Enter

North Yorkshire and York Child Death Review Arrangements

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North Yorkshire
Safeguarding Children Partnership

City of York
Safeguarding Children Partnership

Contents

1. Context

Chapter 5 of Working Together to Safeguard Children 2018 published in July 2018 outlined changes to the child death review process. The government produced a more comprehensive Child Death Review Statutory and Operational Guidance in October 2018 and set out key features of what a Child Death Review (CDR) process should look like and the statutory arrangements 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 North Yorkshire and York. 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 North Yorkshire and York, 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 North Yorkshire County Council and City of York.

To ensure we can review the required number of cases outlined in the statutory guidance (at least 60 deaths each year) an agreement with the neighbouring Child Death Review Panels which includes Hull, East Riding, North Lincolnshire and North East Lincolnshire has been reached to ensure we can thematically review cases and identify wider learning in order to identify any modifiable factors to protect children from harm and, ultimately, save lives.

4. Reporting

All deaths in North Yorkshire and York that meet the criteria under the Child Death Review Operational Guidance will be notified to the Child Death Review Officer within the North Yorkshire and York Safeguarding Children Partnership.

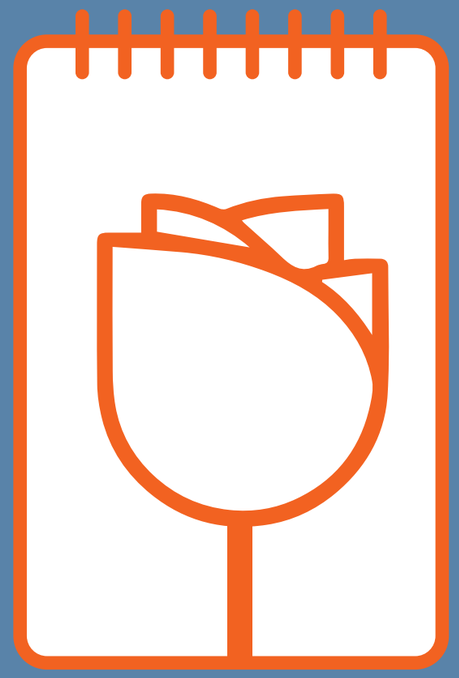
5. Criteria for Reviewing a Child Death

The death of all children who are normally resident within the boundary of North Yorkshire and York 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.

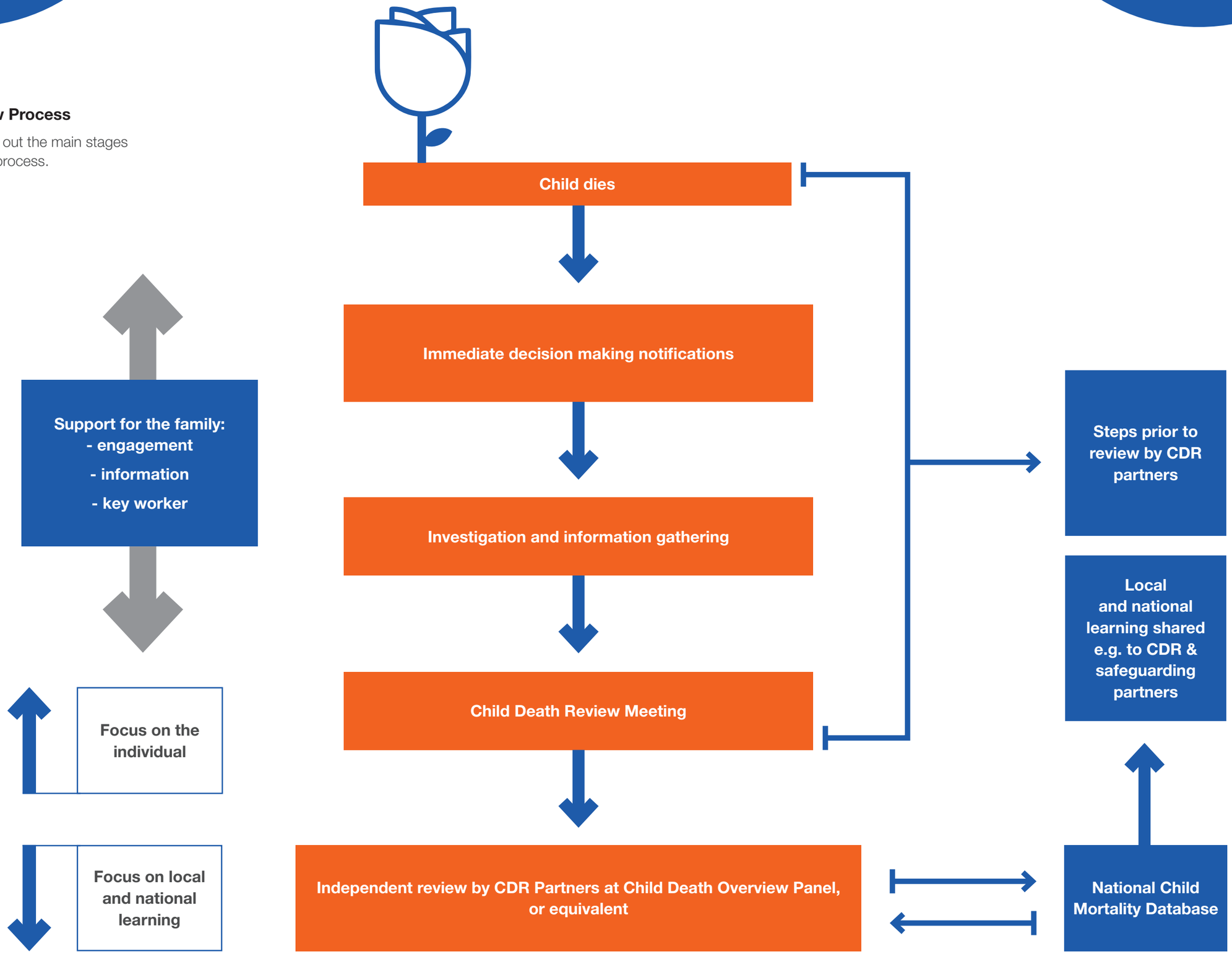
Cases where there is a live birth after a planned termination of pregnancy carried our within the law are not subject to a child death review.

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.



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.

This meeting will be coordinated by the Child Death Review Officer in conjunction with partners and will take place within 72 hours of the death (3 Working Days).

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. Typically, this meeting happens three months or more following the death of a child. 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. North Yorkshire 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. North Yorkshire and York Safeguarding Children Partners that form the membership of the CDOP include; but is not limited to;

- City of York Council Nurse Consultant in Public Health, (Chair)
- Clinical Commissioning Group Designated Doctor for Child Deaths, York and North Yorkshire
- North Yorkshire Safeguarding Children Partnership Manager,
- City of York Safeguarding Children Partnership Manager,
- City of York Group Manager, Children's Social Care,
- North Yorkshire County Council Group Manager, Children & Families,
- North Yorkshire Police Detective Superintendent
- City of York Safeguarding Children Partnership Lay Member
- North Yorkshire County Council Public Health Consultant,
- York Teaching Hospital NHS Foundation Trust Head of Midwifery
- Harrogate District Hospital NHS Foundation Trust Head of Midwifery
- Designated Doctor for Safeguarding Children and Children in Care, Vale of York and North Yorkshire Clinical Commissioning Groups
- Harrogate District Hospital NHS Foundation Trust Professional Lead for 5 – 19 Service
- Harrogate District Hospital NHS Foundation Trust Professional Lead for Health Visiting
- City of York 0-19 Service
- North Yorkshire and York Safeguarding Children Partnership Child Death Review Officer

In addition, the Child Death Overview Panel may co-opt representation from any of the following agencies (this is not an exhaustive list and other representatives may be invited by the chair as appropriate);

- Youth Justice Service
- Children and Adult Mental Health Services
- Road Safety Leads
- British Transport Police
- Yorkshire Ambulance Service

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 North Yorkshire and City of York Safeguarding Children Partnership's or other relevant services promptly so that action can be taken to prevent future such deaths where possible. Where actions are put in place as a result of recommendations from CDOP, the Child Death Review Officer will monitor and review until the CDOP are assured the action is complete.

10. Staffing and Resource

The NYSCP Business Unit manage the CDR process on behalf of North Yorkshire County Council, City of York Council and the North Yorkshire and Vale of York Clinical Commissioning Group.

There is a full time Child Death Review Officer employed with the NYSCP who is managed and supported by the Partnership Manager and wider team

The Designated Doctor for Child Deaths is employed on a part time basis by the four Clinical Commissioning Group in North Yorkshire and is responsible for chairing the child death review meetings for unexpected child deaths, and leading the case discussions at the Child Death Overview Panel meetings, as well as providing advice and support to health providers and other agencies involved in managing child deaths and delivering training on the CDR process in conjunction with the Child Death Review Officer.

11. Annual Report

The CDOP produces an annual report to the North Yorkshire and City of York Safeguarding Children Partnerships who will make the report available on both of their websites.

12. Local, Regional and National Learning

The CDOP will share local data, including emerging patterns and trend's regionally at both the Regional CDOP Coordinators and Sub Regional CDOP Meetings 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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