East Riding Child Death Review Arrangements

1. Context

1.1 Chapter 5 of Working Together to Safeguard Children 2018 published in July 2018, outlined changes to the Child Death Review Process. A more comprehensive Child Death Review: Statutory and Operational Guidance was published in October 2018 and set out key features of what a good Child Death Review (CDR) process should look like and the statutory requirements that must be followed.

2. Accountability

2.1 The East Riding of Yorkshire Council (ERYC) and the East Riding Clinical Commissioning Group (ERCCG) are the local Child Death Review Partners.

2.2 Child Death Review Partners must make arrangements for the review of each death of a child normally resident in the East Riding of Yorkshire area. They must also make arrangements for the collection and analysis of information about deaths reviewed under the new guidance.

2.3 A quarterly report will be proved to the ERCCG and the ERYC via the East Riding Safeguarding Children Partnership.

2.4 Senior leaders within organisations who commission or provide services for children, as well as relevant regulatory bodies, should also follow the procedures set out in the guidance.

2.5 All other professionals who care for children, or who have a role in the Child Death Review Process, should read and follow the guidance so that they can respond to each child death appropriately.

3. Geographical Area

3.1 The East Riding of Yorkshire is a large rural coastal county covering over 930 square miles with a population of approximately 338,061 people, of which 69,800 children and young people aged 0-19 years (Public Health England, 2020) Children and young people live in towns and rural areas which range from wealthy with good access to services and opportunities to those living in poverty and isolation. These diverse dynamic factors significantly educational attainment, income, employment and health

and present considerable challenges for agencies to support children, young people and families who live in the East Riding. It is estimated that the percentage of children living in poverty aged under 16 years 12.2% compared with the England average of 17%.

3.2 Overall, comparing local indicators with England averages, the health and wellbeing of children in East Riding of Yorkshire is better than England.

3.3 The infant mortality rate is better than England but an average of 6 infants die before age 1 each year. Recently there have been 5 child deaths (1-17 year olds) each year on average.

3.4 Public health interventions can improve child health at a local level. In this area:

- The teenage pregnancy rate is better than England, with 72 girls becoming pregnant in a year.
- 14.3% of women smoke while pregnant which is worse than England.
- Breastfeeding rates in this area are similar to England. 64.5% of new-born's received breast milk as their first feed. By 6 to 8 weeks after birth, 47.2% of mothers are still breastfeeding.
- The MMR immunisation level does not meet recommended coverage (95%). By age 2, 94.1% of children have had one dose.
- The number of 5 year olds with one or more decayed, missing or filled teeth is not available.
- 8.7% of children in Reception and 18.0% of children in Year 6 are obese.
- The rate of child inpatient admissions for mental health conditions at 87.4 per 100,000 is similar to England. The rate of self-harm at 303.5 per 100,000 is better than England.

3.5 The hospital admission rate for injury in children (aged 0-14) at 103.5 per 10,000 is similar to England, and for young people (aged 15-24) at 130.4 per 10,000 is similar to England.

3.6 Over a three year period 39 children were killed or seriously injured on the roads. This gives a similar rate to England.

3.7 As of the January 2019 census there were 45,713 pupils in East Riding maintained schools. 3,069 (6.9%) of these school children are from minority ethnic groups.

4. Reporting

4.1 All deaths in East Riding of Yorkshire that fit the criteria under the Child Death Review: Statutory and Operational Guidance (England) will be notified to the Designated Officer for the Child Death Overview Panel, Margaret (Margo) Smith who is located within the East Riding Safeguarding Children Partnership.

4.2 Standard CDOP forms, provided by the Department of Education, will be used in the Child Death Review process, to gather relevant information for reviewing

individual deaths (via eCDOP) https://www.gov.uk/government/publications/child-death-reviews-forms-for-reporting-child-deaths

5. Criteria for Reviewing a Child Death

5.1 The Child Death Review: Statutory and Operational Guidance (England) says that a child death review should be carried out for all children under 18 years of age regardless of the cause of death. This includes the death of any live-born baby where a death certificate has been issued. In the event that the birth is not attended by a healthcare professional, Child Death Review Partners may carry out initial enquiries to determine whether or not the baby was born alive. If these enquiries determine that the baby was born alive the death must be reviewed.

5.2 Cases where there is a live birth after a planned termination of pregnancy carried out within the law are not subject to a Child Death Review.

5.3 The purpose of a review and/or analysis is to identify any matters relating to the death or deaths, that are relevant to the welfare of children in the East Riding of Yorkshire 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. In circumstances where a child has died and abuse or neglect is known or suspected, professionals at the initial information-sharing and planning meeting should notify the safeguarding partners whose responsibility it is to determine whether the case meets criteria for a Child Safeguarding Practice Review (Working Together to Safeguard Children 2018 Chapter 4.18).

5.4 In reviewing the death of each child, ERCDOP will consider modifiable factors, for example, in the family environment, parenting capacity or service provision and consider what action could be taken locally and what action could be taken at a regional or national level.

5.5 The aggregated findings from all child deaths should inform local strategic planning, including the local Joint Strategic Needs Assessment on how to best safeguard and promote the welfare of children in the area.

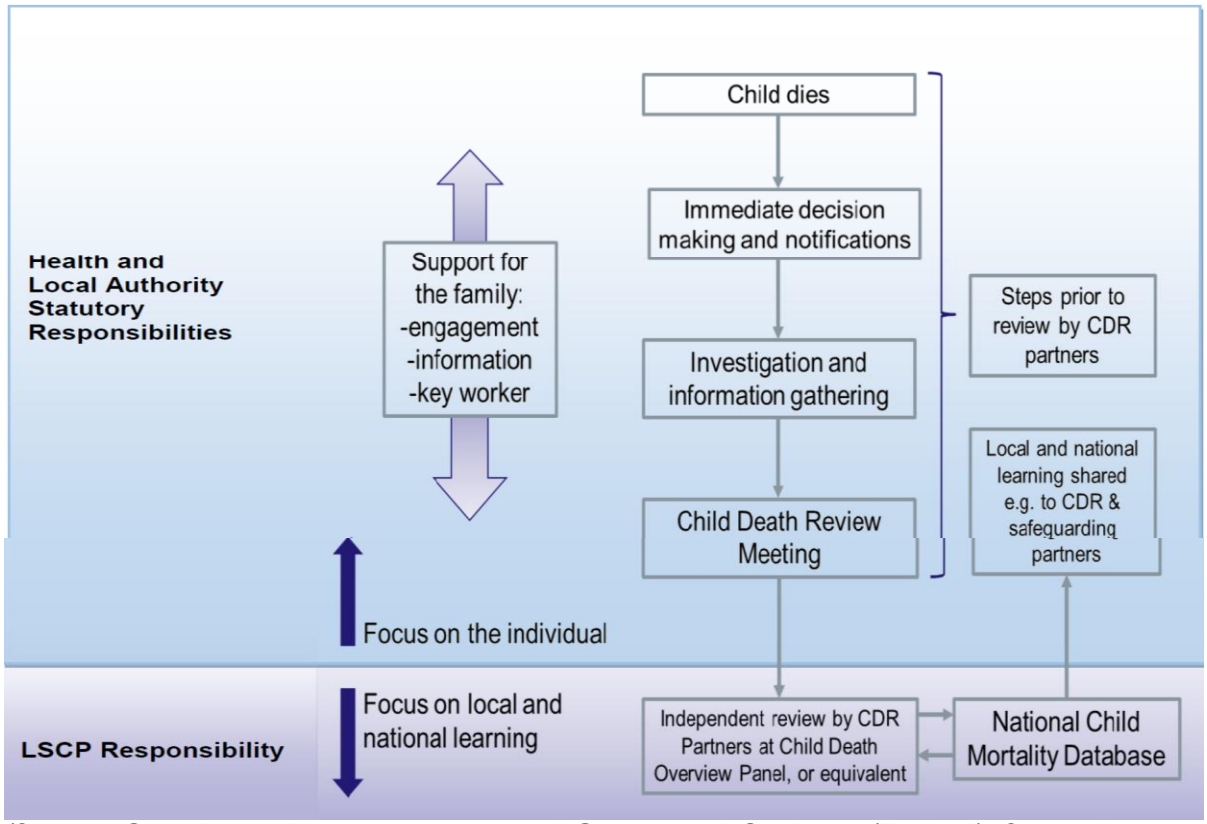
6. Child Death Review Process

6.1 Whilst Child Death Review Partners are free to establish their own structure and process to reviews the deaths of children normally resident in their geographical area of responsibility based on local need, they should ensure that the processes align to the general principles set out in the national guidance in order to enable local lessons to be reflected at a national level.

6.2 The collation and sharing of the learning from reviews will be managed by the National Child Mortality Database through the use of standardised forms.

6.3 The flow chart below sets out the main stages of the Child Death Review Process.

Figure 1: Child Death Review Process



(Source: Child Death Review statutory and Operational Guidance (England), September 2018)

6.4 Chapter 6 and 7 of the Child Death Review Statutory and Operational Guidance lays out the responsibilities for Health and the Local Authority, where Chapter 8 lays out the responsibility for the Child Death Overview Panel.

6.5 **Immediate decision making and notifications** relates to the immediate actions to be taken after the death of a child, such as notification of death, or deciding whether other investigations are warranted. This includes determining whether the death meets the criteria for a **Joint Agency Response (JAR)**.

6.6 A JAR will be triggered if a child's death:

- Is or could be due to external causes (and was not anticipated 24 hours prior to death);
- Is sudden and there is no immediately apparent cause (inc 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 and;
- In the case of a stillbirth where no healthcare professional was in attendance.

6.7 In practice the majority of such discussions will happen in a clinical setting and may take place virtually.

6.8 **Child Death Review Meeting (CDRM)** relates to the discussion of the death of a child by the professionals who were directly involved in the care of that child during their life and those professionals who were involved in the investigation into their death. The outputs of this meeting will inform the statutory independent multi-agency panel arranged by Child Death Review Partners at the Child Death Overview Panel (CDOP).

6.9 The CDRM will output a draft 'Analysis Pro Forma' which will be sent to the CDOP.

6.10 Additional reports will be supplied to the CDRM such as:

- Where the death of a child was unexpected and the SUDIC guidelines were followed. The SUDIC minutes and final report will be sent directly to CDOP.
- Where the death is of a baby <28 days old, a completed Perinatal Mortality Review Form (PMRT) will be provided to CDOP.
- Where the death is subject to a Child Safeguarding Practice Review, the CDOP will accept the full report.
- Serious Incident (SI) Reports.

6.11 **Review of child deaths at the East Riding Child Death Overview Panel (CDOP)**

6.12 The deaths of all children that fit the criteria laid out in Working Together to Safeguard Children 2018 and the supplementary Child Death Review Guidance will be reviewed by the CDOP. East Riding Safeguarding Partners that form the core membership of the CDOP will include, but is not limited to:

- Associate Director of Public Health (Chair)
- East Riding Safeguarding Children Partnership
- Designated Doctor for Child Deaths
- Humberside Police
- Head of Service, Children & Young Peoples Safeguarding Support Service, East Riding of Yorkshire Council
- Humber Teaching NHS Foundation Trust- Named Nurse Safeguarding Children
- East Riding Clinical Commissioning Group Designated Doctor
- East Riding Clinical Commissioning Group Designated Nurse

- Hull University Teaching Hospitals NHS Trust-Named Nurse/Midwife for Safeguarding Children

- Educational Representative

6.13 Other agencies and organisations may be co-opted for specific deaths if appropriate and agreed by the Chair of the CDOP.

7. Family Engagement and Bereavement Support

7.1 The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity. The Child Death Review Process aims to balance improving the experience of bereaved families, and professionals involved in caring for children at a traumatic time ensuring that information is systematically captured in every case to enable learning from those events to prevent future deaths.

7.2 Engaging the family who have lost a child is also an important part of the Child Death Review Process. Recognising the complexity of the process and the different emotional responses that bereavement can bring, families will be given a single, named '**key worker'**, for information on the processes following their child's death and who can signpost them to sources of support.

7.3 The key worker for bereaved families responsibilities and competencies can be found on P67 of the Child Death Review: Statutory and Operational Guidance (England).

8. Collaborative Regional CDOP Arrangements

8.1 The Local Authorities and Clinical Commissioning Groups for East Riding of Yorkshire, North and North East Lincolnshire, Hull, North Yorkshire and York, i.e. the Child Death Review Partners have agreed to come together on a larger footprint on an annual basis to share learning, and identify themes and trends and to align processes and procedures to support analysis and comparison.

8.2 These Collaborative Regional CDOP Arrangements are the process by which the Child Death Review Partners in the 4 localities will ensure compliance with the recommendation in Working Together 2018 for local child death review arrangements to cover a child population such that they typically review at least 60 child deaths per year.

8.3 Local Child Death Review arrangements, including meetings and annual reporting are to be maintained as part of the Collaborative Regional CDOP Arrangements.

8.4 An annual learning event will be established (potentially themed, e.g. approach to modifiable factors, neonatal deaths, etc.) to share practice across the 4 CDOP areas, which should give a typical number of at least 60 cases.

8.5 Local Annual Reports will be aggregated to one report covering the 4 CDOP areas namely: East Riding, Hull, Northern Lincolnshire CDOP (operating across North and North East Lincolnshire), and North Yorkshire and York which should give a typical number of at least 60 cases.

8.6 Annual reports will be on fiscal years for aggregation purposes in the future and the aim is to have an annual report produced following the annual learning event in June of each year.

8.7 There will be some technical issues to review to support consistency, good practice and comparability across the agreed Collaborative Regional CDOP Arrangements area in relation to modifiable factors, categorisation etc. Task and Finish Groups will be established to complete this work.

8.8 A Planning Group for the Learning Event will be established to oversee principles of engagement and outcome management. The Partners will consider how to include parents, families etc., for future planning and coproduction, especially in relation to bereavement.

Summary of the Process

For every child death, the following actions should be taken:

- A notification form should be completed via https://www.ecdop.co.uk/HullER/Live/Public immediately after a child dies.
- The details on the notification form will automatically be entered onto the National Child Mortality Database (NCMD) via eCDOP.
- Information should be gathered from all agencies that were involved with the child during their life or after death through completion of a Reporting Form.
- The CDOP Officer will identify the most appropriate agency to complete the relevant supplementary reporting forms, depending on the cause of death, and request for that agency to complete the relevant forms.
- When completed, Reporting Forms and supplementary Reporting Forms should be returned to the CDOP Officer and the information on them should be entered onto the NCMD.
- A local Child Death Review Meeting (CDRM) should be convened, to include all professionals that were involved with the child during their life or after death, and at this meeting a draft Analysis Form should be completed.
- The draft Analysis Forms should be presented to the CDOP so an independent review of the case can be conducted. The draft Analysis Form will be finalised and agreed at this meeting.
- Following review by CDOP, the details will be entered onto the eCDOP & NCMD.

RELATED GUIDANCE & LINKS

Child Death Review: Statutory and Operational Guidance (England)

Child Death Reviews: Chapter 5 of Working Together to Safeguard Children 2018

Child Death Reviews Legislation: Section 16M-Q of the Children Act 2004