Wakefield Child Death Review Arrangements

Published and Implemented:
July 2022

Wakefield Safeguarding Children Partnership

Contents

1. Context

Chapter 5 of Working Together to Safeguard Children 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 Wakefield. 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 Wakefield, 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 Wakefield. This has been extended to also include North Kirklees within the Mid Yorkshire Local Authority Footprint, which is overseen by Kirklees Safeguarding Children Partnership CDOP.

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 in Kirklees and Calderdale 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 Wakefield that meet the criteria under the Child Death Review Operational Guidance will be notified to the Wakefield Safeguarding Children Partnership Business Unit.

5. Criteria for Reviewing a Child Death

The death of all children who are normally resident within the boundary of Wakefield - 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 alive the death must be reviewed. 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.

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

6. Child Death Review Process

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

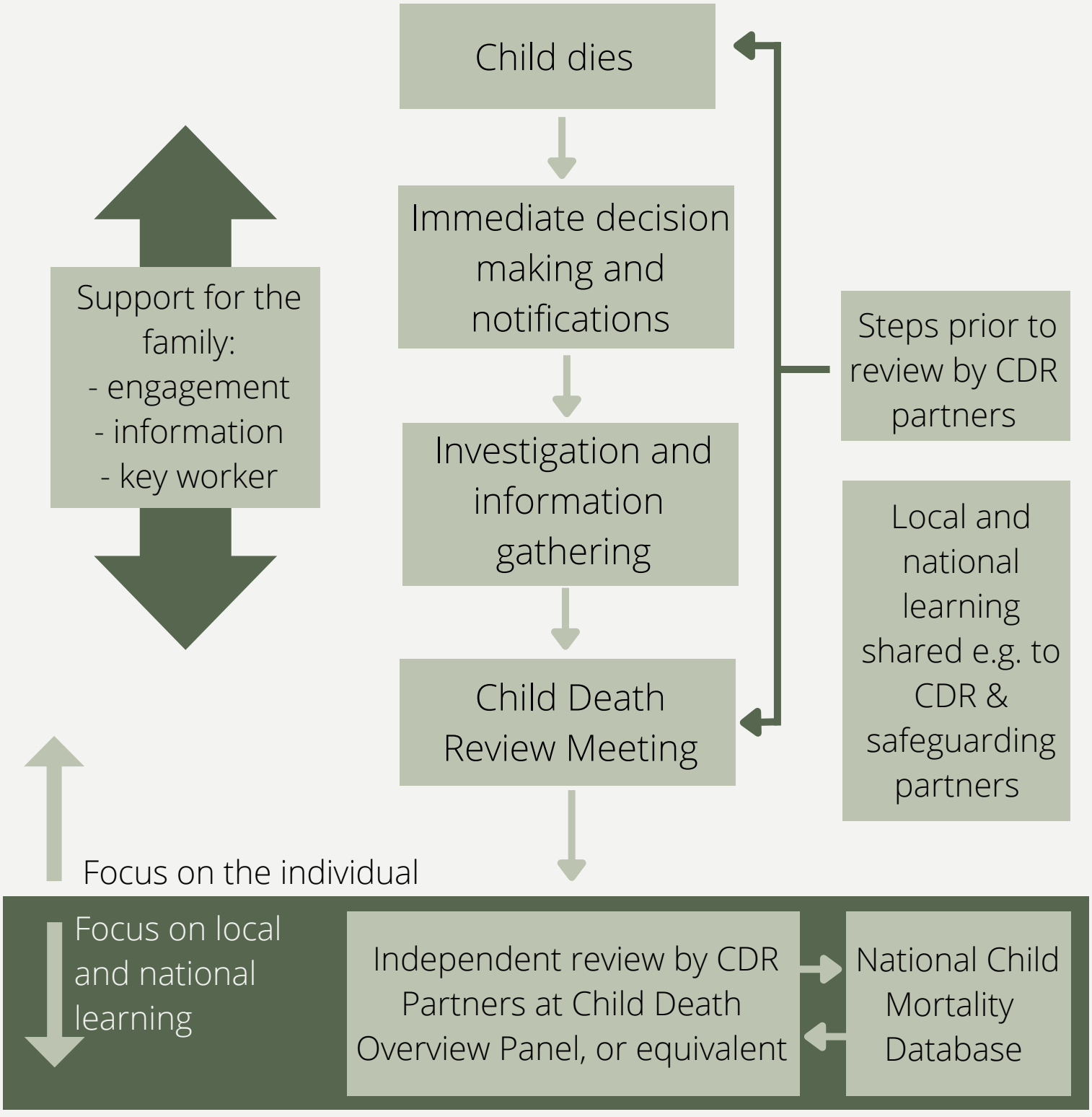

Figure 1. Chart illustrating the full process of a child death review. This includes both the statutory responsibilities of a Child Death Review partners to review the deaths of children (described here as review at CDOP or equivalent), and the processes that precede or follow this independent review. Further explanation is below.

7. Joint Agency Response (JAR) Meeting

A JAR Meeting 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 appropriate lead Child Death Review partner in conjunction with partners and will take place within 72 hours of the death (3 Working Days).

The below flowchart illustrates the JAR process:

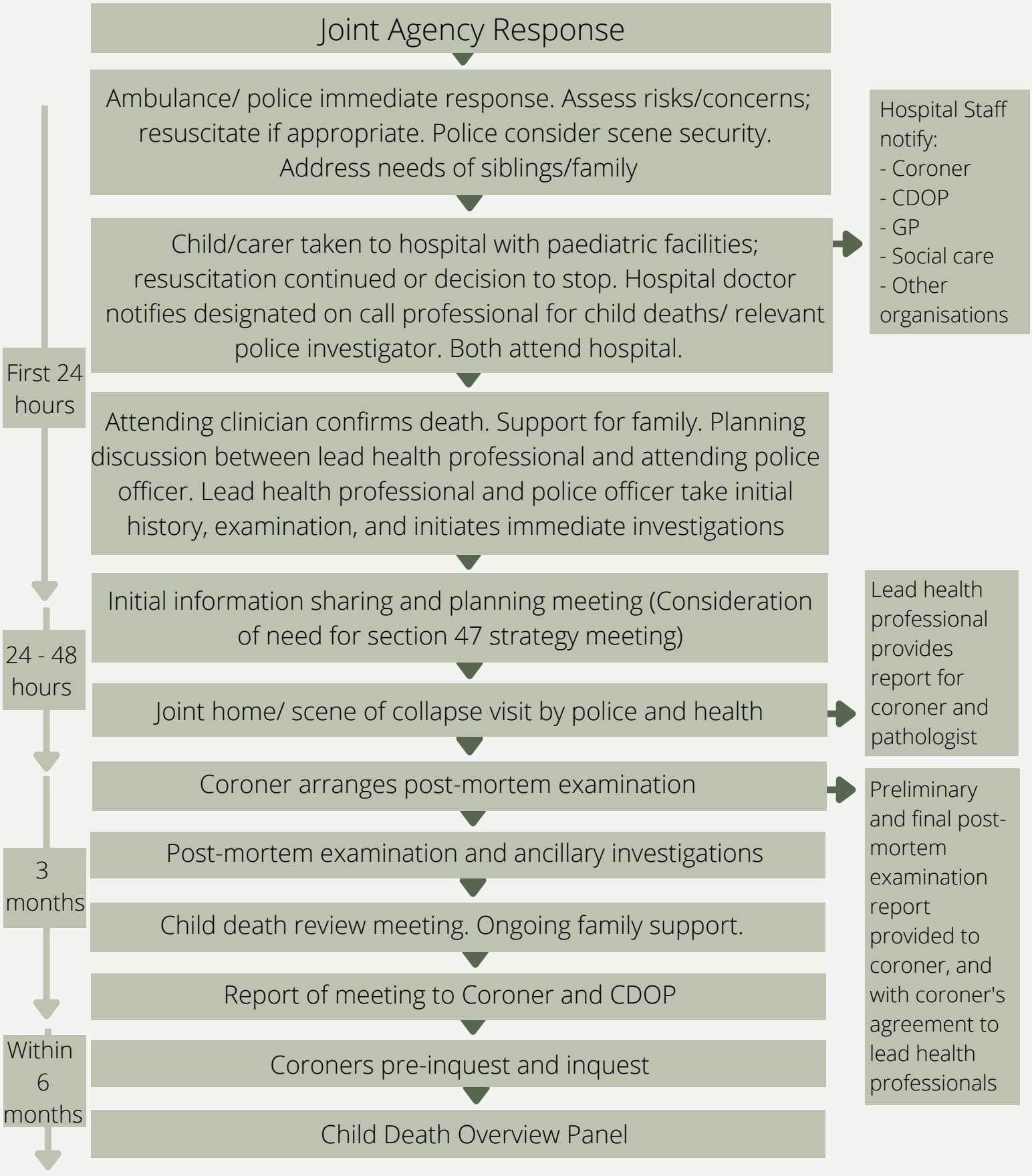

Figure 4: In this flow-chart, CDOP is used to represent the group established by CDR Partners that conducts the final stage of the child death review process.

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. Wakefield 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 Wakefield Safeguarding Children Partners that form the membership of the CDOP include, but is not limited to:

- Wakefield Metropolitan District Council, Service Manager Children's Public Health (Chair)
- NHS Wakefield Clinical Commissioning Group, Designated Nurse Safeguarding Children and Children in Care
- Wakefield Safeguarding Children Partnership Manager
- Wakefield Safeguarding Children Partnership Business Coordinator
- Wakefield Metropolitan District Council, Service Manager Children's Social Care
- Wakefield Metropolitan District Council, SEN support
- West Yorkshire Police, Serious Case Review Officer
- Mid Yorkshire Hospital NHS Trust, Consultant Paediatrician and SUDIC Lead
- Mid Yorkshire Hospital NHS Trust, Lead Nurse for Child Death Review
- Mid Yorkshire Hospital NHS Trust, Named Doctor for Safeguarding

- Mid Yorkshire Hospital NHS Trust, Named Doctor
- Mid Yorkshire Hospital NHS Trust, Consultant Obstetrician and Clinical Manager in Obstetrics
- Mid Yorkshire Hospital NHS Trust, Consultant Obstetrician, Gynaecologist and Perinatal Lead.
- Mid Yorkshire Hospital NHS Trust, Assistant Director Nursing for Children and Radiology
- Mid Yorkshire Hospital NHS Trust, Midwifery
- Wakefield 0-19 Service
- Wakefield GP and Primary Care Representative

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
- Child and Adult Mental Health Service (CAMHS)
- Road Safety Leads
- British Transport Police
- Yorkshire Ambulance Service

The CDOP will identify modifiable factors which may have contributed to deaths and decide what, if any, actions could be taken to prevent future such deaths.

The CDOP will make recommendations to Wakefield Safeguarding Children Partnership 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 Partnership's Business Unit will monitor and review until the CDOP are assured the action is complete.

10. Staffing and Resource

The WSCP Business Unit, alongside Mid Yorkshire Health Trust (MYHT) manage the CDR process on behalf of Wakefield Council and Wakefield Clinical Commissioning Group.

There is dedicated capacity within the Wakefield Safeguarding Children Partnership Business Unit supported by Partnership Managers, alongside a Designated Doctor and a Lead Nurse for Child Deaths. Across this staffing arrangement they are responsible for managing the entire child death process which includes arranging and chairing Joint Agency Review Meetings for unexpected child deaths; arranging Child Death Review Meetings for all child deaths; arranging, chairing and leading 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.

11. Annual Report

Wakefield CDOP produces a joint annual report, alongside Kirklees and Calderdale to the respective Local Safeguarding Children Partnerships who will make the report available on 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.

*The Health and Social Care Act received Royal Assent on the 28/4/22 and following this Department for Health and Social Care (DHSC) and NHS England agreed for Integrated Care Boards (ICBs) to formally take commissioning responsibilities from 1 July 2022. Therefore, where Clinical Commissioning Groups (CCG)s are referenced within this guidance, it is the West Yorkshire ICB who are the lead health agency responsible for the local CDOP arrangements.