Northern Lincolnshire Child Death Review Arrangements 2019/20

June 2019

Signatories

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on behalf of North Lincolnshire Council

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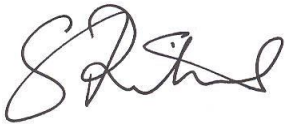

Stephen Pintus, Director of Public Health
on behalf of North East Lincolnshire Council

Introduction and Context

This sets out the arrangements for the Child Death Review processes in North and North East Lincolnshire local authority areas.

In preparing this document, the Child Death Review (CDR) partners have had due regard to:

- Chapter 5 of Working Together to Safeguarding Children, July 2018
- Child Death Review Statutory and Operational Guidance (England), October 2018
- National Guidance on Learning from Deaths
- Sudden unexpected death in infancy and childhood: multi-agency guidelines for care and investigation (SUDI/C Guidelines) 2016
- Guidance for NHS trusts on working with bereaved families and carers
- When a Child Dies: child death review guide for parents and carers

The arrangements will also be underpinned by the Northern Lincolnshire Child Death Review arrangements Memorandum of Understanding and operational multi-agency guidance.

Child Death Review Arrangements

Geographical area

The geographical footprint for the Northern Lincolnshire Child Death Review arrangements is the North Lincolnshire, and North East Lincolnshire local authority areas. This footprint corresponds with that of North Lincolnshire and North East Lincolnshire Clinical Commissioning Groups' (CCG) footprint.

The Northern Lincolnshire Child Death Review arrangements will

- ensure the appropriate review the deaths of all Northern Lincolnshire resident children (up to and including those aged 17), and babies born to Northern Lincolnshire resident mothers, whether the child dies in Northern Lincolnshire or outside the area.
- consider the deaths of non-Northern Lincolnshire resident children where learning for Northern Lincolnshire services may be identified.
- support the learning through Child Death Review arrangements in other localities where Northern Lincolnshire resident children have died, and there may be learning in those external areas

The Lead Health Professionals and the Designated Doctor for Child Deaths will support discussions in relation to the most suitable locality to lead the review.

Child Death Review Partners

In Northern Lincolnshire, the child death partner organisations and the lead representatives are:

- North Lincolnshire Council – Chief Executive
- North Lincolnshire Clinical Commissioning Group – Accountable Officer
- North East Lincolnshire Council – Chief Executive
- North East Lincolnshire Clinical Commissioning Group – Chief Clinical Officer

All four child death partners have equal and joint responsibility for local child death arrangements. Locally, the lead representatives have delegated their functions to the:

- Director of Public Health, North Lincolnshire Council

- Director of Nursing and Quality, North Lincolnshire Clinical Commissioning Group
- Director of Public Health, North East Lincolnshire Council
- Director of Quality and Nursing , North East Lincolnshire Clinical Commissioning Group

These CDR partners have the responsibility and authority for ensuring full participation with Northern Lincolnshire Child Death Review arrangements, though the lead representatives remain accountable for any actions or decisions taken on behalf of their respective agency.

The lead representatives and those they have delegated their authority to, are able to:

- Speak with authority for the child death partner they represent
- Take decisions on behalf of their organisation or agency and commit them on policy, resourcing and practice matters
- Hold their own organisation or agency to account on how effectively they participate and implement the local arrangements.

More detail regarding child death partners' roles and responsibilities will be articulated in the Northern Lincolnshire Child Death Review arrangements Memorandum of Understanding.

Other organisations and agencies

The CDR Partners will ensure the involvement of all relevant agencies and organisations providing services to North and North East Lincolnshire resident children, and their families. These will include:

- Northern Lincolnshire and Goole NHS Foundation Trust
- Rotherham, Doncaster and South Humber NHS Foundation Trust
- North East Lincolnshire Council Children's Health Provision
- Lincolnshire Partnership NHS Foundation Trust
- General Medical Practices within North and North East Lincolnshire
- North Lincolnshire Council
    - Children's Social Care Services
    - Education Services
    - Public Health Services
- North East Lincolnshire Council
    - Children's Social Care Services
    - Education Services
    - Public Health Services
- Humberside Police
- Northern Lincolnshire Coroner's Office
- Schools and Nurseries in North and North East Lincolnshire

The Northern Lincolnshire CDR Partners will also ensure robust arrangements are in place to ensure the involvement of and contribution by key providers of services to Northern Lincolnshire resident children, but which are located outside the locality. These will include:

- Hull University Teaching Hospitals NHS Trust
- Sheffield Children's NHS Foundation Trust

- The Leeds Teaching Hospitals NHS Trust

Governance Arrangements

The CDR partners will establish a Northern Lincolnshire CDR Partners Board which will meet on a quarterly basis to:

- oversee the effectiveness of the Child Death Review arrangements in practice
- agree and monitor the funding in accordance with their statutory requirements issued under section 16Q of the Children Act 2004
- seek and receive assurance on the learning and improvement activity undertaken in the locality in response to the arrangements
- receive and approve the Annual Report

The initial meeting of this Board will be held in September 2019, and will be supported by the CDR manager and administrator.

The Chair will be identified from among the CDR Partners.

Arrangements to discharge Child Death Review functions

The CDR partners will establish a Child Death Overview Panel (CDOP), in accordance with the requirement to have an independent, multi-agency body to review the deaths of all children normally resident in Northern Lincolnshire, and where appropriate, the deaths in Northern Lincolnshire of non-resident children. The Panel will have specific Terms of Reference which will reflect the functions outlined within, the Child Death Review Statutory and Operational Guidance. This Panel will ensure appropriate links are made by the Panel, or as part of the Child Death Review process, with other statutory review processes, including

- The Learning Disabilities Mortality Review (LeDeR) programme
- Learning From Deaths programme
- Child Safeguarding Practice Reviews completed by:
    - North Lincolnshire Children's Multi-Agency Resilience and Safeguarding Board
    - North East Lincolnshire – Children's Safeguarding Partnership

Key Roles

<u>Chair of Child Death Overview Panel</u>

The CDR partners will identify a suitably experienced senior professional who is independent of the key providers of North and North East Lincolnshire NHS, social care and police services to chair the Child Death Overview Panel.

<u>Lay member of CDOP</u>

The CDR partners will secure a lay person, independent of the child death partners, or any provider of services to Northern Lincolnshire resident children or their families, to be a member of the Northern Lincolnshire Child Death Overview Panel. The CDR partners will ensure this individual provides the required expertise as outlined in Appendix 4 of the Child Death Review Statutory and Operational Guidance

<u>Manager and Administrator</u>

The CDR partners will identify a Manager from the CDR partner organisations to manage the CDR arrangements on behalf of the 4 CDR partners

The CDR partners will identify an administrator for the CDR arrangements across the Northern Lincolnshire footprint.

Designated Doctor for Child Deaths

The CDR partners will recruit a paediatrician who is independent of all services provided in North and North East Lincolnshire to fulfil the role of Designated Doctor for Child Deaths. The Job Description for this post will be fully compliant with the requirements as set out in the Child Death Review Statutory and Operational Guidance (England), October 2018

Lead Health Professional(s)

The CDR partners will secure arrangements for Northern Lincolnshire and Goole NHS Foundation Trust to provide the Lead Health Professional function to

- lead and coordinate any Joint Agency Response,
- chair the Child Death Review Meeting

Appropriate training, and support, will be provided to individuals fulfilling this function.

Keyworker

The CDR partners will secure arrangements for the availability of a 'keyworker' – a single, named point of contact for each bereaved family to whom they can turn for information on the child death review process, and who can signpost them to sources of support. The CDR partners recognise that each family's previous contact with services, and needs, will be different. A lead will be identified to coordinate, and ensure the most suitable individual is available to support each family when they require it. The CDR partners will ensure that the 'keyworker' meets the requirements as set out in Appendix 5 of the Child Death Review Statutory and Operational Guidance. Appropriate training, and support, will be provided to keyworkers.

Other roles and functions

The CDR partners have due regard for other roles identified within the Child Death Review Statutory and Operational Guidance, in particular those involved in ensuring coordinated approaches to bereaved families. The CDR partners are working with the key organisations to ensure each family's experience is that

- their child's death is sensitively reviewed, with ongoing information and dialogue about all processes
- cause of death is identified and communicated, and
- where necessary, lessons are learnt that may prevent further children's deaths.

Preparing services for new Child Death Arrangements

The CDR partners will prepare and deliver briefings on the new arrangements for all services in Northern Lincolnshire.

Targeted briefings will be prepared and delivered for staff groups who will be required to provide key information into the new arrangements.

Appropriate training will be provided, and systems of support will be developed for staff delivering specific functions within the new arrangements.

CDOP membership

The Northern Lincolnshire CDR partners have identified the following as members of the Child Death Overview Panel

- Chair of the CDOP
    - Vice Chair will be identified from other membership of the CDOP, but will be an experienced senior professional who is independent of the key providers of North and North East Lincolnshire NHS, social care and police services
- Child Death Review Manager for Northern Lincolnshire
- Child Death Review Administrator for Northern Lincolnshire
- Senior Public Health professional
- Designated Doctor for Child Deaths
- Designated Nurse and Head of Safeguarding, North Lincolnshire CCG or Designated Nurse – Safeguarding, North East Lincolnshire CCG
- Divisional Head of Midwifery and Nursing - Women and Children's, Northern Lincolnshire and Goole NHS Foundation Trust
- Community or Hospital Health professional to complement the experience of the Designated Doctor (on appointment)
- Named GP for Safeguarding Children, North East Lincolnshire CCG or Named GP for Safeguarding, North Lincolnshire CCG
- Senior Representative from
    - Humberside Police
    - North Lincolnshire Council Children's Social Care or North East Lincolnshire Children's Council Social Care
    - North Lincolnshire Council Education services or North East Lincolnshire Education services
- St Andrew's (Andy's) Hospice
- Lay Representative:

Other professionals will be included in the membership of the CDOP on a case-by-case basis, or to inform specific discussions.

Collaborative Regional CDOP Arrangements

The Local Authorities and Clinical Commissioning Groups for North and North East Lincolnshire, Hull, East Riding of Yorkshire, North Yorkshire and York, i.e. the CDR partners for

- Northern Lincolnshire
- East Riding of Yorkshire
- Hull, and
- North Yorkshire and York

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.

These Collaborative Regional CDOP Arrangements are the process by which the CDR 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.

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

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.

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.

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

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.

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 co-production, especially in relation to bereavement.

Annual Report and Review

The annual report will be prepared by the Chair of the CDOP, and Designated Doctor for Child Deaths in collaboration with the CDR partners, CDR Manager(s) and other key professionals to provide detail on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process. This will be received and approved by the CDR Partners Board.

Review of Arrangements

This document will be subject to review, and republication, by September 2019, to allow for refinement in preparation for implementation. The arrangement will also be subject to review, in June 2020, to allow further refinement as the process becomes embedded.