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| **Report to:** | **Health and Wellbeing Board** |
| **Relevant Officer:** | Dr Arif Rajpura, Director of Public Health |
| **Relevant Cabinet Member** | Councillor Graham Cain, Deputy Leader (Children) |
| **Date of Meeting** | 29 January 2020 |

# CHILD DEATH OVERVIEW PANEL NEW ARRANGEMENTS

**1.0 Purpose of the report:**

1.1 Due to the implementation of the Children and Social Work Act 2017 revised statutory guidance was issued that created a new framework of expectations around safeguarding arrangements and Child Death Overview Panels (CDOP).

Subsequently, consideration has been given as to how statutory duties in relation to Child Death Overview Panel can most effectively be met moving forward in a changing safeguarding landscape, alongside sub-regional partners, with whom responsibilities are jointly discharged.

**2.0 Recommendation(s):**

2.1 To agree to continue with a Pan-Lancashire Child Death Overview Panel approach with periodic reviews. This includes a commitment to the current funding and business support model

2.2 The governance for the Child Death Overview Panel is requested to develop a more effective relationship between the Children's Safeguarding Assurance Partnership (CSAP) and Health and Wellbeing Boards (H&WBB) in line with local agreements.

2.3 That Child Death Overview Panel members for each area take responsibility for reporting into the most appropriate local forum for their area and link with peer networks to ensure necessary activity is undertaken

2.4 That Child Death Overview Panel members will review any required operational changes to be in line with statutory guidance such as the undertaking of thematic reviews, policy, and practice guidance amendments.

**3.0 Reasons for recommendation(s):**

3.1 Overall, after a review with Child Death Overview Panel members it would appear that Child Death Overview Panel can continue in its current format with the same stakeholders ensuring the operational activity is in line with statutory requirements. The main area for focus appears to be strategic accountability due to the changes to Local Safeguarding Children Board formats.

3.2 Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.3 Is the recommendation in accordance with the Council's approved budget? Yes

**4.0 Other alternative options to be considered:**

4.1 None.

**5.0 Council priority:**

5.1 The relevant Council priority is: "Communities: Creating stronger communities and increasing resilience".

**6.0 Background information**

6.1 The implication of the Children and Social Work Act 2017 is that Local Authorities, Clinical Commissioning Groups and Police forces have had to revise their current Local Safeguarding Children Board (LSCB) arrangements. As well as disestablishing Children's Safeguarding Boards and creating new arrangements for scrutiny of child safeguarding, as part of these changes they have also been required to establish Child Death Overview Panels (CDOP) as a distinct set of arrangements rather than as an adjunct to Local Safeguarding Children Boards. The split has been reinforced by the introduction of separate Child Death Overview Panel statutory guidance outside of the revised Working Together Statutory guidance.

6.2 Under the revised guidance the new Child Death Review (CDR) partners, the Local Authority (LA) and the Clinical Commissioning Groups (CCG) in an area, have statutory responsibilities to:

- Make arrangements to review all deaths of children normally resident in the local area and, if they consider it appropriate, for any non-resident child who has died in their area.
- Make arrangements for the analysis of information from all deaths reviewed
- Prepare and publish reports on what they have done and effectiveness of arrangements

6.3 The Child Death Review partners have been given freedom to decide the structure within their area to meet these statutory duties which includes continuing with the current arrangements provided a minimum of 60 cases are reviewed and the learning is conducted in a way that can be shared nationally. This includes supporting the plans for a national database and utilising revised forms for the collation and analysis of data.

6.4 Child Death Overview Panel Model in the past

Within Lancashire this has operated on a Pan-Lancashire footing with the Child Death Overview Panel representing the three local authorities (Blackburn with Darwen, Blackpool and Lancashire County Council) and 6 Clinical Commissioning Groups in the area under the scrutiny of the Local Safeguarding Children's Board. The Child Death Overview Panel meets monthly to review all Child Deaths and formerly made proposals to the Local Safeguarding Children's Boards regarding escalation issues or directed specific agencies to respond to actions arising from a child's death, including the instigation of a Serious Case Review where appropriate.

Funding is received from statutory partners which is proportionate to the local child population. This funding has ensured that statutory duties in relation to recording child deaths, collating multi-agency information, reporting to the national system and reviewing child deaths for modifiable factors are conducted. It also generates quarterly reports and an annual report on activity and concerns for the locality.

Meetings are organised with three different focuses with the following membership:

| **Business Meeting (Strategic Overview)** | **Review Meetings** | **Neo-natal Review Meetings** |
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| Chair | Chair | Chair |
| Public Health | Public Health | Public Health |
| Children's Social Care | Children's Social Care | Children's Social Care |
| Lancashire Constabulary | Lancashire Constabulary | Lancashire Constabulary |
| Designated Doctor for child deaths | Paediatrician/Designated Doctor for child deaths | Paediatrician and/or Neonatologist /Designated Doctor for child deaths |
| Designated nurse | Named Nurse for Safeguarding | Named Nurse for Safeguarding |
| SUDC Lead Nurse | Named Midwife | Named Midwife |
| Member of the Health Executive Group | Primary Care (Health Visitor/ GP) | |

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| The business lead for the multi-agency safeguarding arrangements | SUDC Nurse | SUDC Nurse |
| Lay/parent representative | Education (School/ Early Years Rep) | Specialist Professional: Obstetrician/ Neonatologist/ Neonatal Nurse (at least 1) |
| Coronial and Registrar Services when relevant | Lay/parent representative | Lay/parent representative |

6.5 Future Arrangements

Numerous discussions have taken place involving partners and Child Death Overview Panel members. The current Child Death Overview Panel model is working effectively and is in line with statutory guidance in relation to reviewing deaths and identifying local lessons.

The opportunity to share learning and collaborate on a larger footprint for action on shared issues (for example campaigns and thematic reviews) will continue across the North West region. This is currently supported through the activity of the Chair and the panel administrator. A Memorandum of Understanding has been developed and supported by statutory partners, which agreed that Child Death Overview Panel would take on responsibility for providing assurance of Child Death Reviews across Lancashire.

Therefore, partners have agreed that the Pan-Lancashire model is maintained. Partners will monitor the effectiveness of Child Death Overview Panel in 12 months to ensure it continues to operate within Statutory guidance and meet the needs of the Child Death Review partners and the model supports the most effective response to Child deaths in the area.

6.6 Governance

The Child Death Overview Panel continues to be managed and hosted by Lancashire County Council, alongside the Children's Safeguarding Assurance Partnership function, which will help maintain the important links between the two. The guidance is clear that Child Death Overview Panel is now a parallel rather than a subgroup process. The partners have identified that the requirement for analysis and the subsequent lessons emerging from Child Death Overview Panel are predominantly public health

matters as opposed to safeguarding issues.

The functions for Health and Wellbeing Boards focus on the joint activity required between Local Authorities and health partners to improve the health and wellbeing of the community they serve. Where preventable, factors that may influence the death of a child can be identified, such as smoking, obesity and substance misuse for example, the Health and Wellbeing Board is the most appropriate place to address these matters on a population basis rather than being addressed via the current safeguarding mechanisms.

The themes and trends identified through the Child Death Overview Panel process should be placed within the context of the wider health and wellbeing data already considered at Health and Wellbeing Boards to inform their priorities and action, including joint commissioning. Children's Safeguarding Assurance Partnership would still be significant in leading on individual reviews where abuse or neglect is identified in a child death and being assured on the effectiveness of services responsible for supporting parents whose parenting capacity is compromised by their mental health, drug and alcohol misuse and/ or domestic abuse.

In order to manage costs, reporting into these forums will be led by Child Death Overview Panel members for that area, as well as engaging with professional peer groups. This will enable informed scrutiny of Child Death Overview Panel activity and local accountability for ensuring relevant learning is actioned in each area. Therefore, each area will treat its Health and Wellbeing Board as the default governance taking lead responsibility for scrutinising the work of Child Death Overview Panel, agreeing the actions, and over-seeing the effectiveness of those actions, and the Health and Wellbeing Board and how this will function so assurance is provided.

6.7 Next Steps

Child Death Overview Panel members have revised policy, procedures and practice guidance on behalf of the Cheshire Area to ensure that compliant documentation is in place by the deadline which was June 2019 and in operation by September 2019. To facilitate this a workshop is arranged to revise terminology and map the pathways for child death reviews as needed. This will also include revisiting the terms of reference for Child Overview Panel to ensure there is sufficiently robust data analysis for the area in quarterly and annual reports.

It was acknowledged that the transition of the safeguarding arrangements across Lancashire are varied which has created a lack of clarity currently in relation to the continuation of shared approaches. Warrington has agreed to continue to provide business manager support to the Child Death Overview Panel processes up to January 2020 when the model will be reviewed; Lancashire County Council will continue to host and manage the business support functions. This will provide some consistency

during the transition period and allow decisions to be reviewed when greater clarity of the Pan-Lancashire landscape is available.

6.8 Does the information submitted include any exempt information? No

**7.0 List of Appendices:**

7.1 None.

**8.0 Legal considerations:**

8.1 None.

**9.0 Human resources considerations:**

9.1 None.

**10.0 Equalities considerations:**

10.1 None.

**11.0 Financial considerations:**

11.1 None.

**12.0 Risk management considerations:**

12.1 None.

**13.0 Ethical considerations:**

13.1 None.

**14.0 Internal/external consultation undertaken:**

14.1 As outlined in the report with key stakeholders.

**15.0 Background papers:**

15.1 None.