where appropriate to other statutory strategic partnerships including Multi-Agency Safeguarding and Community Safety Partnerships.***
- Explore, develop and monitor consistent Child Death Review practices across the Black Country including:
    - A Black Country notification process
    - A Black Country Database for recording data.
    - A Black Country learning and education programme
    - A Black Country Sudden Unexpected Death in Childhood (SUDC) protocol
    - A Black Country Memorandum of Understanding with the coroner
    - Child Death Review protocols/ policies local standard and operating procedures for the Black Country
    - Protocols to link local hospital mortality reviews, regional networks with CDOP
    - Data collection procedures and data sharing agreements including the results of hospital mortality review processes
    - Standardising mechanisms and protocols of sharing the learning from Black Country child death reviews and the Local Maternity System
    - Standardising the Learning Disability Death review (LeDeR) processes

Update:

- The Black Country Strategic CDOP group will be known as the *Black Country CDOP Strategic Business Partnership* and will be established Nov/Dec 19
- A Black Country CDOP Coordinator has been appointed
- A budget for CDOP reviews and strategic/business functions have been secured on a partnership model
- eCDOP software has been commissioned to simplify and standardise notification, reporting, information gathering and analysis; this has been initiated
- North and South CDOP Review meetings continue to operate for all non-neonatal cases
- A Black Country thematic neonatal review panel is being organised for Feb 20 which replace neonatal cases in the North (Wolverhampton and Walsall)/ South (Sandwell and Dudley) review panels.
- Links to the West Midlands neonatal network and Local Maternity System have been developed, and processes incorporated. Neonatal reviews undertaken by the network will be made available to the BC Neonatal review group
- A Self Assessment Framework against all the national CDR standards is being used to:
    - Identify risks and develop an action plan
    - Support trusts and providers to identify gaps in their processes and;
    - Provide assurance by the Black Country CDOP Strategic Business Partnership to statutory partners;

Challenges:

Whilst great progress has been made over the last 12 months, there remain many challenges including:

- Ensuring that there is ongoing dialogue and communication with partners and stakeholders during the period of transition

- Ensuring that there is ongoing commitment to the development of child death review processes across a Black Country footprint
- Ensuring that eCDOP is comprehensively embedded across the area, and that it is the main system for notification, information gathering/ sharing, and analysis
- Shifting the responsibility of "ownership" of CDOP and Child Death Reviews from Children's Safeguarding Partnerships to Health and Wellbeing Boards in a timely manner
- Ensuring that professionals involved in the current arrangements for reviewing child deaths at a North/South area are actively involved in Black Country reviews
- Competing pressures on professionals' time to support the child death review processes
- Additional expectations on the outputs from internal organisation child death reviews (Child Death Review meetings), especially NHS Trusts

Recommendations:
Health and Wellbeing Board members are asked to:

1. Note the above update and challenges
2. Support the proposition that the responsibility for oversight of child death review processes, transfers from Children's Safeguarding Partnerships to Local Health and Wellbeing Boards. The Black Country CDOP Strategic Business Partnership will provide this oversight on behalf of the partners.

John Denley,
Director of Public Health
Wolverhampton
Black Country Strategic Lead for Child Deaths