Bolton, Salford and Wigan Child Death Overview Panel

Statutory Responsibilities and Child Death Arrangements Implementation Plan June 2019

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1. Overview

The Child Death Review Partners for Bolton, Salford and Wigan will ensure that all child deaths are reviewed under the requirements of the Children Act 2004 as amended by the Children and Social Work Act 2017 and Working Together 2018.

2. Purpose

Bolton, Salford and Wigan Child Death Review Partners will ensure that the Child Death Overview Panel (CDOP) will undertake a review of all child deaths (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) up to the age of 18 years normally resident in Bolton, Salford and Wigan and if they consider appropriate any non-resident child who has died their area.

The Child Death Review Partners and CDOP will adhere to the statutory guidance 'Child Death Review Statutory and Operational Guidance (England) 2018':

"The process of systematically reviewing the deaths of children is grounded in respect for the rights of children and their families, with the intention of learning what happened and why, and preventing future child deaths." (Working Together to Safeguard Children, 2018).

3. Child Death Review Partners Statutory Responsibilities

The Bolton, Salford and Wigan Child Death Review Partners have made arrangements for a structured and consistent approach to review all deaths of children under 18 years of age in line with Working Together, 2018.

Statutory requirements place the responsibility for the reviews of child deaths on the Clinical Commissioning Group (CCG) and Local Authority from where the child was resident. The ten areas across Greater Manchester operate a tri partite arrangement. The current Greater Manchester CDOP arrangements are consistent with the revised national statutory requirements. In line with the 2008 Department for Education recommendation that CDOPs should cover a population of 500,000 of children or higher, three of the CDOPs are made up of multiple Local Safeguarding Children Partnerships which also fall under the same geographical areas as the Coroner's Office jurisdiction and are as follows:

- **Bolton, Salford and Wigan CDOP**
- Bury, Rochdale and Oldham CDOP
- Manchester City CDOP
- Tameside, Trafford and Stockport CDOP

The geographical footprint of Bolton, Salford and Wigan CDOP reflects the network of NHS health providers, Police and Social Care providers for this cluster. The arrangements are as follows:

- The child death review process will be modelled on, and adhere to, Child Death Review Statutory and Operational Guidance (2018) this will include the continued utilisation of the Child Death Overview Panel as the chosen forum for reviewing all child deaths.
- The Child Death Review Partners will work with Greater Manchester partners to determine funding for a Designated Doctor for Child Death and a Lead Nurse for the Child Death Review process which incorporates the Link/Key worker role as stated in the statutory guidance and as required by 29 September 2019.
- The partners will continue to be able to access an electronic case management system. This will support data submission into the National Child Mortality Database.
- The Partners will have oversight and be assured of the development and progress of the Child Death Review Process and CDOP through agreed governance and reporting mechanism.
- The Child Death Review Partners will publicise information regarding the arrangements for reviewing child deaths in Bolton, Salford and Wigan.

4. Child Death Overview Panel Responsibilities

- To collect and collate information about a child's death, seeking relevant information from professionals and where appropriate family members.
- To analyse the information obtained, including the report from the Child Death Review Meeting in order to confirm or clarify the cause of death, to determine any contributing factors, and to identify any learning arising from the child death review process that may prevent future death.
- To make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths and will promote the health safety and well-being of children.
- To notify the relevant locality's 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 (once introduced) and the doctor who certified the cause of death, if it is identified there are any errors or deficiencies in an individual child's registered cause of death.
- To provide specific data to NHS digital through the National Child Mortality Database.
- To produce an annual report for Child Death Review Partners on local patterns and trends in child deaths, and any lessons learnt and actions taken and the effectiveness of the wider child death review process.

- 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.

5. Child Death Overview Panel Operational Arrangements

The Bolton, Salford and Wigan CDOP will:

- Meet bi-monthly to enable the deaths of children to be discussed in a timely manner and within the statutory timeframe of six months. Frequency of meetings to be reviewed as required by the CDOP panel. Exceptions are where there is a current criminal or coronial investigation.
- Themed panels will be considered and determined by the needs of local child deaths.
- Ensure that effective rapid response arrangements for sudden deaths are in place, to enable key professionals to come together to undertake enquiries into and evaluate and make an analysis of each unexpected death of a child.
- Review the appropriateness of agency responses to each death of a child.
- Review relevant environmental, social, health and cultural aspects of each death to ensure a thorough consideration of how such deaths may be prevented in the future.
- Determine whether each death had any potentially modifiable factors.
- Make appropriate recommendations to Bolton, Salford and Wigan Safeguarding Partnership's where there are concerns of abuse and neglect in order that prompt action can be taken to learn from and prevent future deaths where possible.
- Report and inform the Learning Disabilities Mortality Review (LeDeR) process of any deaths of children over 4 years who have a Learning Disability.

5.1. Panel Membership

The Child Death Review Panel is currently chaired by an appointed Independent Chair. This arrangement will be reviewed by the Tripartite Partnership going forward as required. Consideration will be given to employing an independent chair or utilising a chair from within the local partnership as required.

This will be reviewed annually when the terms of reference are reviewed.

The Child Death Review Statutory & Operational Guidance states: "The CDOP should be chaired by someone independent of the key providers (NHS, social services, and police) in the area."

CDOP is a multi-professional panel. The core membership will include senior representatives from the following agencies:

- Public Health, Public Health Consultant
- Designated Doctor for Child Deaths (and a hospital clinician if the Designated Doctor is a community doctor or vice versa)
- Children Social Care, Strategic Lead for Front Door
- Greater Manchester Police, Detective Inspector
- NHS Clinical Commissioning Group, Designated Nurse for Safeguarding Children
- Primary Care, Named General Practitioner for safeguarding children
- Maternity Services, Head of Midwifery
- Children's Community Health Services, Strategic Health Service Lead
- Lay representation

This membership will consist of at least one of the above designations from one of the three boroughs.

In addition to the core membership of CDOP, relevant experts from health and other agencies will be invited as necessary to inform the discussion and may include:

- Child and Adolescent Mental Health Service (CAMHS), Consultant Clinical Psychologist
- Education, Director of Education
- Early Years, Head of Early Years
- Children's Community Nursing Team , Palliative Care Nurse

5.2. Quoracy

The Child Death Overview Panel will be quorate if there are five or more core members present at the meeting, this must include attendance by lead professionals from health and the Local Authorities.

5.3. Decisions and Disputes

Decisions will be normally reached by consensus. In the event of a disagreement, a vote of members of the panel will be taken. In the event of a failure to resolve an issue, the chair will discuss this further with the Designated Doctor for Child Death and the Vice Chair to come to a resolution. The Chair will have the casting vote.

5.4. Conflict of Interest

Panel members must declare any conflict of interest at the outset of each meeting. Panel members should not lead discussions if they are the named professional who had responsibility for the care of the child prior to their death.

5.5. Confidentiality

All information discussed at the Child Death Overview Panel is strictly confidential and must not be disclosed to a third party without discussion and agreement of the Chair. A confidentiality agreement will be read and signed by all members of the panel at the beginning of each meeting.

5.6 Terms of Reference

The terms of reference of The Bolton, Salford and Wigan CDOP will be subject to annual review, or more frequently, if required.

6. Governance and Accountability

The Child Death Overview Panel is accountable to the Bolton, Salford and Wigan Child Death Review Partners.

Minutes of each meeting are recorded and are available with permission from the Chair to the Child Death Review Partners.

An annual summary of key learning will be developed and reported to the Child Death Review Partners. The Child Death Overview Panel will report quarterly to:

- Local Health and Well Being Boards for Bolton, Salford and Wigan.
- Local Safeguarding Partnerships within Bolton, Salford and Wigan.

The report will include numbers of child deaths reviewed, recommendations, learning and any delays on reviewing child deaths due to criminal or coronial investigations.

The data will also be used in the annual CDOP report for Greater Manchester, allowing any Greater Manchester themes or issues to be identified.

The chair of the Child Death Review Panel and Strategic Partners will write and present an Annual Report. This will be presented to the Child Death Review Partners and to Bolton, Salford and Wigan local Health and Wellbeing Boards and Safeguarding Partnerships.

Any concerns regarding responsibilities and functions of the Child Death Review process and the Child Death Overview Panel will be reported and escalated to the Child Death Review Partners by the Chair or Vice Chair of CDOP.

7. Implementation

The CDOP plan will be implemented on 29th September 2019; at this point the Bolton, Salford and Wigan Child Death Overview Partners will take responsibility for the implementation of the new arrangements as set out within this document.

8. Publication

The Bolton, Salford and Wigan Child Death Review Partners and Child Death Overview Panel arrangements will be published on:

- NHS Bolton CCG website
- NHS Salford CCG website
- NHS Wigan Borough CCG website
- Bolton Council website
- Salford Council website
- Wigan Council website
- Bolton Safeguarding Children Partnership website
- Salford Safeguarding Children Partnership website
- Wigan Safeguarding Children Partnership website

The CCGs will also notify NHS England of the new arrangements by emailing England.cypalignment@nhs.net before the 29th June 2019