Surrey's plan for a Child Death Review Partnership

This paper details the plan of the Surrey Child Death Review Partners to meet the requirements of Working Together 2018 and the Child Death Review Statutory and Operational Guidance. The partners associated with this plan are the six Surrey Clinical Commissioning Groups (CCGs) and Surrey County Council.

Background

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

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. Following the submission of the plan for their new arrangements, CDR partners then have until 29th September 2019 to implement their new arrangements.

The new arrangements for responding to child deaths in Surrey, contained in this document, are designed to ensure compliance with the guidance and deliver strong and effective partnership arrangements.

The Plan

1. Introduction

This plan details the approach that will be taken by the Surrey Child Death Review Partners. For the purposes of this plan the Surrey Child Death Review Partners (CDR) have established a Child Death Overview Panel (CDOP). The CDOP will enable the six CCGs and Surrey County Council to review the deaths of children

under the requirements of the Children Act, 2004 and Working Together to Safeguard Children, 2018. The CDOP will be a standing group of the Surrey safeguarding children partnership. Prior to the deaths being considered at CDOP the work to support families and to manage the child death process and requirements will be undertaken by the child death team who are hosted by Guildford and Waverley CCG on behalf of the partnership.

1.1 CDOP Governance and accountability

The CDOP is accountable to the Child Death Review Partnership and is a standing sub group of the Surrey Safeguarding Children Partnership. The CDOP will present regular reports to the Surrey Safeguarding Children Partnership detailing activity, outcomes and impact. This will include the publication of an annual report and thematic reviews as key themes emerge.

1.2 CDOP Purpose

The purpose of the Surrey CDOP is to undertake a review of all child deaths (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) up to the age of 18 years, normally resident in Surrey, irrespective of the place of their death. The Surrey CDOP will adhere to the statutory guidance: Child Death Review Statutory and Operational Guidance (England) 2018: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england.

1.3 CDOP Responsibilities

- To collect and collate information about each child death, seeking relevant information from professionals and, where appropriate, family members;
- To analyse the information obtained, including the report from the CDRM, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths;
- To make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children;

- To notify the Child Safeguarding Case Review Panel and local Safeguarding Partners when it suspects that a child may have been abused or neglected; this will include a referral to the local authority to consider the event as a potential serious child safeguarding incident.
- To notify the Medical Examiner (once introduced) and the doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction;
- To provide specified data to NHS Digital and then, once established, to the National Child Mortality Database;
- To produce an annual report for CDR Partners on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process; and
- To contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.

1.4 CDOP Management of Decisions and Disputes

Decisions will normally be reached by consensus. In the event of a disagreement, the CDOP Chair will make the ultimate decision and has the option to escalate to the statutory Child Death Partners and if resolution is not reached to consult the Independent Scrutineer of the Surrey Safeguarding Children Partnership.

Section 1: Contact Details of Child Death Review Partners

Names of Child Death Review Partners.		
Name of organisation	Name of contact for child death reviews within organisation	Email address of contact
Guildford and Waverley Clinical commissioning group on behalf of: • East Surrey Clinical Commissioning Group • North East Hampshire and Farnham Clinical Commissioning Group • North West Surrey Clinical Commissioning Group • Surrey Downs Clinical Commissioning Group • Surrey Heath Clinical Commissioning Group	Amanda Boodhoo, Associate Director for Safeguarding	Amanda.boodhoo@nhs.net
Surrey County Council	Dave Hill, Executive Director Children, Families, Lifelong Learning and Culture	Dave.Hill@surreycc.gov.uk
The lead CDR partner	Guildford and Waverley Clinical Commissioning Group	
The CDR partner(s) who are responsible for commissioning the new arrangements	As above	

Section 2: Details of Child Death Overview Panel (CDOP or equivalent structure, hence referred to as CDOP).

Details of CDOP or equivalent	
Name of CDOP	Surrey Child Death Overview Panel
Name of CDOP Administrator	Emily Welch/Harpreet Sagoo
Email address of CDOP	cdop@surreycc.gov.uk
Telephone number of CDOP	01372 833319
Please list ALL the local authority areas covered by your CDOP	Surrey
Number of deaths reviewed in total in the 2018/19 year in the areas listed above	81

Section 3: Requirements of Working Together to Safeguard Children 2018 and the Child Death Review Statutory and Operational Guidance.

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
Overview of your local arrangements for reviewing child deaths.
The core team will include the Designated Doctor, Named Nurse for Child Deaths, CDOP Co-ordinator, a number of Nurse Specialists and a Public Health Professional. Recruitment to the additional posts required to meet the responsibilities of the child death partners will take place after the date of publication and prior to 29th September 2019. The notification Form and Information Gathering will be completed via eCDOP. This will be monitored and managed primarily by the CDOP Co-ordinator. Child Death Review Meetings will be organised and overseen by the Child Death Team who will arrange, manage, chair and oversee their completion. For children who die in a hospital outside of Surrey, the completion of a Child Death Review Meeting will be negotiated on a case by case basis. CDOP Meetings will be held bi-monthly and a separate themed Neonatal Panel meeting will be held quarterly.
The process that will be followed when a child not resident in Surrey dies in Surrey.
The child's area of residence will be notified by Surrey CDOP via eCDOP. This information will be transferred to the area of residence via eCDOP (or email if eCDOP service not available in the child's area of residence). Each case to be considered/negotiated individually between the Specialist Nurse, Designated Doctor and CDOP area of residence, considering factors such as where the majority of services supporting the family were located or where learning could be most beneficial. Surrey CDOP maintain basic demographic records for all children notified who are not resident in the area for information only. For a child resident outside of Surrey, a review will usually be completed by the area of residence, unless specific Surrey learning is anticipated.

How the Surrey CCG hosted team will engage with hospitals to ensure good communication and sharing of information when a child dies.
Update training sessions will be delivered on a rolling annual basis are planned to ensure the processes are followed consistently Surrey-Wide. A CDOP handbook will be shared with all Hospital and Provider Named Nurses for dissemination. eCDOP to be used for reporting and supplementary form collection. As Child Death Review Meetings will be managed county wide by the Child Death Team, agency report forms will be held centrally by CDOP and the Child Death Team.
Requirement WT2: To make arrangements for the analysis of information from all deaths reviewed
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.
eCDOP will be used to ensure secure, complete and timely upload to the NCMD. Local monitoring of themes and modifiable factors will result in whole system approach to embed learning, and will be supported and informed by the national reporting. Public Health will play a key role within Surrey CDOP to develop local analysis and identification.
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
Plans for publication of reports related to this requirement.
The Surrey CDOP will undertake thematic reviews and will prepare and publish reports on at least an annual basis and more frequent if key themes emerge.

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

Details of the agencies who form the membership of the Surrey CDOP.

Core Membership:

- Public Health Independent Chair
- Designated Doctor for Child Death Reviews
- Specialist Nurse for Child Death Reviews
- CDOP Co-ordinator
- Public Health Lead
- Identified representatives from
- Police
- Ambulance
- Hospice
- Education
- Social Care
- GP

The Neonatal Panel has specialist representatives from Midwifery and Neonatal Paediatricians from the 5 Acute Hospitals, joining the core CDOP Panel of Designated Doctor, Specialist Nurse, CDOP Co-ordinator, Public Health Lead. These meetings are also led by the Independent Chair from Public Health.

Public Health Development Worker (lead for Suicide Prevention in Surrey) will attend themed panels for Surrey suicide cases when required.

The Child Death Partnership is working towards the appointment of a Lay Member, to join the CDOP Panel in line with the recommendations within the new guidelines but has not made the appointment at the time of publication.

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

Details of this role in Surrey.

The Designated Doctor for Child Deaths is employed as a Consultant Developmental Paediatrician within the community provider, Children and Family Health Surrey. He works 2 PAs per week as the Designated Doctor for Child Death Reviews. There is an SLA for the role within the CCG team.

The process for notifying the Designated Doctor for Child Deaths when a death occurs.

Within Surrey, a child death will be notified via a Notification Form for eCDOP. The Specialist Nurse for Child Death Reviews and CDOP Co-ordinator will monitor the incoming forms and disseminate these to the Designated Doctor. Should a death require a Joint Agency Response, the Police and/or Hospital will call the Specialist Nurse directly who will attend the scene if within working hours. If outside working hours, a message will be left on the voicemail and contact will be made the next working day to arrange a Joint Home Visit. A Notification Form will still be submitted in these circumstances, however to ensure a timely response to initiate the Joint Agency Response, the call goes directly to the practitioner required. Once a Joint Agency Response is instigated, the Specialist Nurse for Child Death Reviews becomes the Lead Health Practitioner.

The Designated Doctor for Child Death Reviews is notified of deaths requiring a Joint Agency Response (JAR) via the Specialist Nurse for Child Death Reviews (who holds the JAR phone number) and the CDOP Co-ordinator (via email) for all other deaths. A discussion happens between the Designated Doctor and Specialist Nurse following the notification, to consider the actions taken/required and to discuss any factors for consideration.

The Designated Doctor for Child Deaths does not hold direct responsibility for completing the JAR process. The day to day collation and management of all deaths lies with the Specialist Nurse for Child Death Reviews and the CDOP Co-ordinator.

Requirement WT6: Publicise information on the arrangements for child death reviews in your area.
Details on where the information for child death reviews in Surrey can be publicly accessed.
Information outlining the Surrey CDOP arrangements and key contacts will be available on both the CCG and the Surrey Safeguarding Children Partnership websites.
Requirement WT7: Child death review partners should agree locally how the child death review process will be funded in their area.
Details on how the CDR process in your area is being funded
The Child Death Review process is jointly funded between Surrey County Council and the 6 CCGs for Surrey.

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.
Approach to gaining assurance that all staff within the child death review process are aware and follow the operational guidance.
A CDOP booklet containing flowcharts and operational guidance will be updated and sent out to Named Professionals within every organisation on a regular basis. These will be sent within an email that explains the requirement for dissemination within their organisation and also signposts to National guidance and further reading. This booklet will also contain the name and contact details of the Child Death Team. Regular training sessions will be offered, delivered within the local organisational setting on a rolling basis for all partners; Police, Social Care,

Acute Hospitals, 0-19 Teams and Hospice/Palliative Care Teams within Surrey. The audit programme and the annual accountability and assurance process undertaken by the Countywide team will provide partners with the assurance that staff within the child death review process are aware and follow the operational guidance.

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.

The process for assuring that relevant organisations have appointed a key worker in the event of a child death.

Each organisation within Surrey will have referral details for the Key Worker (Nurse Specialist) who will make contact and support the family through the Child Death Process following notification of the death. The Key Worker will be centrally located within the Surrey CCGs hosted Countywide safeguarding team, allowing for continuity of care across Surrey and the highest standards of family care. Once notified of the death the Nurse will contact the family direct. The Key Worker will be part of the Child Death Team and a key CDOP member. The Key Worker, as a Nurse Specialist, will maintain an up to date and detailed knowledge of the processes including but not limited to Funeral Directors, Post Mortems, Police, Coroner and also provide families with information on the Child Death Review Process. They will be available to update and support the family as required. Being independent of any specific Acute Hospital, they will be able to provide an unbiased opportunity for families to speak freely about their experiences and can inform the Child Death Process from a neutral standpoint and maintain the family voice throughout the review.

Requirement OG3: To report deaths of children with learning disabilities or suspected learning disabilities to the Learning Disabilities Mortality Review Programme (LEDER).

The Surrey process for notifying LEDER of the death of a child with a learning disability.

The CDOP Co-ordinator will notify Surrey LeDeR directly via the designated LeDeR email address following the death of a child with a learning disability.

Requirement OG4: A Joint Agency Response (JAR) should be considered if certain criteria, set out in the guidance are met.

Description of the Surrey model for JAR.

The Lead Health Professional for the Joint Agency Response is the Specialist Nurse for Child Death Review (Qualified Paediatric Nurse and Health Visitor).

The JAR Process in Surrey is aligned with the processes and flowchart outlined within the Child Death Review Statutory and Operational Guidance.

Extensive training has been completed with Surrey Police to ensure the Joint Agency Response mechanism is in place and robust. It has been established and in place for a year and is deemed to be working well.

In 2018-19 there were 18 deaths that fulfilled the criteria for requiring a Joint Agency Response, and these were effectively managed under the existing JAR arrangements described above.

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

How the child death review meeting will be convened for the following groups:

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

- **Children who die in hospitals in Surrey**
  When a child dies in hospital this triggers a Joint Agency Response, the Child Death Review Meeting will be arranged and chaired by the Child Death Team to ensure continuity and independent scrutiny.

- **Neonatal deaths in hospitals**
  For Neonatal deaths, decisions will be made on a case by case basis. If the death was not anticipated a Child Death Review Meeting will be held by the Child Death Team. If the death was anticipated or the baby was not compatible with life, this will be considered within the Mortality meeting already held within the hospital and minutes will be provided to CDOP. A member of the Child Death Team will attend the meeting where appropriate.

- **Children who die within the community in Surrey**
  It is anticipated that a regular meeting will be organised in conjunction with the local Hospice where multiple cases can be considered at

a single meeting. This would be the best use of time and resources because the majority of cases would be managed by a select few practitioners. Should a child be cared for by an alternative healthcare team, this will be managed in the same way as a hospital death.

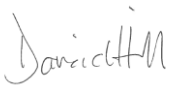
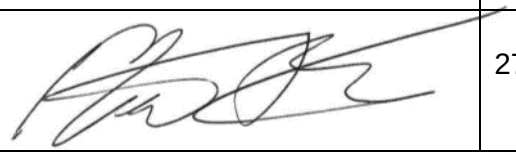
- **Children whose death triggers a Joint Agency Response**
  When a Joint Agency Response is triggered, the Child Death Team will manage the Child Death Review Meeting as per a child who dies in hospital.

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

Details of when Surrey child death partners will produce an annual report and where it will be published

An annual CDOP report has been completed every year for the last 6 years, this is finalised in the May following closure of the year. A 5 year report gathering all the learning into one document has recently been completed and is going to become a rolling 5 year document. The future arrangements are that the reports will be published on the CCG and Safeguarding Children Partnership websites. This arrangement for annual and 5 yearly summary learning and impact reporting will continue within the new arrangements and plan.

An annual audit report has been completed for the last 2 years evaluating the effectiveness and areas for improvement for the Joint Agency Response across Surrey. The plan is that this on-going audit and annual report will continue in the new arrangements to allow monitoring and streamlining.

Organisation:	Name:	Title:	Signature:	Date:
Surrey County Council	Dave Hill	Executive Director for Children, Families, Lifelong Learning and Culture		27.06.19
On Behalf of the 6 Surrey CCGs	Matthew Tait	Joint Accountable Officer Surrey Heartlands CCG's		27.06.19