NCMD

National Child Mortality Database

Knowledge, understanding and learning to improve young lives

Chapter 6 Working Together to Safeguard Children: Key Updates

Dr James Fraser, NCMD Clinical Advisor and Vicky Sleap, Deputy Director, NCMD

Tuesday 20th February 2024

10.00am to 11.15am

Presentation will start at 10.05am to allow participants time to join

Chapter 6 Working Together to Safeguard Children: Key Updates

Dr James Fraser, NCMD
Clinical Advisor

Vicky Sleap, Deputy Director

20 February 2024

NCMD
National Child Mortality Database

Knowledge, understanding and learning to improve young lives

What will this webinar cover?

- How Working Together fits in to the statutory framework for child death reviews
- Updates to Chapter 6 of Working Together 2023
- Focus on review of non-resident deaths
- Practical advice for CDOPs on how to deal with non-resident deaths
- Questions

Working Together 2023 and the statutory framework for CDR

The legislation relevant to child death reviews is enshrined within **The Children Act 2004**

16Q Guidance and interpretation

(1) The child death review partners for a local authority area in England must have **regard to any guidance given by the Secretary of State** in connection with functions conferred on them by sections 16M to 16P

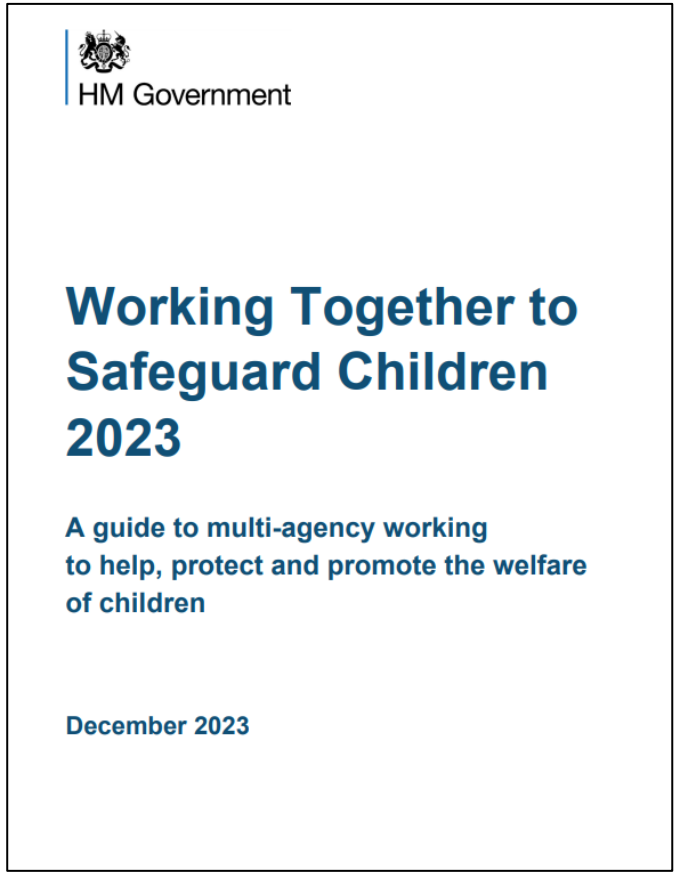
[S. 16Q inserted (29.6.2018) by Children and Social Work Act 2017 (c. 16)]

Working Together 2023 and the statutory framework for CDR

- Working Together to Safeguard Children 2023 Chapter 6 provides guidance to CDR partners on their statutory responsibilities.
- Child Death Review: Statutory and Operational guidance (2018) sets out in a single document the key features of what a good child death review looks like. Aims to ensure outputs from CDR process standardised as far as possible and of uniform quality.
- Sudden unexpected death in infancy and childhood multi-agency guidelines (2016), known as “Kennedy Guidance” covers how to conduct a Joint Agency Response (no statutory basis).

Summary of Updates to Working Together

- ‘Child death review partners’ are defined as the local authority and any Integrated Care Boards (ICBs) operating in the local authority area.
- The term ‘Child Death Overview Panel (CDOP) framework’ has been replaced with **Child Death Review Statutory and Operational Guidance (2018)**
- The language describing the responsibility of ‘child death review partners’ towards the review of deaths of non-resident children who have died in their area on behalf of their CDR partners has been strengthened (‘*if they consider it appropriate’* to ‘*as indicated’*).
- It reflects new guidance requiring coroners to send post-mortem reports to CDOPs for relevant child death reviews.
- It reflects changes of name by removing independent review by ‘child death review partners’ and replacing with ‘child death overview panel’.
- The language around the responsibility to inform relevant safeguarding partners and the Child Safeguarding Practice Review Panel where there has been evidence of abuse or neglect has been strengthened to include all professionals.



Requirements of the Children Act 2004

- Section 16(M) of the Act makes provision for CDOPs to review the deaths of both resident and non-resident children
- The purposes of a review or 'analysis of information' under this section of the Act are:
  - to identify any matters relating to the death or deaths that are **relevant to the welfare of children in the area or to public health and safety**, and
  - to consider whether it would be appropriate for anyone to take action in relation to any matters identified

Review of non-resident deaths by CDOP

- In the previous version of Working Together the language used contributed to inconsistencies amongst CDOPs in the review of deaths of children not-normally resident in their area
- There are two broad groups of non-resident children.
- Group 1: Those children who are normally resident in England and die in England but outside of their area of normal residence
- Group 2: Those children who are normally resident in another country (including the devolved nations) and die in England
- The purpose of child death review is to learn from deaths in order to reduce the number of children who die. It is therefore important that all deaths are learned from.
- The Children Act requires that CDOPs must make arrangements for the analysis of information of **deaths of children in their area** so they can be satisfied that they have learned from all deaths and that any possible themes or patterns are picked up on
- To avoid duplication of effort, in every case, there must be agreement between CDOPs concerning which CDOP will conduct the review.

What to consider when deciding which CDOP should review a death (Statutory Guidance 5.5.1 & 2)

- While in all cases, the CDR partners in the area where the child is normally resident is responsible for ensuring that a CDOP review takes place , legislation allows for CDR partners to make pragmatic arrangements for the review of a death in their area of a child not normally resident there
- This should be guided by which area is likely to derive the most local learning in each type of death

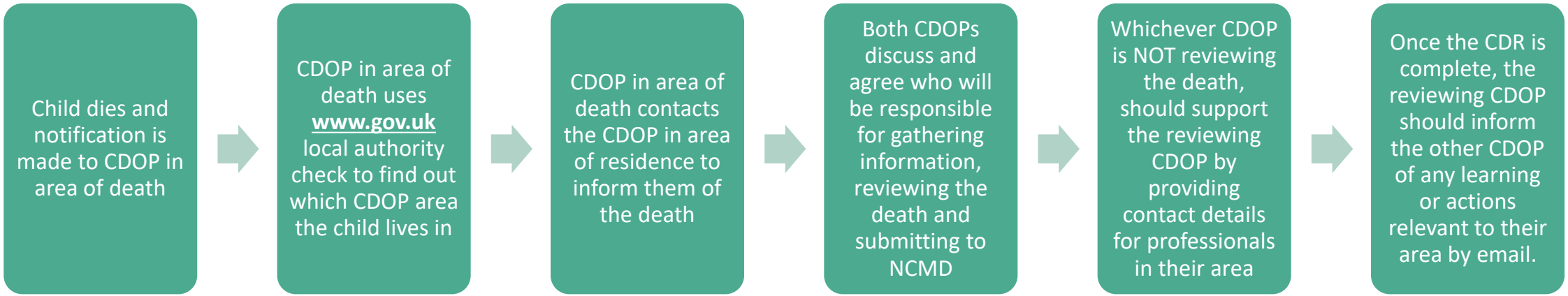
Type of death	Suggested CDOP to review
Trauma deaths occurring in a public place (e.g. drowning, road traffic collision)	CDOP in the area of death
SUDIC, suicide or homicide	CDOP in the area of residence (shared learning vital)
'Looked after' child	CDOP in the area of death (WT, 2023)
Neonatal deaths and deaths of children under specialist care (e.g. cardiac or oncology)	CDOP in the area where the majority of clinical care has been given. This might include babies who have been born and died in a tertiary hospital where antenatal care has been given there
Children with chronic or life-limiting conditions on complex, regional care pathways	CDOP in the area of residence

Other sources of information for CDOPs

- In order to comply with the Children Act requirements, CDOPs should have knowledge of the numbers and causes of deaths within their area.
- CDOPs can obtain information on deaths in their area which they have not reviewed from a number of different sources
  - NCMD is working towards providing reports on total number of deaths by Trust to help CDOPs to be sighted on deaths in their area
  - 'Outlier reports':
    - PICAnet data dashboard shows data on paediatric intensive care admissions in the UK - https://www.picanet.org.uk/data-collection/picanet-data-dashboard/
    - PMRT standardised real-time mortality trend analysis data; 'Reading the Signals' Neonatal outcome working group
  - Coroner's regulation 28 reports to prevent future deaths can be accessed here - https://www.judiciary.uk/courts-and-tribunals/coroners-courts/reports-to-prevent-future-deaths/

How to deal with non-resident deaths in Group 1

- Group 1: Those children who are normally resident in England and die in England but outside of their area of normal residence



How to deal with non-resident deaths in Group 2 – Devolved Nations

- Group 2: Those children who are normally resident in the devolved nations and die in England
- Scotland, Wales and Northern Ireland each have a CDR process and should be notified by an English CDOP if a child normally resident in their country dies in England.

  Scotland – Email - his.cdrnationalhub@nhs.scot

  Wales – Complete Welsh Child Death Notification Form

  Northen Ireland – Email sinead.magill@hscni.net

- The review process in the country where the child is normally resident should take primacy, unless there is agreement between the CDR team in that country and the CDOP that the English process will apply.

How to deal with non-resident deaths in Group 2 – Outside the UK

- Group 2: Those children who are normally resident outside of the UK and die in England
- Most other countries in the world do not have a child death review process
- If a child from outside the UK dies in England, the CDOP in the area of death should determine if it is appropriate to review the death.
- If the child was previously well and dies in circumstances triggering a JAR e.g. drowning, it is likely there will be useful learning for services here and many of the same contributory factors may apply as for English children. CDOP in the area of death should review the case.
- If the child was in England receiving medical care (medical tourism), then there is likely to be learning for services here and information should be obtained from the team(s) caring for the child. CDOP in the area of death should review the case.
- If the child had not had any contact with services here, it may not be appropriate for CDOP to review the death

Keep in touch

Follow	us on X (formerly Twitter) @NCMD_England
Visit	our website at www.ncmd.info
Sign up	to our mailing list here to be notified of future events and publications
Look at	Our web pages for professionals here

Questions