Cumbria Safeguarding Children Partnership

CSCP

Cumbria Child Death Review Arrangements

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1. Introduction

This document sets out how the Child Death Review partners and professionals in agencies across Cumbria will work together to review child deaths at a local level in order to identify learning that may help to prevent future child deaths.

Chapter 5 of Working Together to Safeguard Children 2018 published in July 2018 outlines the child death review process and the Child Death Review Statutory and Operational Guidance published in October 2018 sets out in full the statutory requirements that must be followed.

2. Accountability

"Child Death Review Partners" as defined in section 16Q of the Children Act 2004 include the local authority and any Clinical Commissioning Group for an area, any part of which falls within the Local Authority area.

The Clinical Commissioning Group and Local Authority must make arrangements for the review of each death of a child normally resident in Cumbria. They must also make arrangements for the analysis of information about deaths reviewed under the new guidance.

Senior leaders within organisations who commission or provide services for children in Cumbria, as well as relevant regulatory bodies, should also follow the procedures set out in the Child Death Review Guidance.

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

The geographical area for Child Death Reviews is defined by the local authority boundary area for Cumbria County Council.

4. Reporting

All deaths in Cumbria that meet the criteria under the Child Death Review Operational Guidance will be notified to the Child Death Review Coordinator within the Cumbria Safeguarding Children Partnership.

5. Criteria for Reviewing a Child Death

The death of all children who are normally resident within the boundary of Cumbria County Council local authority will be reviewed under these arrangements, including live born babies where a death certificate has been issued (including under 22 weeks).

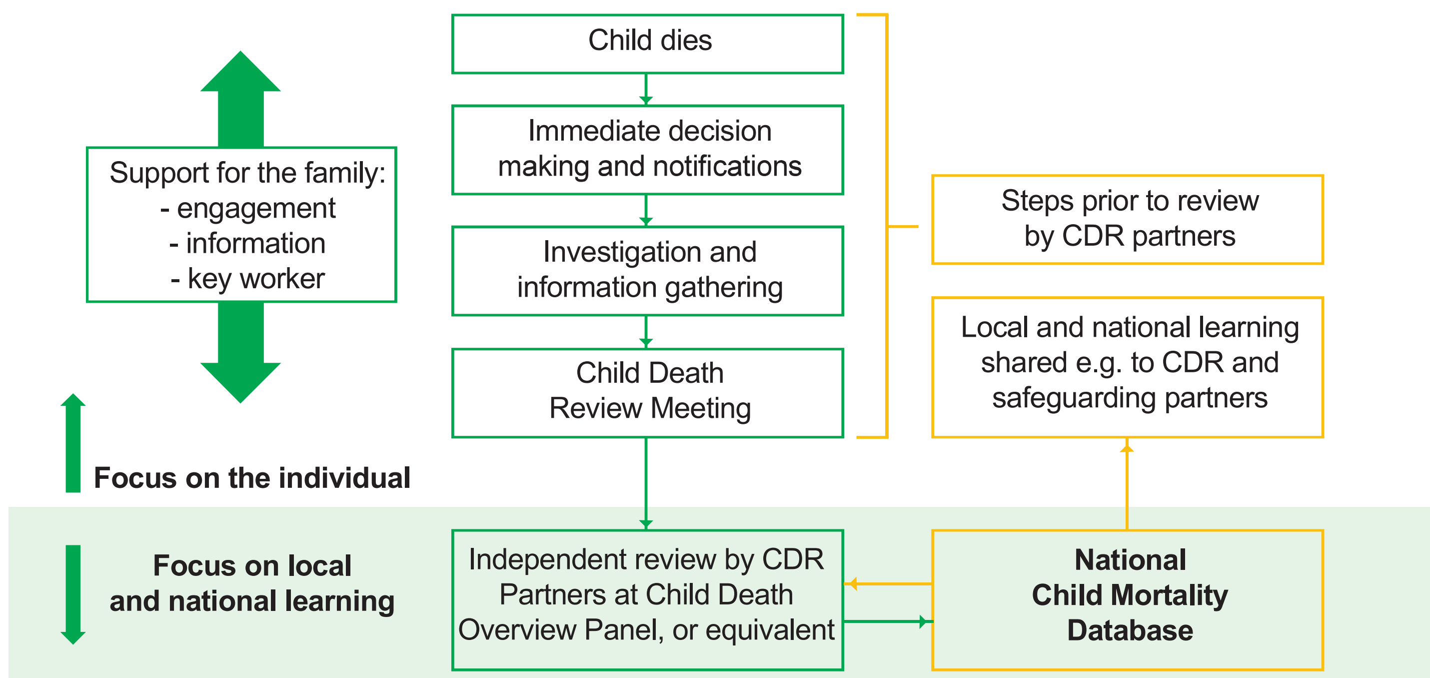
In the event that the birth is not attended by a clinician, child death review partners may carry out initial enquires to determine whether or not the baby was born alive. If these enquiries determine that the baby was born a live the death must be reviewed.

Cases where there is a live birth after a planned termination of pregnancy carried our within the law are not subject to a child death review.

In circumstances where a child has died and abuse or neglect is known or suspected, professionals at the initial Joint Agency Response Meeting (JARM) should notify the safeguarding partners whose responsibility it is to determine whether the case meets the criteria for a Safeguarding Practice Review.

6. Child Death Review Process

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



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

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 CDOP.

7. Joint Agency Response Meeting (JARM)

A Joint Agency Response Meeting (JARM) will be triggered in full for all child deaths that are sudden or unexpected.

An unexpected death is a term used at presentation for the death of an infant or child whose death was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death.

Sudden and Unexpected Death in Infancy and Childhood: multi-agency guidelines for care and investigation (2016) provides clear guidance on the process that should commence following the unexpected death of a child.

8. Child Death Review Meeting (CDRM)

The CDRM is a multi-agency meeting where all matters relating to an individual child are discussed by professionals directly involved in the care of that child during their life.

The purpose of the CDRM is to discuss and review the background history, treatment and outcomes of investigations to determine, as far as possible the likely cause of death; to ascertain contributory and modifiable factors across domains specific to the child, the social and physical environment and service delivery; to describe any learning arising from the death and, where appropriate, to identify actions that should be taken by an organisation involved to improve the safety or welfare of children or the child death review process and to review the support provided to the family and to ensure that the family are provided with the outcomes of any investigation into their child's death. The analysis form must be drafted within the meeting which will then be presented to the CDOP.

The CDRM will review the deaths of all children and will complete a draft 'Analysis Form' which will be submitted to the CDOP. A CDRM can take many forms such as a Local Case Discussion, Perinatal Mortality Meeting, an NHS Serious Incident Investigation or a Hospital Morbidity and Mortality Meeting.

9. Cumbria Child Death Overview Panel (CDOP)

The deaths of all children that meet the criteria stated in Working Together to Safeguard Children 2018 and supplementary Child Death Review Statutory and Operational Guidance 2018 will be reviewed by the CDOP. Cumbria Safeguarding Children Partners that form the membership of the CDOP include, but is not limited to:

Cumbria County Council Director of Public Health,
North Cumbria CCG Designated Doctor,
North Cumbria CCG Named Nurse Safeguarding,
Morecambe Bay CCG Designated Doctor,
Morecambe Bay CCG Named Nurse Safeguarding,
North Cumbria Integrated Care Consultant Paediatrician.
North Cumbria Integrated Care Named Nurse Safeguarding
Cumbria County Council Service Manager, Children & Young People Services,
Cumbria Police Detective Superintendent
North West Ambulance Service
CSCP Partnership Manager
Child Death Review Coordinator

This is not an exhaustive list and other representatives may be invited by the chair as appropriate.
The CDOP will determine whether each child death is deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths.

The CDOP will make recommendations to the Cumbria Safeguarding Children Partnership or other relevant services promptly so that action can be taken to prevent future such deaths where possible.

10. Staffing and Resource

The CSCP Business Unit manage the CDR process on behalf of Cumbria County Council, North Cumbria Clinical Commissioning Group and Morecambe Bay Clinical Commissioning Group.

There is a Child Death Review Coordinator employed within the CSCP who is managed and supported by the Partnership Manager and wider team.

11. Annual Report

The CDOP produces an annual report to the Cumbria Safeguarding Children Partnerships who will make the report available on their website.

12. Local, Regional and National Learning

The CDOP will share local data, including emerging patterns and trend's regionally to gain the appropriate footprint and identify commonalities and learning on a regional scale.

The learning from all child death reviews are shared with the National Child Mortality Database to contribute to the identification of national trends or similarities in deaths and inform systematic or local changes to prevent future deaths.

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