

TRAFFORD COUNCIL

Report to: Health and Wellbeing Board
Date: 19 July 2019
Report for: Information
Report of: Eleanor Roaf, Director of Public Health

Report Title

Health and Wellbeing Board's responsibility for oversight of child deaths in Trafford.

Summary

This paper informs the Health and Well Being Board of their new statutory requirement and accountability for the oversight of all child deaths in Trafford.

It outlines the current arrangements and the new processes to ensure that we are compliant with national legislation. The Health and Well Being Board will scrutinise the CDOP (Child Death Overview Panel) process, receive information such as the annual report and consider emerging trends in child deaths with the aim to prevent further deaths.

Recommendation(s)

Members of Trafford's Health and Wellbeing Board are asked:

- i. to confirm and accept the responsibility for governance of CDOP to be transferred from Trafford's Safeguarding Board to the Health and Wellbeing Board.
- ii. to ensure that mortality reviews of all children who have died within their services are carried out using a multi-agency model of review.
- iii. to note that they will receive the 18/19CDOP report upon completion.

Contact person for access to background papers and further information:

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Health and Wellbeing Board's responsibility for oversight of child deaths in Trafford

1. Purpose of the paper

This paper has been prepared to inform the Health and Well Being Board of their new statutory requirement and accountability for the oversight of all child deaths in Trafford.

It outlines the current arrangements and the new processes to ensure that we are compliant with national legislation. The Health and Well Being Board will scrutinise the CDOP (Child Death Overview Panel) process, receive information such as the annual report and consider emerging trends in child deaths with the aim to prevent further deaths.

2. Background

Since 2008, in line with Working Together to Safeguard Children guidance, there has been a statutory requirement for Local Safeguarding Children Boards (LSCB) to ensure that the deaths of all children under the age of 18 years (excluding stillbirths and legal terminations of pregnancy) are reviewed. The purpose of a review is to identify any matters relating to the death that are relevant to the welfare of children or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If CDOPs find action should be taken by a person or organisation, they must inform them. In addition, CDOPs:

- must, at such times as they consider appropriate, prepare and publish reports on:
 - what they have done as a result of the child death review arrangements in their area, and
 - how effective the arrangements have been in practice;
- may request information from a person or organisation for the purposes of enabling or assisting the review and/or analysis process - the person or organisation must comply with the request, and if they do not, the CDOP (CDR Partners) may take legal action to seek enforcement.

Under the current structure, CDOP reports are presented and considered by the Trafford Safeguarding Executive Board. The Wood Review (2016) identified the need for change in the way that child deaths reviews are completed. The review recommended the transfer of the responsibility to Local Authorities and Clinical Commissioning Groups (CCGs). The Child Death Review Statutory and Operational Guidance (England) was published in October 2018 which sets out the requirement and legal responsibility for CDOPs and Child Death Review Partners (CDR Partners) to ensure that the deaths of children normally resident in their area are reviewed.

3. Changes outlined in the Operational Guidance

CDOPs will no longer be part of the revised Local Safeguarding Partnership (LSP) arrangements and as of October 2018 the national line of accountability was transferred from the Department for Education (DfE) to the Department for Health and Social Care (DHSC). In Greater Manchester CDOP accountability and reporting will be to the Health and Wellbeing Boards (H&WB), who will scrutinise the process and receive information such as the annual report and emerging trends in child deaths across the region.

The purpose of this paper is to ensure that the Trafford Health and well Being Board is clear on the statutory requirement to carry out a review for all child deaths, irrespective of cause, age 0 – 17 years (before the child's 18th birthday), excluding stillbirths and legal terminations of pregnancy. This is to ensure that there are:

- clear reporting structures for CDOP findings to the Health and Wellbeing Board in Trafford.
- clear processes are in place for child reviews to take place.
- clear procedures continue to share information with the CDOPs.

- information gathered is used to identify emerging themes with the aim to prevent further deaths.
- effective services are commissioned and provided to bereaved families who have suffered the death of a child.

4.i. Local Position

The DfE recommendation that CDOPs require a total population of 500,000 or higher. Trafford is included in the GM CDOP arrangements, the current four existing panels will continue to meet. Trafford is part of the CDOP with Tameside and Stockport localities.

GM CDOPs	GM Coronial Jurisdiction	Population
Tameside, Trafford & Stockport CDOP	Manchester South Coroner's Office	750,657

4.ii. Stockport, Tameside and Trafford Membership

Until recently the Stockport, Tameside, and Trafford CDOP had an independent chair, however since May, the chair ship has transferred to a Public Health Consultant. Membership is on a rotational basis and is under review as per the Child Death Review Statutory and Operational Guidance, 2018. The current membership is as follows:

- Helen Gollins – Trafford Public Health
- Shelley Birch – Joint CDOP manager
- Dr Rashad Nawaz – Consultant Community Paediatrician - Trafford
- Ann Evans – Palliative care nurse – Trafford
- Claire Mee – MFT south midwifery - Wythenshawe
- Jane Connell - Designated Doctor Safeguarding Children Stockport
- Catherine Fleming – Safeguarding Board Manager – Stockport
- Sharon Hyde – Head of Midwifery – Stockport
- Dr Munera Khan – Consultant Paediatrician - Tameside
- Julie Parker - Designated Nurse Safeguarding Children
- Estelle Mathieson - Detective Superintendent GMP
- Andrea Edmondson – Safeguarding Practitioner NWS

4.iii. GM CDOP Network

CDOP Chairs and CDOP Coordinators/Managers currently come together to form the GM CDOP Network. This Network meets on a quarterly basis to ensure that the approach to data collection, application of modifiable factors and interpretation of data is consistent across GM. The GM CDOP Network also highlight any emerging themes in child deaths across GM, share good practice and work together to support the GM CDOP Annual Report.

4.iv. Annual Reports

In line with Working Together Guidance, the Tameside Trafford and Stockport CDOP prepares a local annual report containing relevant statistical analysis, information and recommendations for the Trafford Safeguarding Executive Board. Trafford Health and Well Being Board will receive these upon completion.

5. Child Death Mortality Reviews

The Manchester University NHS Foundation Trust undertake a significant amount of work through the processes of investigating all neonatal and child deaths, when a child dies or is taken to one of the Trust's sites.

There is a requirement for all CDMR reviews to be submitted to the CDOP area of residence so that further analysis of data can be made. The Tameside, Trafford and Stockport CDOP are currently working on the arrangements for this new requirement and will inform the Health and Wellbeing Board when completed.

6. Recommendations for 2019/20

Members of the Health and Wellbeing Board are asked to:

- i. confirm and accept the responsibility for governance of CDOP to be transferred from Trafford's Safeguarding Board to the Health and Wellbeing Board.
- ii. ensure that mortality reviews of all children who have died within their services are carried out using a multi-agency model of review.
- iii. note that they will receive the 18/19 CDOP report upon completion.

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