West of England Child Death Overview Panel Arrangements:

Plan to meet the requirements of Working Together 2018 and the Child Death Review Statutory and Operational Guidance

In July 2018 the Department of Health (DH) published a revised version of Working Together to Safeguard Children. In October 2018 they published an additional document for the child death review process entitled "Child Death Review Statutory and Operational Guidance" (referred to hereafter as Operational Guidance). These two statutory documents lay out in detail the processes that must be followed when a child dies.

The Working Together Transitional Guidance can be found here:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722306/Working_Together-transitional_guidance.pdf

This guidance requires Child Death Review Partners (Clinical Commissioning Groups and Local Authorities) to agree and publish their new arrangements for child death reviews by 29th June 2019. They should notify NHSE of the new arrangements by emailing england.cypalignment@nhs.net by that date. Following the submission of the plan for their new arrangements, CDR partners then have until 29th September 2019 to implement their new arrangements.

The following template is intended as a guide for CDR partners to use to submit details of their arrangements for child death reviews.

Section 1: Contact Details of Child Death Review Partners

Names of Child Death Review Partners *This section should include details of ALL the child death review partners for your area. Please add more rows if needed.*		
Name of organisation	Bristol, North Somerset and South Gloucestershire CCG	X Clinical Commissioning Group ☐ Local Authority
Name of contact for child death reviews within organisation	Jackie Mathers, Head of Children's Safeguarding	
Email address of contact	Jackie.Mathers@nhs.net	
Telephone number of contact	0117 900 2670	
Name of organisation	Bath & North East Somerset CCG	X Clinical Commissioning Group ☐ Local Authority
Name of contact for child death reviews within organisation	Liz Plastow , Designated Lead Safeguarding, Banes CCG	
Email address of contact	Liz.Plastow2@nhs.net	
Telephone number of contact	01225 394 182	
Name of organisation	Bristol City Council	☐ Clinical Commissioning Group X Local Authority
Name of contact for child death reviews within organisation	Becky Lewis, Acting Quality Assurance & BSCB Service Manager	

Email address of contact	Becky.Lewis@bristol.gcsx.gov.uk	
Telephone number of contact:	07795 091 264	
Name of organisation	South Gloucestershire Council	☐ Clinical Commissioning Group X Local Authority
Name of contact for child death reviews within organisation	Catherine Boyce, Strategic Safeguarding Manager	
Email address of contact	Catherine.Boyce@southglos.gov.uk	
Telephone number of contact:	01454 868924	
Name of organisation	North Somerset Council	☐ Clinical Commissioning Group X Local Authority
Name of contact for child death reviews within organisation	Jo Baker, Service Leader for Strategic Safeguarding & Quality Assurance	
Email address of contact	Jo.Baker@n-somerset.gov.uk	
Telephone number of contact:	01275 88 8244	
Name of organisation	Bath & North East Somerset Council	☐ Clinical Commissioning Group X Local Authority
Name of contact for child death reviews within organisation	Lesley Hutchinson, Director of Safeguarding and Quality Assurance	
Email address of contact	Lesley_Hutchinson@BATHNES.GOV.UK	
Telephone number of contact:	01225 396339	
Please indicate the lead CDR partner *(NB: this*	Bristol, North Somerset and South Gloucestershire CCG (BNSSG CCG)	

must be one of the organisations listed above)	
Please indicate which CDR partner(s) are responsible for commissioning the new arrangements if different from above	Bristol, North Somerset and South Gloucestershire CCG commission the arrangements for West of England CDOP on behalf of the 6 CDR partners detailed above.

Section 2: Details of Child Death Overview Panel (CDOP) or equivalent

Details of CDOP or equivalent *This section should include details of the area covered by your CDOP*	
Name of CDOP	West of England CDOP
Name of CDOP Manager / Administrator	Vicky Sleap
Email address of CDOP	ubh-tr.cdop@nhs.net
Telephone number of CDOP	0117 342 5277
Please list ALL the local authority areas covered by your CDOP	Bath & North East Somerset Bristol North Somerset South Gloucestershire
Number of deaths reviewed in total in the 2018/19 year in the areas listed above	52 (* see Q1.2)

Section 3: Requirements of Working Together to Safeguard Children 2018

Requirement WT1: To make arrangements to review the deaths of children normally resident in the local area (including if they die overseas) and, if they consider it appropriate, for any non-resident child who has died in the area
Q1.1 Please give an overview of your local arrangements for reviewing child deaths. *This should include details of the administrative and logistical processes and should give details of the local arrangements for the notification process, information gathering, child death review meetings, frequency of CDOP meetings*
The West of England CDOP has a well-established process which has been in place since the inception of the CDR process in April 2008. The administrative function is subcontracted to the University of Bristol (UOB) Child Death Enquiries Office (referred to as the CDOP office). The CDOP office is responsible for receiving notifications on all children who die in the West of England area (as described above), collecting information using statutory reporting forms and the supplementary reporting forms and administrating the CDOP meetings which take place monthly with the exception of August. The eCDOP case management tool is used to manage the process and ensure compliance with GDPR. This also allows for automatic upload of case information to the National Child Mortality Database (NCMD), which is a requirement of the new statutory guidance. Around 62% of children who die in the West of England area die at one of the two tertiary centres (Bristol Royal Hospital for Children and St Michael's Hospital) within University Hospital Bristol NHS Foundation Trust (UHB). These two hospitals have comprehensive processes for conducting child death review meetings (CDRM) for children who die within their units. This includes ensuring multi-disciplinary attendance and multi-agency attendance where appropriate and completion of the statutory Analysis Form for each child. Both hospitals have a child mortality lead who is responsible for convening these meetings and completing the paperwork. 19% of children who die in the West of England (WOE) area, die at other hospitals in the region. A similar process exists in these hospitals to conduct child death review meetings. This also includes ensuring multi-disciplinary attendance and multi-agency attendance where appropriate and completion of the statutory Analysis Form for each child. These hospitals also have a child mortality lead who is responsible for convening these meetings and completing the paperwork. The remaining 19% of children die in a hospice, at home or in other locations (e.g. public place). Some of these deaths trigger a Joint Agency Response (JAR) and the child death review meetings are usually convened by the community paediatrician who conducted the JAR at the time the child died, unless the child is already known to a paediatrician in which case they may lead the CDRM For these deaths the CDOP office undertake the administration of arranging these meetings and ensuring appropriate individuals are invited in conjunction with the chair. The Chair (a paediatrician) then completes the Analysis form and returns it to UOB following the meeting. Please see detail included for requirement OG4 below for further information on our JAR processes. For those children resident in WOE area who die elsewhere, the CDOP office liaise with their counterpart CDOP manager to ensure a CDRM is convened

in the most appropriate location, and then the case can be reviewed at WOE CDOP.

Q1.2 Please describe the process that will be followed when a child not resident in your area dies in your area. *This should include how the CDOP in the area of residence will be notified, how decisions will be made about who conducts the review and retains responsibility for the case.*

The West of England CDOP is currently notified of a high number of non-resident deaths because the regional tertiary hospitals for neonates and children are located in Bristol.

Approximately 43% of notifications received by the CDOP Office are for non-residents. Hospitals in the West of England (WoE) notify the WoE CDOP office when a non-resident child dies. The CDOP office then will inform the CDOP in the child's area of residence. A conversation takes place between the CDOP Managers in the two locations, involving the Designated Doctor in those regions where necessary, and a joint decision is made about who should collect the information and conduct the CDOP review.

Where the child has been under the specialist care of cardiac services or other specialists, the West of England CDOP convenes themed panel meetings to ensure a high level of independent scrutiny There are also plans to work with the SW regional cardiac, neonatal and trauma networks in the future. In 2018/19 it was not formal practice for the WoE CDOP to routinely review non-resident deaths and, in addition to a fall in the number of deaths locally, this took the total number of cases reviewed at CDOP to <60.

In recognition of the Guidance requirement for the WoE CDOP to review > 60 deaths a year, CDR partners will consider reviewing non- resident as well as resident deaths in order to ensure that, going forward, they reliably meet this threshold .

Q1.3 Please describe how you will engage with hospitals in your area to ensure good communication and sharing of information when a child dies. *This should include consideration of the notification process, completion of reporting forms and supplementary reporting forms, and whether you support arrangements for child death review meetings through provision of agency reporting forms*

Existing processes are in place with all the hospitals and other relevant teams in the WOE region to ensure prompt notification when a child dies. In addition, CDOP Office has a number of "back-up" systems in place to ensure they are aware of all deaths in the rare event a death is not notified via the usual routes. This includes the following:

- Weekly inquest returns from the Coroner's Office
- Information downloads from the I.T. departments at University Hospitals Bristol NHS Foundation Trust, and North Bristol NHS Trust
- Print outs from the Child Health System
- Weekly reports from the local Registrars
- Reports from BADGERnet

Communication with hospital professionals regarding completion of statutory reporting forms is good and contact is made directly between the CDOP admin team and those professionals who have been involved in the care of the child. The admin team also has access to hospital systems within UHB to find out who those professionals are and to access to a secure email system (nhs.net) to contact them. For hospitals not within UHB systems are in place to contact the relevant teams (e.g. risk management / admin for Central Delivery Suite) to find out which professionals had contact with the child. All other communication and information sharing is achieved via the eCDOP system and local professionals have been set up as users on the system so they can securely log in and see all the reporting forms / supplementary reporting forms they are required to complete.

The process for the child death review meetings is detailed in requirement OG5 below.

Requirement WT2: To make arrangements for the analysis of information from all deaths reviewed

Q2.1 National analysis of information from deaths reviewed will be undertaken by NCMD, and there is a statutory duty to provide data to NCMD for this purpose. Please describe how you will provide information to NCMD. *This should include details of how you submit data to NCMD securely and details of any other local analysis you plan to undertake*

West of England CDOP uses the eCDOP case management tool which allows real time secure upload of information to NCMD as cases progress.

The WOE Annual Report includes a sub-analysis or themed review of a particular category of death, and has previously focused on SUDIs, suicides, trauma, palliative care, infection and for 2018/19 this will be on oncology deaths.
Additional subgroup analysis is undertaken in response to specific questions e.g. numbers of families who would have wished their child to have end-of-life care at home

Please see requirement OG6 below for more detail on this.

Requirement WT3: At such times as are considered appropriate, prepare and publish reports on what you have done as a result of the child death review arrangements in your area, and how effective the arrangements have been in practice

Q3.1 Please describe your plans for publication of reports related to this requirement. *This should include details of what reports you plan to publish (if appropriate) and where they will be published*

WOE CDOP produces an annual report which gives details of arrangements for child death reviews as well as actions, local learning and themes. This report is also delivered as a presentation to CDR partners and is available publically on the CCG website.

These arrangements are the same as they have been previously in this area, so most professionals are aware of local processes.

An annual multi-agency training event is provided by the Designated Doctor and Police rep, as well as training to individual departments as requested.

Regular CDR paediatric peer review meetings take place to ensure those professionals involved in conducting JARs are fully up to date with any changes in process and this also gives an opportunity to review the arrangements and ensure they are effective.

Requirement WT4: To consider the core representation of your CDOP (or equivalent)

Q4.1 Please give details of the agencies and job roles of the individuals on your CDOP. *This should include details of core members and any members that are co-opted for specific discussions / themed panel meetings*

	Core Member (Y/N)
Nominated Chair (this will be rotated between the LA areas across WoE)	Yes
Consultant in Public Health	Yes
Designated Doctor for Child Deaths	Yes
Coroner's Officer	Yes
Children's social care	Yes
Police	Yes
Head of safeguarding CCG	Yes
Professional Midwifery Advocate, Midwifery Matron	Yes
General Practice	Yes
Paediatric Palliative Care & Bereavement Team representative	Yes
Mortality Lead for Bristol Children's Hospital / Consultant Paediatric Intensivist	Yes
Consultant in Paediatric Emergency Medicine	Yes
Consultant Community Paediatrician	Yes
Safeguarding Named Professional, Ambulance Service	Yes

Consultant in Obstetrics	Neonatal themed meetings only
Mortality Lead for St Michael's Hospital / Southmead Hospital / Royal United Hospital / Consultant in Neonatology	Neonatal themed meetings only
Lay membership (from an appropriate parent support group)	Yes

Requirement WT5: To appoint a Designated Doctor for Child Deaths. This should be a senior paediatrician who can take a lead in the review process, and to ensure the Designated Doctor for Child Deaths is notified of each child death and sent relevant information

Q5.1 Please give details of this role in your local area. *This should include which organisation the role is employed within and the number of working hours for the post. Please also include a job description if available.*

The current Designated Doctor for Children's Deaths has been in post since 2013 and is an experienced consultant community paediatrician employed by Sirona who provide the Community Child Health service across Bristol and South Gloucestershire. The CCG fund this role through the CDOP contract held by UHB. Invoicing arrangements between the providers have been agreed. The role is currently funded for 1.5pa.

The Job description is available on request to the BNSSG CCG who commissions the CDOP service but is in line with the job description in the 2018 guidance.

Q5.2 Please describe the process for notifying the Designated Doctor for Child Deaths when a death occurs. *This should include details of who is responsible for carrying out the notification and how this occurs (e.g. email / telephone via the CDOP admin team).*

When a death is notified to the CDOP office, they are responsible for onward notification to the Designated Doctor. Currently this happens by email, except in the case of a death attracting a joint agency response (JAR) when contact would initially be made by phone with a follow-up email.

Requirement WT6: Publicise information on the arrangements for child death reviews in your area.

Q6.1 Please give details on where the information for child death reviews in your area can be publicly accessed. *The information publicly available should include who the accountable officials are (the local authority chief executive and the accountable officer of the clinical commissioning group), which local authority and clinical commissioning group partners are involved, what geographical area is covered and who the designated doctor for child deaths is*

The new CDR arrangements will be published on the CCG websites of the West Of England partners and on the partner's own websites. This will include details of accountable officials, the Designated Doctor, and the geographical area covered.

Requirement WT7: Child death review partners should agree locally how the child death review process will be funded in their area.
Q7.1. **Please give details on how the CDR process in your area is being funded?** *This might include mention of funding coming from LA, CCG and Health Care Trusts.*
BNSSG CCG is the lead Child Death Review (CDR) partner for the West of England (WOE) region. They have established a budget for the commissioning of the CDR work which is also contributed to by BANES CCG and the 4 local authority areas (BANES, Bristol, North Somerset and South Gloucestershire). BNSSG CCG is responsible for commissioning the service on behalf of the other CDR partners. Funding and procurement of the CDR process will be regularly reviewed.

Section 4: Requirements of the Child Death Review Statutory and Operational Guidance

Requirement OG1: Chief Executives of clinical commissioning groups (CCGs) and local authorities should ensure that all of their staff who are involved in the child death review process read and follow the operational guidance.
Q1.1 Please describe how you have ensured that all staff within the child death review process have read and follow the operational guidance. This should include methods of dissemination of the guidance and any training / awareness raising sessions that have been provided
An annual multi-agency training event is provided by the Designated Doctor and Police representative. During 2019 this included an update on the changes in Child Death Review (CDR) arrangements. The annual CDOP report presentation and several other presentations by the Designated Doctor have also included reference to the operational guidance. CDOP is writing to local Trust Chief Executives and other relevant organisational leads to ascertain how they will implement relevant aspects of the operational guidance within their organisation. A CDOP strategic operational group led by the CCG will oversee the implementation of this new CDR process. This group will have representatives from the core partners and provide regular feedback to the executive leads involved in the WOE CDOP. This will be reviewed through the executive partnership managing the implementation of the new safeguarding arrangements ASSSP (Avon and Somerset Safeguarding Strategic Partnership.)
Requirement OG2: Families should be given a single, named point of contact, the "key worker", for information on the processes following their child's death, and who can signpost them to sources of support.
Q2.1 Please describe your process for assuring that relevant organisations have appointed a key worker in the event of a child death. *This should*

include details of the responsibilities of that post
The Bristol Royal Hospital for Children Bereavement Team is currently fulfilling the key worker role for all children who die within the hospital, unless they are already known to a specialist team in which case the relevant specialist nurse will take on the key worker role eg Lifetime palliative care nurse, cardiac or oncology specialist nurse. They also provide support to families with children on palliative care pathways. For those children whose death triggers a Joint Agency Response, the community paediatrician on call at the time of the child's death, and who leads the JAR fulfils the lead health professional role. When the Police are taking the lead in the JAR (in circumstances where an unlawful act has taken place or in Road Traffic Collisions) then the Police Family Liaison Officer takes this role. The professionals that fill these roles are aware of the CDR process and advise the family that the process will take place at the time their child dies. They are also given the "When a Child Dies: A Guide for Parents and Carers" leaflet. This is updated with local contact details. The key worker is also responsible for contacting the family in advance of the child death review meeting to ask if they have any questions or comments they would like to be raised at the meeting. Following the CDRM the key worker and other relevant professionals meet with the family to answer their questions / sign post them to the right people if they cannot answer their questions. At this time they are also given feedback from the CDRM. UHB has a bereavement pathway which is followed when a child dies. This clearly lays out what care the family should receive and when.
Requirement OG3: To report deaths of children with learning disabilities or suspected learning disabilities to the Learning Disabilities Mortality Review Programme (LEDER).
Q3.1 Please describe your process for notifying LEDER of the death of a child with a learning disability. *This should include details of who is responsible for making the notification and how it occurs (e.g. telephone / email)*
When the CDOP Office receives notification of the death of a child that meets the criteria for a LEDER review, they complete the online notification for LEDER and send a copy of the Notification Form. If it is unclear to the team whether the child meets the criteria, a discussion takes place with the Designated Doctor who advises whether notification should be made.
Requirement OG4: A Joint Agency Response (JAR) should be considered if certain criteria, set out in the guidance are met.
Q4.1 Please describe your model for JAR. *This should include details of who the lead health professional will be (e.g. nurse / health visitor / paediatrician), details of who attends when a home visit is required and the times between which the JAR is available e.g. is there an on-call element? Please also include details of the estimated number of deaths requiring a JAR in your area each year.*
The WOE Joint Agency Response (JAR) is led by community paediatricians and detective sergeants within Avon & Somerset Police. The service is currently provided 24 hours a day / 7 days a week and mirrors the community paediatric on-call rota for child protection. The paediatrician and detective liaise with the Emergency Duty Team in social care and determine what level of response is required. If a home or scene visit is felt to be indicated, then the paediatrician and detective will attend the home jointly with the family to examine the scene and go over the preceding events.

In the small number of cases where a death has occurred due to an unlawful act taking place, a discussion will take place between all relevant parties in order to agree a bespoke response where a joint home or scene visit is not possible. There are around 20 deaths requiring a JAR each year.

Requirement OG5: Conduct a child death review meeting for every child

Q5.1 Please describe how the child death review meeting will be convened for the following groups:

- **Children who die in hospitals in your area**
- **Neonatal deaths in hospitals in your area (this should include use of the Perinatal Mortality Review Tool (PMRT)**
- **Children who die in the community in your area**
- **Children whose deaths trigger a joint agency response**

For Children who die in hospitals in our area

For children who die at the Bristol Royal Hospital for Children there is a comprehensive process for conducting child death review meetings. There is a lead for child mortality who is a consultant paediatrician and this person is responsible for convening the meeting and ensuring the appropriate people attend. Administrative support is provided for this from the hospital patient safety team. Arrangement of the meetings includes determining who the essential attendees are (i.e. those without whom the discussion cannot take place) and inviting multi-disciplinary and multi-agency professionals where appropriate. Where the child's care has been provided by multiple hospitals, professionals from all hospitals are invited to take part / submit a report to the meeting. Following the meeting the mortality lead is responsible for completion of the statutory Analysis Form for each child.

For Neonatal deaths in hospitals in our area (this should include use of the Perinatal Mortality Review Tool (PMRT))

For neonatal deaths that occur at St Michael's Hospital, Southmead Hospital and Royal United Hospital, a perinatal mortality meeting (PMM) takes place. A number of deaths are discussed within each PMM. Each Hospital has a monthly mortality meeting and St Michael's Hospital also holds 3-4 surgical perinatal mortality meetings per year, and 1-2 "child specific" perinatal mortality meetings per year in addition to the monthly meetings.

The "child specific" meetings are convened for very complex cases where it is felt that discussion at a normal perinatal mortality meeting would not give sufficient time for review. Arrangement of the meetings includes determining who the essential attendees are (i.e. those without whom the discussion cannot take place) and inviting multi-disciplinary and multi-agency professionals where appropriate. Where the child's care has been provided by multiple hospitals, professionals from all hospitals are invited to take part / submit a report to the meeting. Following the meeting the mortality lead is responsible for completion of the statutory analysis form for each child.

The Perinatal Mortality Review Tool (PMRT) is currently used by all hospitals, however it does not yet include the analysis form fields so at present this introduces some duplication of effort by professionals who have to complete both the tool and the analysis form.

For Children who die in the community in our area

All deaths in the community have a CDR meeting. For children with life-limiting conditions who die at home or at the children's hospice, the Designated

Doctor assists the CDOP office in identifying a Chair for those meetings and the UOB admin team are responsible for arranging the meeting and inviting professionals to attend. The Chair will be a paediatrician and that person is responsible for completion of the Analysis Form and its return to the CDOP office.

For Children whose deaths trigger a joint agency response
The child death review meetings for these children are convened by the community paediatrician who conducted the JAR at the time the child died. For these deaths the CDOP office manages the administration of arranging these meetings and ensuring appropriate individuals are invited in conjunction with the chair. The Chair (a paediatrician) then completes the analysis form and returns it to UOB following the meeting.

Agency Reporting forms will be provided to Chairs of CDRMs.

Requirement OG6: Produce an annual report on local patterns and trends in child deaths, any lessons learnt, and actions taken, and the effectiveness of the wider child death review process

Q6.1 Please give details of when you will produce your annual report and where it will be published

WOE CDOP has produced an annual report every year since the inception of the process in 2008. Each report includes the following sections:

- Acknowledgements
- Foreword
- Executive Summary
- The Child Death Review Process (includes a summary of the arrangements)
- The production of annual report (processing and verification of data)
- Summary Notification Data (five-year dataset)
- Child Death Overview Panel Review Data
- Focus section (an in-depth look at a subset of child deaths related to a specific disease or group e.g. neonates / suicide / SUDI)
- Child Death Overview Panel Activity
- Future Priorities and Challenges

The report is signed off at the July CDOP meeting. Dissemination of the report is via email from the CDOP office. The list of individuals who want to receive the report is reviewed and updated each year and anyone can ask to be added to the list. The annual report will be published on the CCG website.