

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

Section 1: Contact Details of Child Death Review Partners

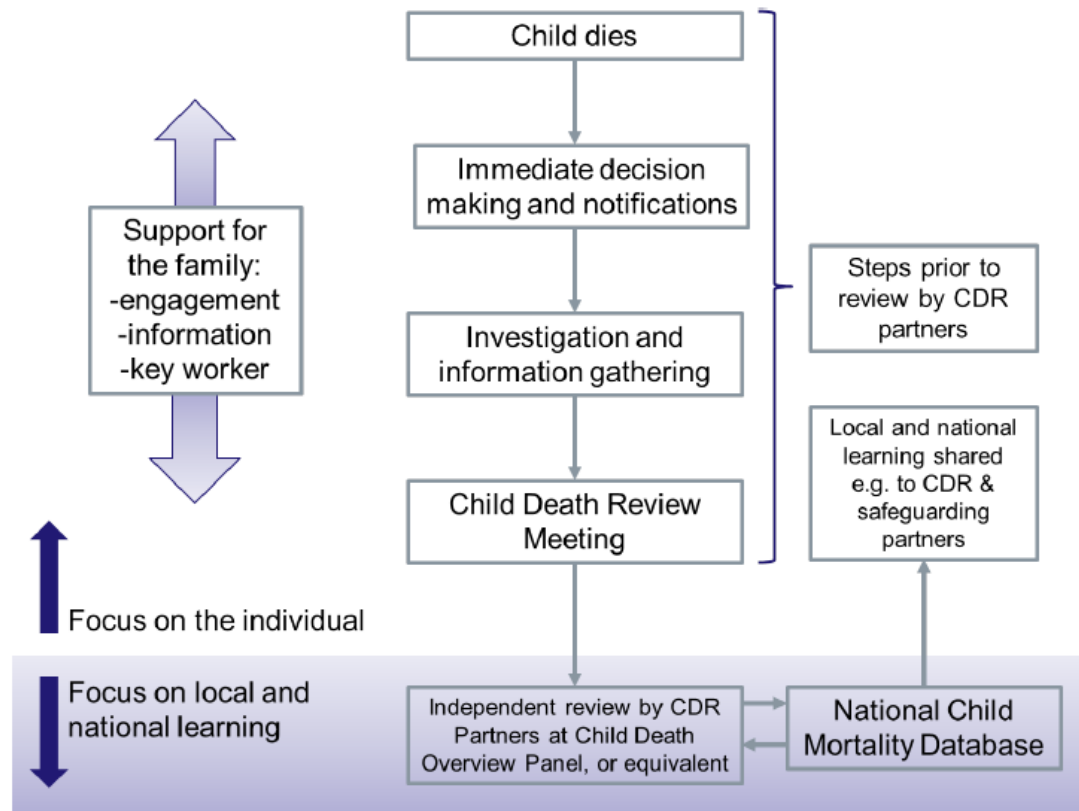
Names of Child Death Review Partners		
Name of organisation	Hull City Council	<input type="checkbox"/> Clinical Commissioning Group <input checked="" type="checkbox"/> Local Authority
Name of contact for child death reviews within organisation	Alison Murphy Corporate Director, Children, Young People & Family Services	
Email address of contact	Alison.murphy@hullcc.gov.uk	
Telephone number of contact	(01482) 613232	
Name of organisation	NHS Hull Clinical Commissioning Group	<input checked="" type="checkbox"/> Clinical Commissioning Group <input type="checkbox"/> Local Authority
Name of contact for child death reviews within organisation	Sarah Smyth Director of Quality and Clinical Governance/ Executive Lead Safeguarding Children and Adults	
Email address of contact	sarah.smyth4@nhs.net	
Telephone number of contact	(01482) 344827	
Please indicate the lead CDR partner (<i>NB: this must be one of the organisations listed above</i>)	NHS Hull CCG	

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

Details of CDOP or equivalent <i>This section should include details of the area covered by your CDOP</i>	
Name of CDOP	Hull Child Death Overview Panel
Name of CDOP Manager / Administrator	Cathy Eccersley, Co-ordinator
Email address of CDOP	cdop@hullcc.gov.uk
Telephone number of CDOP	(01482) 379090
Please list ALL the local authority areas covered by your CDOP	Hull
Number of deaths reviewed in total in the 2018/19 year in the areas listed above	19

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



Current notification process by CDOP Co-ordinator and specified health professionals, including the Designated Doctor for the child death review process works well and will be retained.

Health responsibilities for the process include providing a Designated Doctor for Child Deaths who will take a lead role in co-ordinating responses and health input to the child death review process within the city of Hull boundary.

Additional child death review process requirements identified in the guidance have been incorporated into the revised service specification by NHS Hull CCG with Hull University Teaching Hospital Trust which include:

- identifying the key worker as a single point of contact for a bereaved family
- ensuring appropriate health professional membership, including the Designated Doctor for Child Deaths and midwife, of the Hull Child Death Overview Panel.
- undertaking the role of lead health professional when a Joint Agency Response is triggered.
- co-ordinating a Joint Agency Response where a child's death meets the criteria described in statutory guidance, with the child death review co-ordinator.
- co-ordinating and/ or chairing the multi-agency Child Death Review Meeting including co-ordinating the receipt of learning from other relevant reviews, for example a perinatal mortality review group meeting; paediatric mortality meeting; NHS Serious Incident Investigation; LeDeR review with the CDOP co-ordinator.
- co-ordinating the Perinatal Mortality Review Group additional requirements to fulfil the role of the Child Death Review Meeting.
- providing the role of "case manager" to have oversight of procedures, where there is more than one investigation
- working closely with the key worker to ensure parents have an opportunity to input into the process and establish how they would like to receive feedback.

CDOP Co-ordinator will receive reporting forms from agencies involved with the child, after or at the time of their death, and ensure these are available at Child Death Review Meetings (CDRM). An analysis form will be completed at each child death review meeting and sent to the CDOP Co-ordinator for final review at a CDOP meeting within 6 weeks of the CDRM.

The CCG/hospital Trust will consider where existing hospital review processes can be effectively used to meet the requirements of the CDRM, to avoid duplication.

The local CDOP will be chaired by Public Health and meet within 6 weeks of the CDRM or coroner's inquest.

The CDR partners in the area where the child is normally resident is responsible for ensuring that a review takes place at CDOP level, however, consideration will also be given to deaths occurring out of area as to the lead being in the CDOP area where there is likely to be the most learning.

Member Local Authorities and CCGs of East Riding of Yorkshire CDOP, Hull CDOP, Northern Lincolnshire CDOP (operating across North and North East Lincolnshire Councils), and North Yorkshire/York CDOP 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. Arrangements are outlined in a Letter of Agreement/Understanding which have been approved by the statutory organisations.

When a child not resident in our area dies in our area local CDOP Co-ordinator will notify the CDOP Co-ordinator in the area where the child lived. The decision to determine who leads the review and retains responsibility for the case will take place on a case by case basis, considering where most learning is likely to be identified. The decision will be made by the Designated Doctor in liaison with other partners.

To ensure good communication and sharing of information when a child dies, there are effective communication and sharing of information processes in place for notifications of child deaths in Hull.

Additional administrative support will be provided by Hull University Teaching Hospital Trust (via the CCG service specification) to arrange:

- for reporting forms and supplementary reporting forms relating to the child's medical condition and treatment to be completed for the CDRM
- for the completion of the analysis form at the CDRM for children who have died in Hull.

The local CDR process will use the national template forms.

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

There is a statutory duty to provide data to NCMD for national analysis of information from deaths reviewed by NCMD; the CDOP Co-ordinator will input data from the notification, reporting, supplementary and analysis forms for deaths reviewed in Hull. This will be via the NHS Digital secure portal.

Local analysis will be provided by Designated Doctor and Public Health lead.

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

An annual local review report will be undertaken to review how effective the child death review arrangements are in practice. This information will also be aggregated into a regional CDOP annual report. The reports will be published on the Hull Safeguarding Children Partnership website and the websites of our regional partners.

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

Hull CDOP members

Chair: Assistant Director Health and Wellbeing, Hull City Council
Designated Doctor for Child Deaths, Hull University Teaching Hospitals Trust
Named GP, NHS Hull CCG
Designated Nurse for Safeguarding Children, NHS Hull CCG
Designated Doctor for Safeguarding Children, NHS Hull CCG
DCI, Humberside Police
Head of Service, Children, Young People and Family Services, Hull City Council
Area Coroner
CDOP Co-ordinator

Initial meetings of the CDOP will consider Lay membership.

In addition to the core membership, relevant experts from health and other agencies will be invited as necessary to inform discussions.

Regional CDOP

Currently a working group is in place to determine formal membership/roles from the member agencies.

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

The Designated Doctor for Child Deaths is employed by the Hull University Teaching Hospitals NHS Trust.

The Designated Doctor is currently appointed for 1 day per week and a service specification has been revised to incorporate some of the additional requirements outlined in the Child Death Review Statutory and Operational Guidance.2018. The job description and service specification are under revision and can be made available upon request.

The Designated Doctor is made aware of child deaths in hospital by the hospital trust's Safeguarding Team or the doctor who has certified the death. Notifications may also be received from other sources, for example, police, coroner, children's social care, the LA Emergency Duty Team or the CDOP Co-ordinator. In every case, the CDOP Co-ordinator will always communicate with the Designated Doctor by email to ensure there is awareness of the child death.

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

Information about child death reviews can be publicly accessed through the websites of the Hull Safeguarding Children Partnership (HSCP) and those of the local child death review partners, NHS Hull CCG and Hull City Council

Requirement WT7: Child death review partners should agree locally how the child death review process will be funded in their area.

CDR Partners to continue determining, at a local level, the funding contributions to the process for Chairing, CDOP Co-ordinator and Designated Doctor for Child Deaths.

Partners to contribute equal amounts for any future expenses or in-kind support associated with training, collaborative regional CDOP arrangements, learning events and publication of local and aggregated annual reports.

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.

Operational guidance and training has been made available to staff through:

- LSCB e-bulletin – to raise awareness
- CDOP meeting agenda items
- Joint Agency Response training facilitated by Designated Paediatrician, Police, Children’s Social Care, hosted by the LSCPs in Hull and East Riding of Yorkshire
- Learning event about future local multi-agency safeguarding arrangements
- Senior Leadership Team NHS Hull CCG (chair Accountable Officer)
- NHS Hull CCG website

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 organisation where the child’s death was certified will identify a key worker for the family (this could be a range of practitioners).

Parents will be informed by their key worker about the purpose and remit of the review at CDOP.

A summary of responsibilities and competencies for the key worker role will be as identified in statutory guidance.

Joint Agency Response meetings will consider identifying a keyworker for the family.

CDOP Co-ordinator will monitor compliance of allocating a key worker and support them in their role.

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

In consultation with the Designated Nurse Safeguarding/CCG, the CDOP Co-ordinator will notify LeDeR of the death of a child with a learning disability via the secure electronic notification process.

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

The lead health professional for leading Joint Agency Responses will be the Designated Doctor for Child Deaths (HUTHT).

Home visits to be co-ordinated by the Designated Doctor and Police Decision Maker.

A JAR is available Mon-Fri 9am-5pm. There is currently no on-call element.

From data over the previous 3 years, we estimate that approximately 6 deaths per year in Hull may require a JAR.

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

Child death review meetings will be convened for the following groups:

- **Children who die in hospitals in Hull** – by the organisation responsible for the declaration of death
- **Neonatal deaths in hospitals in Hull** (this should include use of the Perinatal Mortality Review Tool (PMRT)) - by the organisation responsible for the declaration of death
- **Children who die in the community in Hull** – Designated Doctor, in consultation with CDOP Co-ordinator (and where appropriate, lead professional in organisation where death occurred e.g. hospice)
- **Children whose deaths trigger a joint agency response** - Designated Doctor in consultation with CDOP Co-ordinator

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

Public health lead and Designated Doctor, in liaison with partners, will produce an annual report on a financial year basis and publish it on the HSCP, NHS Hull CCG website and Hull City Council websites.

The annual report for Hull will also inform an amalgamated Regional annual report.