



Barking and Dagenham, Havering and Redbridge (BHR) Child Death Review System (CDRS) and Child Death Review Partnership (CDRP).

An Overview

June 2019 Version 1.2

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Version Control

Issue Date	Author	Detail
Draft 1.0 June 2019	Jacqui Himbury, Janet Powell, Doug Tanner, Daniel Devitt	Initial Draft – outlining outline structures and functions flowing from preparation for DfE assurance template submission.
Draft 1.1 June 2019		High Level final draft shared with the local CDR system
Draft 1.2 June 2019	Jacqui Himbury, Doug Tanner, Daniel Devitt	Revised Draft incorporating feedback from partners.

Revision Schedule:

This overview published in June 2019, aims to both describe and support the new Child Death Review (CDR) System that will be introduced following on from the Children and Social Work Act 2017¹ and updated operational guidance.²

An ongoing commitment to revision and review of the arrangements is a key feature of the new system and will be a core feature of the partnership as it is established and moves into maturity. The Statutory Partners, will work with local public health, safeguarding, scrutiny, governance and assurance, clinical, commissioning, social care and participation – including Voice of the Bereaved – structures to ensure that processes evolve in light of operational experience and needs. These key principles are also reflected in the new safeguarding arrangements plan.

A revision of the arrangements will be initiated at least annually, and all partners are required to contribute to the revision process, which will be centrally overseen by the CDR secretariat and Child Death Implementation Group. The next scheduled revision is therefore 29th June 2020.

Publication/Revision/Interim Update	Timescale for drafting/revision	Due Date
Initial Publication	October 2018 to June 2019	29 th June 2019
Scheduled revision	29 th June 2019 to 29 th June 2020	29 th June 2020

¹ See <http://www.legislation.gov.uk/ukpga/2017/16/contents/enacted>

² See <https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england>

Glossary

BASU	Business As Usual
BCU	Basic Command Unit
BHR ICS	Barking & Dagenham, Havering and Redbridge Integrated Care System
BHR CVS	Barking Havering and Redbridge Community and Voluntary Sector
BHRUT	Barking, Havering and Redbridge University Hospitals NHS Trust
CSWA17	Children and Social Work Act 2017
CCG	Clinical Commissioning Group
CDISG	Child Death Implementation Steering Group
CDOP	Child Death Overview Panel
CDR	Child Death Review
CDRS	Child Death Review Partner (s)
CDRM	Child Death Review Meeting
CQC	Care Quality Commission
DCS	Director of Children’s Services
DfE	Department for Education
DHSC	Department of Health and Social Care
ECDRG	Executive Child Death Review Group
JAR	Joint Agency Response
NELFT	North East London Foundation Trust
MD	Managing Director
BHR CCG	Barking & Dagenham, Havering & Redbridge Clinical Commissioning Group
LBR	London Borough of Redbridge
LBBD	London Borough of Barking and Dagenham
LA	Local Authority
LSCB	Local Safeguarding Children Boards
LDNSCB	London Safeguarding Children Board
NCB	National Children’s Bureau
NELCA	North East London Commissioning Alliance
Ofsted	Office for Standards in Education, Children's Services and Skills
SCP	Safeguarding Children Partnerships
SUDI/C	Sudden Unexpected Death of an Infant/Child
WT18	Working Together 2018 - The core statutory guidance for multi-agency Safeguarding children revised following the 2017 legislation – sometimes referred to as “The Guidance”. Chapter 5 and supplementary statutory guidance related to Child Death Review processes.

Introduction

The death of a child at any age is a devastating event for the parents, carers, siblings, friends and communities they lived in.

It is crucial that we have robust support and review systems in place to understand why a child death has occurred and provide appropriate support to the bereaved. The overall aim of the review process, alongside seeking to understand issues related to care is ultimately to draw learning from individual cases to prevent, where possible, future deaths. The operational guidance following on from the Children and Social Work Act 2017 required the transformation of local child death review practices and structures.

In order to do this, we need a sustainable and robust model for CDR that meets these needs. The task of understanding the new legislative challenges and ensuring that we develop a CDR system that both learns from each case in order to drive the prevention of future deaths and supports those impacted by the death of a child is complex and requires commitment across all partners to the BHR CDR system. This vital work is being driven by a multi-agency Child Death Implementation Steering Group³ whose work has informed both this overview and the detailed planning document (see appendix A) submitted to the Department for Education.

My thanks go to them and to all those who are working so hard to build the new CDR system for BHR. We have done much already and will continue to build a compassionate, sustainable and responsive system that meets or exceeds the requirements flowing from legislation and crucially serves the needs of the bereaved.

We wish to dedicate this overview and the CDR plan⁴ it addresses to the memories of all deceased Barking and Dagenham, Havering and Redbridge children and young people and their bereaved parents, carers and siblings.



Jacqui Himbury

Jacqui Himbury- Nurse Director
Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups
and Chair BHR CDR Executive Group
June 2019

³ See Appendix D

⁴ See Appendix A

Executive summary

Following on from the Children and Social Work Act 2017 the National and local system for reviewing the deaths of children and young people is changing. The new requirements include:

- **Establishment of multi-agency Child Death Review Meetings (CDRM)**
Every child's death to be reviewed at a CDRM held at provider trust level (acute/community or mental health) to ensure local learning involving practitioners directly involved in the child's care prior to discussion at CDOP
- **CDOP business managers to work closely with CDR partners** to arrange attendance at CDR meetings or gather/ collate reports (form B) to inform CDOP consideration and creation of form Cs.
- **Revised CDR output** (form C) with new domains 'Social environment including family and parenting capacity', and 'Physical environment' alongside safeguarding and clinical issues.
- **CDRMs to routinely send a report to the CDOP** to inform review of the case – alongside Serious Incident summaries.
- **Larger footprint of the CDR systems with a minimum 60 caseload**
Shift of government department lead responsibility from Department for Education to Department of Health and Social Care
- **A focus shift to modifiable factors and proportionate appropriate review of all deaths.**
- **Development of a new “key worker” role** to act as a single point of contact with the bereaved for information on the child death review process, and who can signpost them to sources of support.
- **Revision of additional requirements to address a number of “complex” circumstances, including:** deaths of UK-resident children - overseas, with learning disabilities, in adult healthcare settings, suicide and self-harm, deaths in inpatient mental health settings, and deaths in custody
- **Themed review meetings for high volume or high complexity deaths.**

This Overview document presents the BHR response to the reforms and our commitment to developing a robust, sustainable and compassionate local child Death Review Partnership. With initial plans to be published by 29th June 2019 and operational delivery from 29th September 2019, works have been underway since 2016 to build the foundations for the new system.

1. BHR CCGs Objectives

Barking and Dagenham, Havering and Redbridge CCGs have shared a set of corporate objectives for the past six years, reflecting our collaborative approach⁵. We know that we cannot solve our system challenges by working alone and over the past year have intensified system and partnership working. Our objectives build on those agreed last year, but have been refreshed in light of the NHS Long Term Plan. Values, Vision, Aims and for the new CDRP

The BHR CDRP has elements that speak to all areas of these objectives and we are currently in the process of refining the specific Vision, Values, Aims and Objectives.

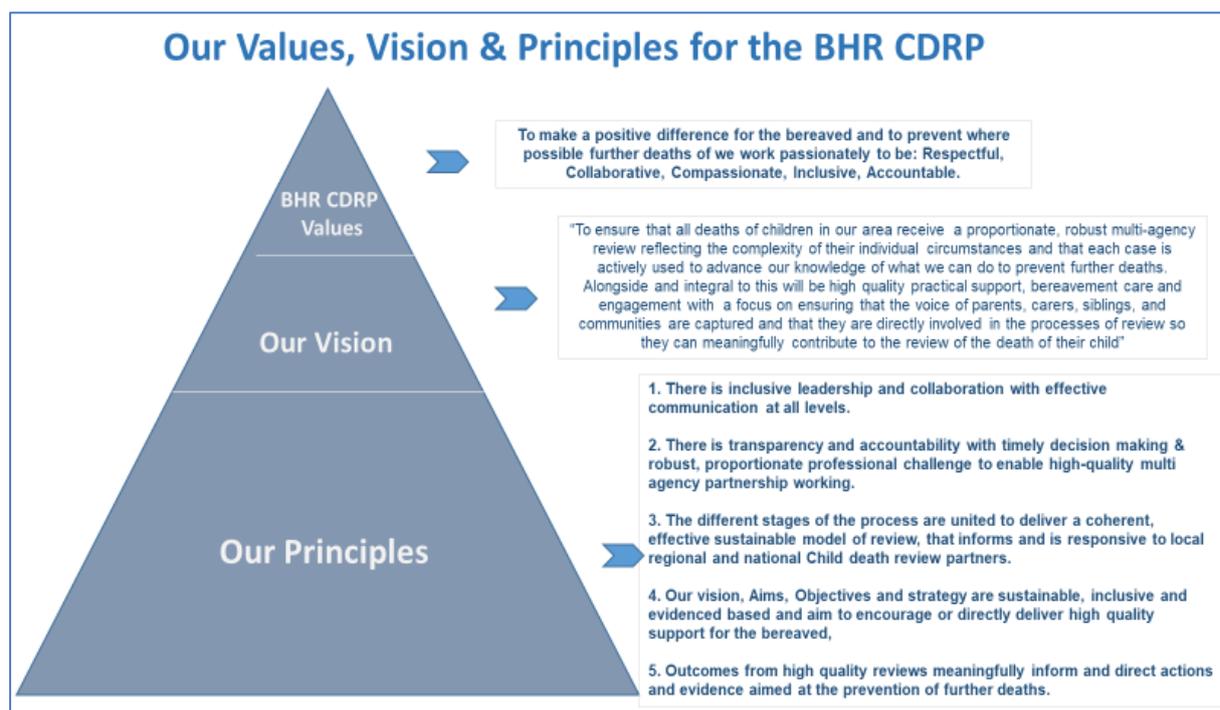


Fig 1 Draft Values, Vision and Principles summary for the BHR CDRP.

A draft outline of these is included above to support understanding of the commitment and cultural assumptions and operating principles underpinning the BHR model for the Partnership.

2. Context for the Development of the BHR CDR system.

The Children Act 2004 introduced a requirement for local authorities in England to review the death of any child resident in their area.

Further to the Children & Social Work Act 2017 gaining royal assent and the publication of the Working Together guidance issued in 2018, the three Local Authorities LB Havering, LB Barking & Dagenham and LB Redbridge and the BHR Clinical Commissioning Group agreed to strengthen local working and develop a new Child Death Review System in keeping with the requirement to establish a new model

⁵ See <http://bhr.nhs.sitekit.net/About-us/our-corporate-objectives.htm> for more information about the BHR CCGs.

across BHR. This work has proceeded alongside the work to establish the new local BHR Safeguarding Children Partnership.

Alan Woods Review of Local Childrens Safeguarding⁶ examined the Child Death Overview Panel (CDOP) process in depth and found that only a small proportion of child deaths were the result of neglect or abuse and these were reliably identified and investigated through parallel safeguarding procedures.

The majority of modifiable factors associated with child deaths relate to sub-optimal clinical care or lifestyle and societal factors that might be amenable to more effective public health action.

This analysis informed changes introduced in the Children and Social Work Act 2017 and subsequent statutory guidance. In summary the key changes for Child Death Review are:

- Responsibility for child death review shifted from Local Safeguarding Children Boards (LSCBs) to a joint partnership of local authorities and clinical commissioning groups (CCGs), named Child Death Review Partners (CDRP)
- Arrangements to cover a minimum geographical footprint yielding sufficient deaths for review (effectively between 60 and 150 per annum) to identify local patterns in cause of death and underlying modifiable factors and monitor trends overtime.
- Every child death to be subject to a thorough mortality review led by clinicians in the acute hospital or trust or primary care setting most involved in the care of that child or appropriate to the review.
- Support to families affected by child death to be improved by:
 - identification of a key worker to support the family and help them understand the circumstances of the death
 - the offer of bereavement support, if needed, at an appropriate time.
 - The refresh of a locally customisable bereavement resource explaining the new processes to the bereaved, and its sharing with the bereaved at the time of the death of their child or young person.⁷

There are on average around 60 deaths in the Barking and Dagenham, Havering and Redbridge system each year.

Area	Numbers
Barking & Dagenham Local Authority	17
Havering Local Authority	13
Redbridge Local Authority	32
Total	62

Fig. 2 Number of child death notifications in 2018-2019 by area.

This is also the required footprint of the developing Integrated Care System, which will provide the bulk of care for children and their families.

⁶ See <https://www.gov.uk/government/publications/wood-review-of-local-safeguarding-children-boards>

⁷ See: <https://www.england.nhs.uk/wp-content/uploads/2018/07/parent-leaflet-child-death-review-v2.pdf>

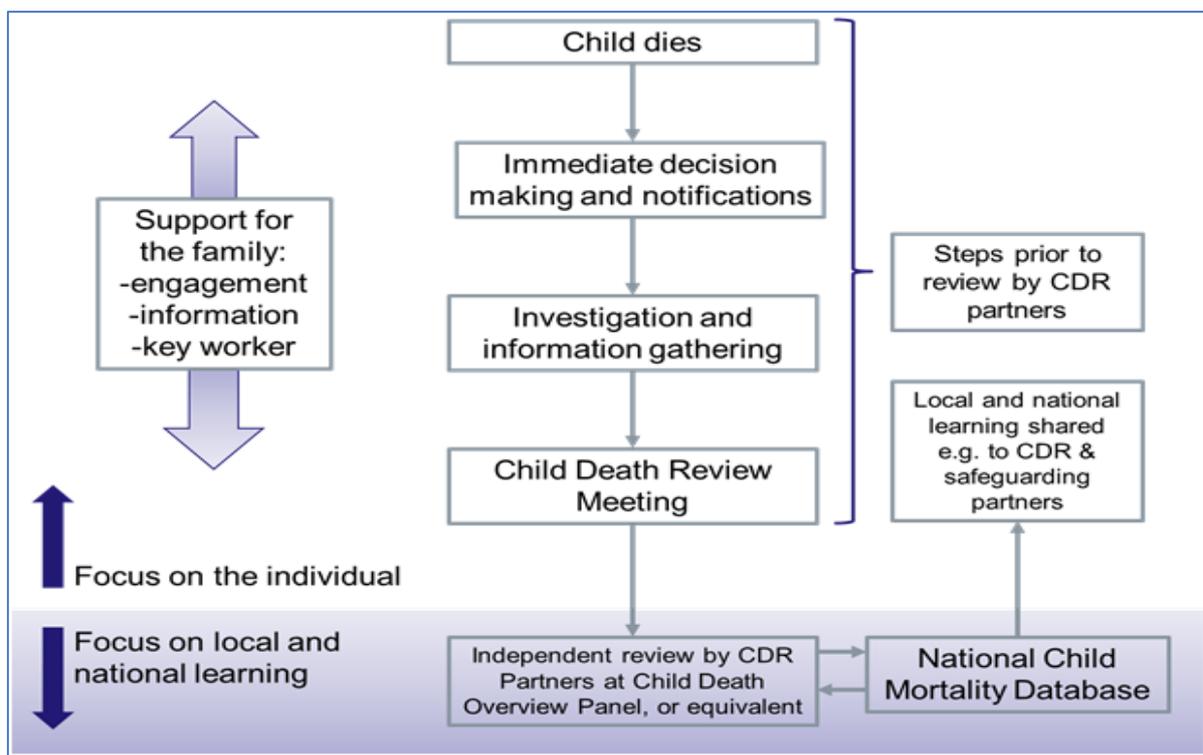


Fig 3 The New CDR Process as described in the operational guidance⁸

Hence BHR CCGs and the three local authorities are currently working together to put in place new arrangements, along with BHRUT and NELFT, and other partners including the Metropolitan Police Service (MPS), and the Coroner.

3. The new CDR System:

The New CDR system requires a local adaptation of existing resources and processes to meet the new method of child death review.

In principle, all requirements within the new statutory guidance have been delivered in some form or other, with considerable examples of good practice and exemplary working from three local CDOPs, but the larger scale footprint for the CDR Partnership, and the specific focus on development of existing trust level mortality and morbidity review mechanisms into the new model of multi-agency CDRM represents a new level of challenge.

In particular this requires adaptation of local mortality and morbidity review mechanisms in provider trusts to meet the new CDRM functions, and transformation of the local CDOP into a body strictly dealing with the outputs of provider based CDRM mechanisms and feeding of recommendations and learning into national, regional or local systems.

⁸ See <https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england>

4. Timetable for Implementation and CDR process

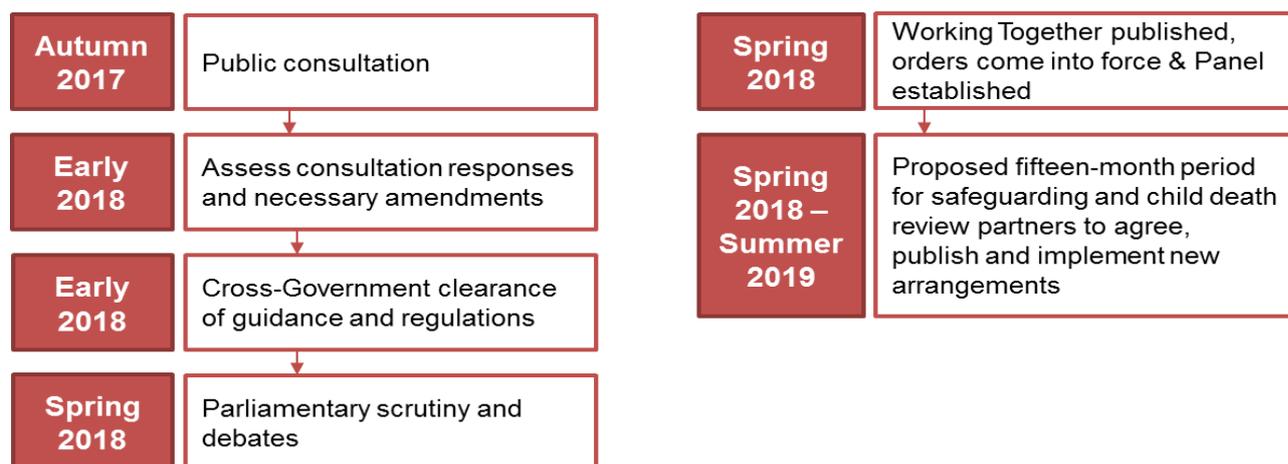


Fig 4 Overall timetables from the national CDR programme

With initial plans to be published by 29th June 2019 and operational delivery from 29th September 2019, both the timetable for delivery and the complexity of the works required are considerable.

The overall process, as outlined in the Healthy London Partnership 2017 resource⁹ consists of four stages:

Stage One: At death a discussion and strategy planning session on the appropriate review with notification to relevant multi-agency partners. Includes **initial case strategy, rapid response and initiation of bereavement support.**

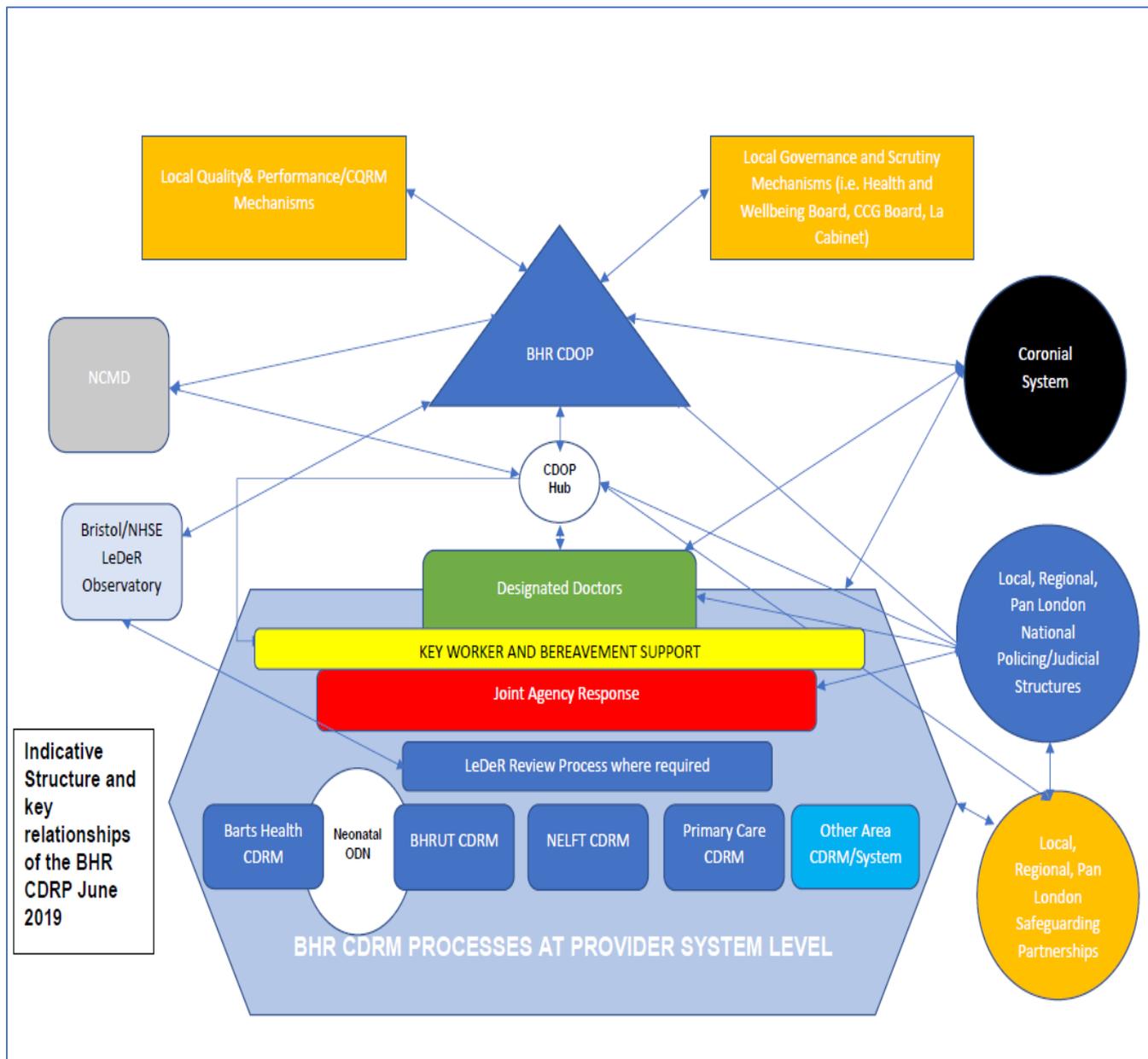
Stage Two: Initial Investigation and information gathering – depending on the specific process required. If the death is a sudden unexpected death in infancy or childhood (SUDI/C) related a joint visit or other process initiation.

Stage Three: Multi Agency Child Death Review Meeting (CDRM) conducted by the NHS trust (acute, community or mental health) with care responsibility for the deceased. This aims to establish chronology and causation, submitting local recommendations/actions to CDOP.

Stage Four: CDOP to consider the CDRM input and identify local or regional learning. **Submission to the Department of Health and National Child Mortality Database** to inform national identification of trends to enable population-based interventions for the prevention of child deaths.

⁹ See <https://www.healthylondon.org/our-work/children-young-people/child-death-review-programme/>

Fig 5 Indicative structure and key relationships of the BHR CDRP June 2019.



5. The New CDR Partnership

East London Health & Care Partnership (ELHCP) is the overarching partnership of 7 CCG's in North East London. There will be two Child Death Review (CDR) systems in North East London, BHR and WELC (City & Hackney, Tower Hamlet, Newham and Waltham Forest.) This plan is the response from the BHR CDR system and is being developed alongside neighbouring CDRP in neighbouring areas, particularly the WELC system CDRP.

Fig 6 CDR Partnership member organisations.

Local Authority Partner	NHS CCG Partner
London Borough of Barking and Dagenham	The BHR CCGs system as described above in section 1.
London Borough of Havering	
London Borough of Redbridge	

A full breakdown of all local partners and identified CDR leads is included in Appendix A. below. The lead area for developing the CDRP is Redbridge CCG.

6. The Geographical Footprint

The BHR CDRP will operate within the geographical boundaries of the combined areas of Barking and Dagenham, Havering and Redbridge as outlined in the map below.

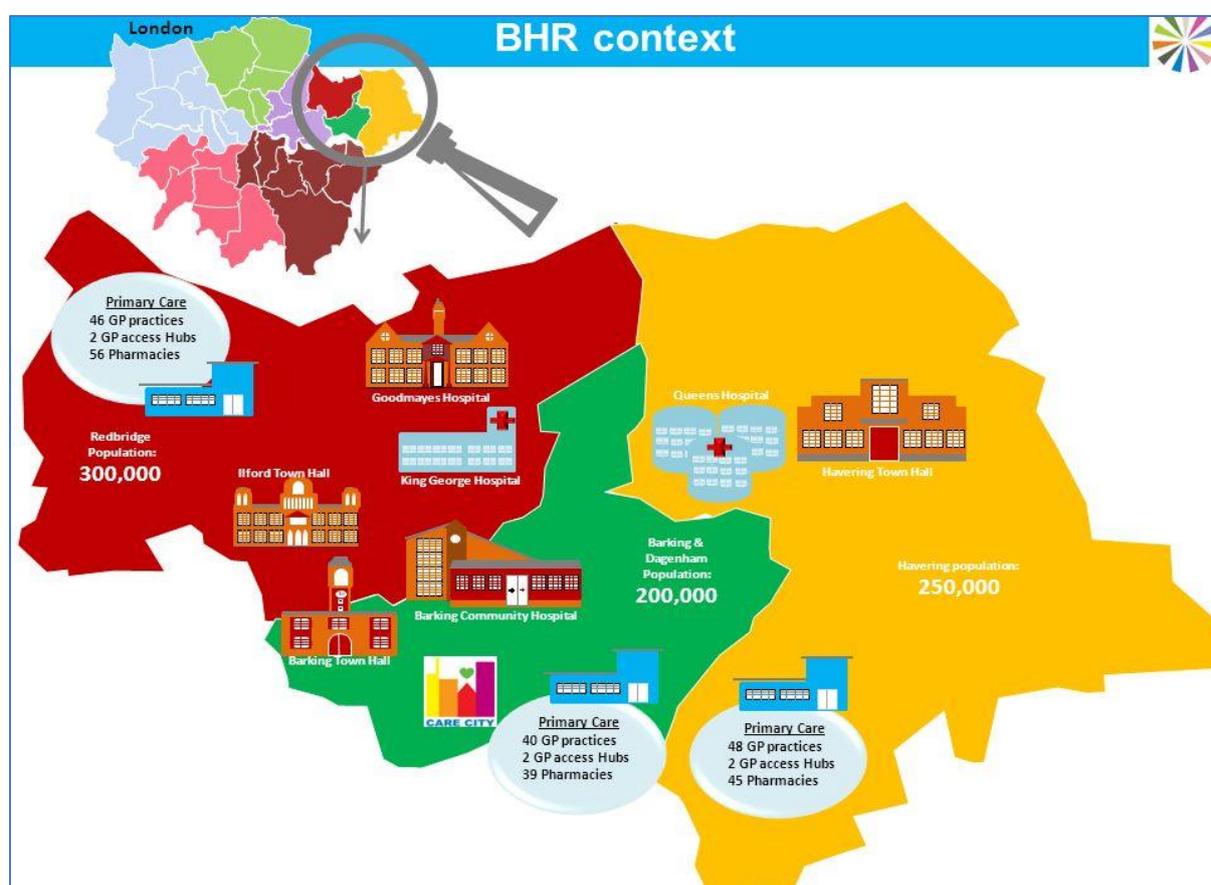


Fig 7. Context for the BHR Boroughs and key health infrastructure¹⁰.

The BHR footprint is served by Barking, Havering and Redbridge University Hospital NHS Trust (BHRUT) at two sites (King George Hospital and Queen’s Hospital) with Community and Mental Health services (including services for children and young people) provided by North East London Foundation Trust (NELFT).

¹⁰¹⁰ See <https://slideplayer.com/slide/9656683/> from Dustin Lester Slide Share in 2016.

In addition, there is a wide range of aligned public health and primary care services in the community including Health Visiting, School Nursing, Childrens Continuing Care and the Primary Care services provided by General Practitioners (GP), Pharmacists, Dentists, and other allied health professionals and the voluntary and community sector. All of these are key to the delivery of local health and care services and the safeguarding of children and young people.

Each borough has a vibrant and diverse voluntary and community sector, who will, especially with regards to the support available to the bereaved and capture of their voice and input into the system be increasingly important.

Alongside this the Metropolitan Police reorganisation in line with the One Met 2020 Strategy¹¹ have developed a shared Basic Command Unit (BCU) serving all three boroughs.

With a centralised “safeguarding hub” in each area, a wide range of safeguarding functions are hosted including officers associated with the emerging BHR Safeguarding Children Partnership and specialist officers associated with SUDI/C works who are crucial to the delivery of Joint Agency Responses.

There are clearly geographical and system linkages with the North East London, North Central London and Essex geographies¹². This means that in order for the system to be effective it must take into account robust cross-border collaborations to address the needs of communities who may cross into or out of our area. This is particularly important when assessing the needs of specific groups of children including the neonatal and school aged groups and those accessing BHR acute and specialist services or tertiary care in London. A clear and robust protocol for addressing cross-border working and inter system case-management is under development. See System Linkages below.

7. System Linkages - Cross border collaborations

In addition to these local partners the BHR CDRP has links into the wider regional and national system, specifically close links with the emerging WELC CDR system serving City and Hackney, Tower Hamlets, Newham and Waltham Forest, Healthy London Partnership’s CDOP programme¹³, and neighbouring CDR functions in West Essex. Given the complexity of clinical pathways associated with specialities such as neonatal care and trauma there is an ongoing and vibrant relationship with regional specialists including the Neonatal Organisational Delivery Network, the Barts Health NHS Trust Health (especially via Royal London Hospital, Whipps Cross and Newham sites), Great Ormond Street Hospital and the Children’s Ambulance Trust (CATs), pathology and coronial systems, London Ambulance NHS Trust, specialised and

¹¹See <https://www.met.police.uk/SysSiteAssets/media/downloads/met/about-us/strengthening-local-policing-programme.pdf>

¹² And potentially Hertfordshire given the proximity to North Central London where the flow of CYP into NCL health systems, particularly CAMHS may have an impact on the BHR system.

¹³ With membership of the HLP CDOP programme from the Redbridge CDOP chair leadership and participation and engagement with the HLP programme since its inception in 2016 from all CDR partners in BHR.

regional commissioning systems (NELCA and NHS England Specialised Commissioning, Maternity Transformation etc). Key to this area of work will be consistent use of the Perinatal Mortality Reporting Tool (PMRT)¹⁴ and related Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRACE) work streams.

We are exploring links with the Local Maternity Transformation Programme¹⁵ and Neonatal Organisational Delivery Network to ensure data flow and lessons learnt are driving improvements across all maternity provision in the BHR and wider regional system.

We will be exploring themed panel review of asthma related deaths to ensure that we are capturing all possible learning and driving the prevention of asthma and allergy related deaths. Locally a vigorous action plan is underway following on from a Regulation 28 (Prevention of Future Deaths) following an asthma death. We will be seeking to support the response to this and ensure that local primary, community and acute resources, alongside schools colleges and training providers, and of course parents and carers are well equipped and able to act decisively to prevent deaths of children and young people in BHR.

Local, regional and national end of life care agendas, services and agencies are clearly identified as partners we have engaged with. We will continue to strengthen these links and the regional work on end of life care across NELCA as it develops. In addition to this, it is crucial to engage with national, regional and local voluntary and community sector organisations, including the hospice movement, given their specialist role in support, information, advice and advocacy for those affected or impacted by the death of a child.

These relationships, pathways and processes are under continual review and revision to ensure that the BHR system is being developed in a responsive, inclusive transparent and innovative ways to strengthen the multi-agency delivery of child death reviews.

8. Delivering the Transformation

The task of managing the work involved in transforming the three existing CDOP systems to meet the new requirements has been organised by a multi-agency partnership¹⁶ working across the BHR footprint to build the new CDRP.

Group	Core functions
The Executive Child Death Review Group	<ul style="list-style-type: none"> ○ Strategic Oversight, ○ Direction setting and sign off,

¹⁴ See <https://www.npeu.ox.ac.uk/pmrt>

¹⁵ See <https://www.england.nhs.uk/mat-transformation/>

¹⁶ See Appendix B for Terms of Reference and Membership.

	<ul style="list-style-type: none"> ○ BHR system ownership promotion and strategic level system engagement, ○ BHR system level reporting & assurance
The Child Death Review Implementation Steering Group	<ul style="list-style-type: none"> ○ Operational development and implementation ○ Design and delivery of system processes and protocols ○ Operational Engagement ○ System level communication

Fig. 8 Core development Groups and functions

These multi-agency groups have delivered significant progress to date on the building of the new system. They will continue to deliver the key structures, processes and crucially the relationships that are required to ensure the BHR CDRP reaches maturity.

As with other changes regarding children’s safeguarding, CDRPs must publish their plans by 29th June 2019 and have until 29th September 2019 to meet the new statutory requirements. There is a statutory requirement for notifications to flow from CDR systems into local safeguarding partnerships and a determination that this will include collaboration with local regional and national safeguarding structures to address key areas such as local case review¹⁷, serious incidents investigation and wider police and judicial processes.

9. Model for the new CDR system

Following on from the overall process mapping figure we have drafted an indicative initial model for the BHR CDR System.

The Key components of the model are set out in the table below:

System Element	Function
Child Death Overview Panel (CDOP)	<ul style="list-style-type: none"> • Multi Agency Strategic Group charged with holding the local system to account and agreeing Draft Form C feeds from the local CDRM system. • Generates final Form C feed for sharing with the National Child Mortality Database (NCMD). • Responsible for challenge and engagement with the CDRM and wider system partners including Police/Judicial/Coronial and local Safeguarding, Quality Performance and Commissioning Mechanisms.
Child Death review Meeting (CDRM)	Multi-agency process and meetings held at provider trust level to deliver the review of individual child death cases.
Joint Agency Response (JAR)	This is the multi-agency three stage review process to provide an initial understanding of the “unexpected” death of a child. A JAR is required if the death of a child:

¹⁷ Which has replaced the Serious Case Review as a key output from the local safeguarding system.

	<ul style="list-style-type: none"> • Could be due to external causes (such as an accident) • Is sudden with no immediately apparent cause • Has occurred in police custody or where the child was detained under the Mental Health Act (MHA) • Where the death appears not to have occurred as a result of natural causes <p>Where a JAR is convened it follows the principles and practices outlined in the Kennedy Guidelines for investigation of sudden unexpected death of an infant or child. See section below and the Kennedy Guidelines¹⁸</p>
LeDeR Reviews	<p>LeDeR is the review process arising from the National Learning Disability Mortality Review Body. It seeks to learn from mortality reviews of people with learning disabilities and provide a driver to reduce inequalities in care for this population.</p> <p>LeDeR provides a review process for the deaths of people aged 4 to 74 years with learning disabilities in England. The CDR process must address LeDeR reviews from the age of 4 to the 18th birthday. See Section 15 Below.</p>
National Child Mortality Database (NCMD)	<p>Use of the eCDOP system results in the automated feed into NCMD.</p> <p>Recurrent funding for the eCDOP system has been agreed – see CDOP above section 12 and elsewhere.</p>

Fig 9 System Elements and Functions

10. Outline Process for review of the death of a child.

The BHR CDRP has been formed in response to the Children and Social Work Act (2017) requirement for a revised Child Death Review system including clear details of local systems and processes relating to the reformed statutory arrangements.

The Barking & Dagenham, Havering and Redbridge CDOP chairs and Local Safeguarding Children Board (LSCB) chairs agreed to combine the three existing CDOPs and child death review processes into single arrangements in line with the requirements from Working Together to Safeguard Children (2018). The CDR system footprint also maps to the Barking & Dagenham, Havering and Redbridge Integrated Care System (BHR ICS) which is co-terminus with the local maternity system and the Metropolitan Police Service BCU East Area. The Children Act (2004) requires CDR partners to make arrangements to carry out child death reviews, and should be

¹⁸ See <https://www.rcpath.org/uploads/assets/874ae50e-c754-4933-995a804e0ef728a4/sudden-unexpected-death-in-infancy-and-childhood-2e.pdf>

conducted in accordance with this guidance and Working Together to Safeguard Children (2018).

Following discussions at the Executive Child Death Review Group meetings a decision was made for all six partner organisations (BHR CCGs and BHR Local Authorities) to agree to the formal amalgamation of existing CDOPs into a single CDR system.

A discussion on available resources for the BHR system informed a decision to equally apportion resources in support of two new roles to provide co-ordination and development capacity across BHR. The roles are CDOP Manager (Band 8a) and CDOP Coordinator (Band 5) to support the CDOP. The business case for this work was approved on the 3rd June 2019.

The formal HR processes, (hosting, job matching, recruitment, TUPE, equalisation of terms and conditions) are still to be completed given the complex nature of the existing workforce and alignment of three separated CDOP functions.

The need to follow the appropriate CDR programme and HR processes to achieve the amalgamation required for the new CDR System has been embraced and is actively being worked through across the new partnership.

11. eCDOP, Information Governance and the flow of Data in the BHR CDRP

BHR CCGs have been using the eCDOP case management tool from Quality Education Solutions Ltd (QES) since May 2018. This tool ensures that the process is completely compliant with GDPR and benefits from an automatic link between NCMD and eCDOP which transfers data automatically into NCMD.

An overview of the eCDOP system and processes including feed from CDRM and reporting into the NCMD are included below.

The BHR CDR system has clear data sharing and information governance. It reflects the statutory authorities as set out in the Children Act Section Under s16M (3) which requires Child Death Review Partners to “make arrangements for the analysis of information about deaths reviewed under [s16]”. Analysis by the NCMD is considered to be part of a Child Death Review as described in the data flow diagram in the statutory guidance Working Together to Safeguard Children (2018).

This document, together with the Child Death Review Statutory & Operational Guidance requires Child Death Review Partners to investigate all cases of child deaths and to request that their CDOP (or equivalent) transfers data to NCMD for further analysis.

The BHR CDR system requires partners to share collated data relating to any case, and ultimately to support the sharing of eCDOP reporting feed into the NCMD, in order that that information can be analysed.

A decision was reached by all six partner organisations (BHR CCGs and BHR Local Authorities) to the formation and equal funding for both system roles (two new roles CDOP Manager post, Band 8a and CDOP Coordinator, Band 5 to support the CDOP) and crucially the shared funding of eCDOP.

From 1st April 2020, QES¹⁹ will require a contract with a lead organisation from Redbridge, LBBD or Havering. BHR CCGs are required to sign a contract with QES who will invoice from 1st April 2020. The national pricing model for eCDOP is based on the number of deaths reviewed which are taken from the last published annual government statistical release.

A decision has been taken for all six partner organisations (BHR CCGs and BHR Local Authorities) to agree to equal funding based on a 60-90 deaths, equating to £9,813 per annum recurrent funding.

Following on from the initial roll-out financed by the Healthy London Partnership in 2018 and subsequent continuation of central funding in 2019, the BHR CDRP has identified continuing funding for eCDOP for the system.

As existing users of eCDOP all of the constituent CDOP areas in BHR have already accessed a standardised reporting mechanism for the old CDOP system. The requirements will be addressed through the continued usage of eCDOP, and its newly updated modules.

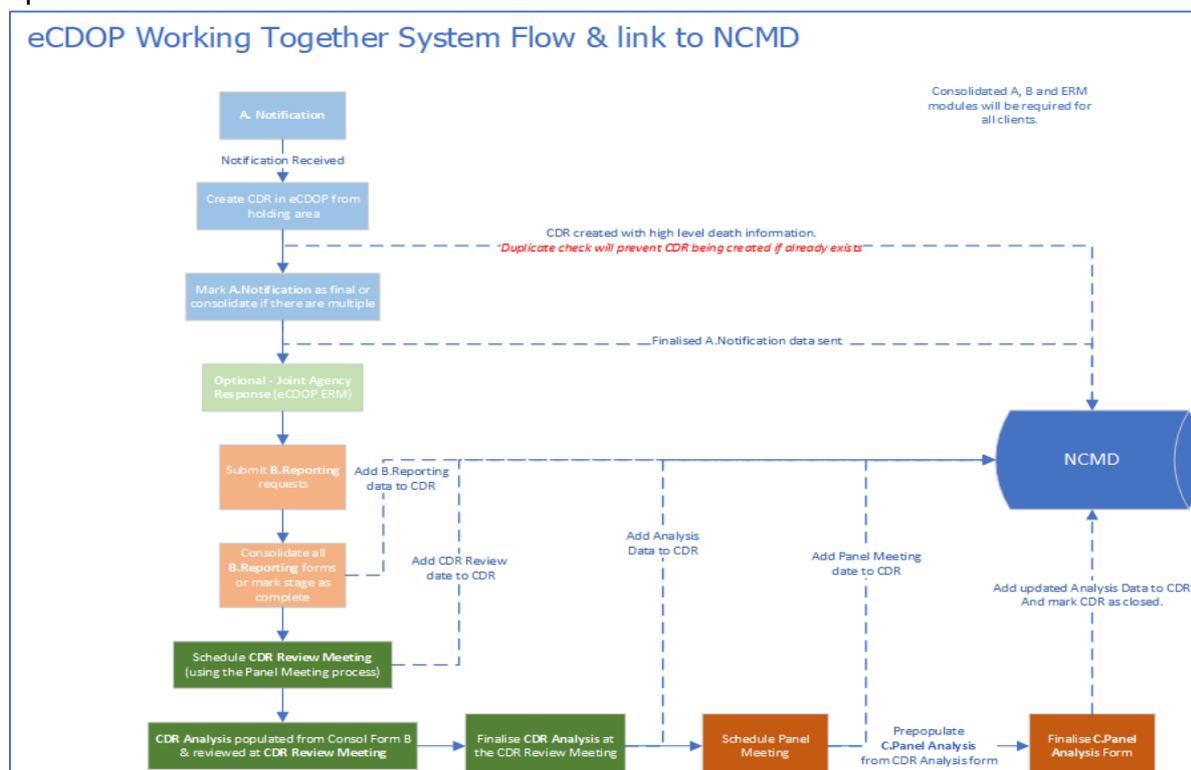


Fig. 10 the ECDOP system flow and link to NCMD provided by QES.

¹⁹ see <https://www.qes-online.com/QESeCDOP> and <https://www.healthylondon.org/our-work/children-young-people/child-death-review-programme/>

The local programme has developed an approach aimed at ensuring all partners are aware of the specific requirements and differences arising from the changes in legislation.

The BHR CDR system is explicitly founded on rigour and shared communication and information sharing principles. This system initially funded by the Healthy London Partnership will be maintained as a local asset to support the new CDR operation. (See below for commitment of continued funding for eCDOP).

The BHR CDR system uses eCDOP for all key processes and it is a shared expectation across the partnership that eCDOP will continue to provide a standardised process for all child death reviews, excluding those addressed by the Perinatal Mortality Reporting Tool (PMRT) or MBRACE systems. The CDRM system in the local footprint is expected to use eCDOP as a core notification and case processing tool alongside all local trust specific mechanisms. Through a shared approach to information collection, sharing and processing we aim to standardise and strengthen reporting and analysis of CDR related information.

We will ensure that local provider trusts (acute, community and mental health) are supported to use eCDOP as a key part of their CDRM response and where they are not familiar with its operations, we are looking to support learning and training opportunities to enable them to quickly utilise its as their core CDRM system.

12. CDRM in the BHR CDRP

The BHR CDRS is developing a suite of processes and protocols aimed at ensuring operational readiness is achieved for the full go-live of the system in September 2019.

Specific work is under way to bolster, develop and augment existing provider trust and community mortality and morbidity reviews to embrace the new multi-agency requirement of the CDRM in BHRUT, NELFT and Barts Health NHS Trust²⁰. Given the potential for CDRM to be required at a primary care level, we are developing materials to enable primary care based delivery.

At North East London level, Barts Health NHS Trust and the Homerton Hospital NHS Foundation Trust are both key partners with particular regards to both neonatal and trauma caseloads. The BHR CDRS is developing a suite of processes and protocols aimed at ensuring a secure assessment of cases, themed panels and system level learning. The PMRT will provide the overarching system for capturing data associated with these cases.

These Trusts, while not local, are significant partners alongside the neighbouring CDR system covering City and Hackney, Tower Hamlet and Waltham Forest (WELC). We are committed to ensuring the local systems evolves alongside neighbouring systems including West Essex with an emphasis on continuity of standards, quality and commitment to place the bereaved at the heart of what we do.

²⁰ Primarily the Whipps Cross and Royal London Sites, but also the Newham Site.

Alongside this we will ensure that reform of processes and procedures across the CDR partnership allows timely and detailed reporting into the NCMD and involves a shared approach to standardising recommendations arising from the work of partnerships. This will feed into local system learning and maintain a clear and productive relationship with local provider and commissioning systems. (See System Linkages section 8 above.)

The hospitals in the locality are Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), (King George Hospital Ilford and Queen's Hospital, Romford) and Barts Health NHS Trust. A Community provider Trust to be considered is North East London Foundation Trust (NELFT), alongside local primary care where practices could be asked to deliver a CDRM function.

Given the use of eCDOP in the BHR system we are refreshing key links and awareness across the local system to enable the standardised process to be delivered.

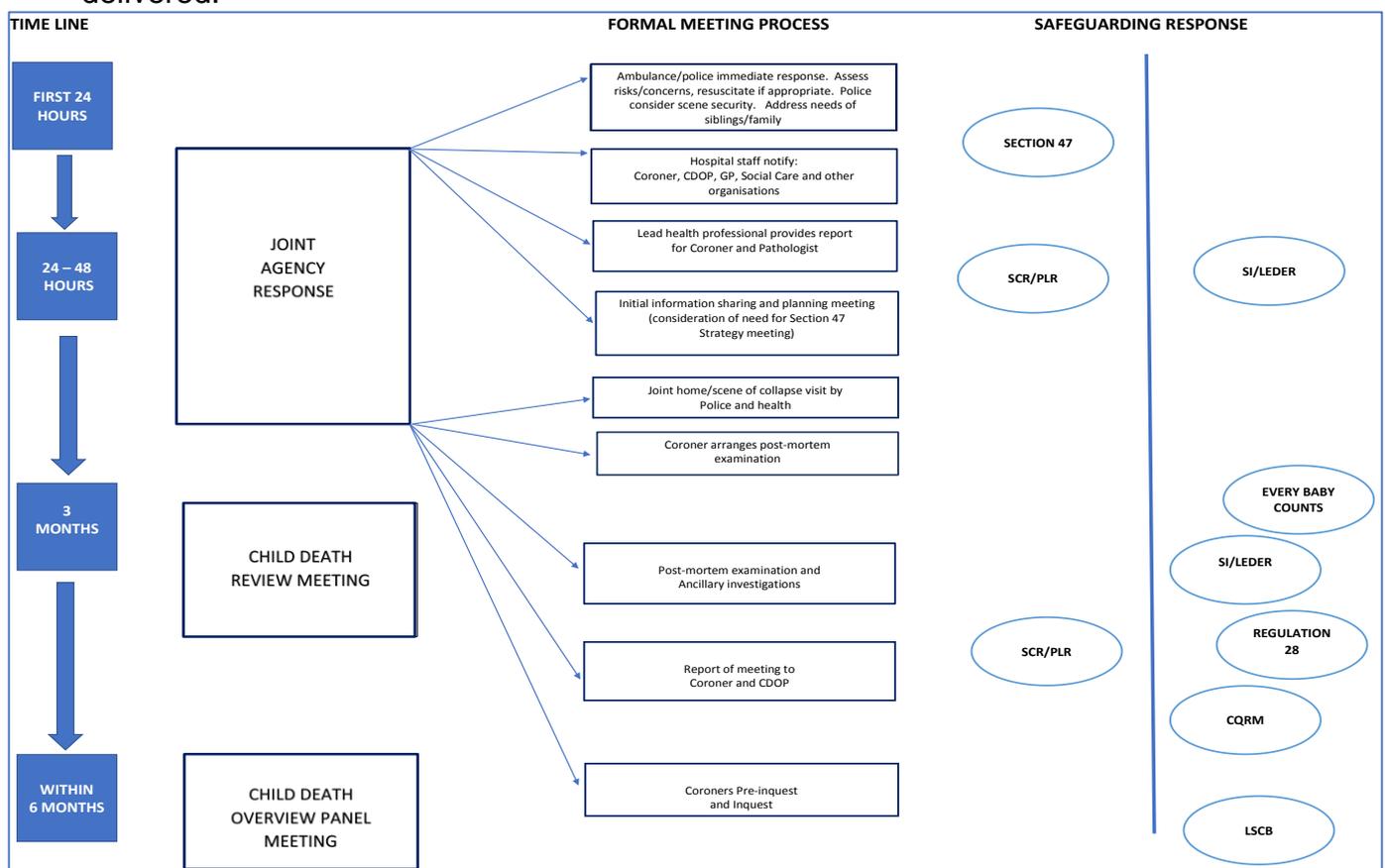


Fig 11 Local process mapping for the new system from the BHR CDRP 2018/19

With the regards to BHRUT, the eCDOP link will be Named Midwife.

With the regards to NELFT, Barts Health NHS Trust and the Homerton NHS Foundation Trust, the eCDOP links are still being clarified.

At CDOP level the CDOP Manager and Panel Co-ordinator will have access to the joint Redbridge, LBBB and Havering eCDOP system. All authorities working within the joint

area will access one standard system. This system will be in line with the new Working Together (2018) national statutory guidance, including the new forms and processes. It will also link to National Child Mortality Database (NCMD), and automatically transfer data when required.

This will include the following additional features available in eCDOP: Consolidated Form A, Consolidated Form B, Health Dashboard, Joint Agency Response Process, Designated Doctor User Role and Out of Area deaths (See below for Deaths of Non-Resident Children & Out of Borough Deaths Section 16.)

13. Joint Agency Response (JAR) and SUDI/C

In 2016 the multi-agency guidelines for joint agency response – The Kennedy Guidelines were published²¹. They provided a much needed operationally essential refresh of existing processes for the initial stages of a review of a child death conducted by multi-agency partners. Baroness Kennedy underscored, in the introduction to the guidance, the importance of a robust sensitive, compassionate and professional response to unexpected deaths of children and young people:

“Parents suffering a terrible tragedy need sensitive support to help deal with their loss. It is every family’s right to have their baby’s death properly investigated. Families desperately want to know what happened, how the event could have occurred, what the cause of death was and whether it could have been prevented. This is important in terms of grieving but is also relevant to a family’s high anxiety about future pregnancies and may identify some hidden underlying cause, such as a genetic problem. And if there happens to be another sudden infant death in the family, carefully conducted investigations of an earlier death also help prevent miscarriages of justice”²²

There are three main stages to the Joint Agency Response:

Process Stage	Timescale for Action	Details of stage and key actions
1. Immediate response:	Straight away	The dead child or young person will usually have been transferred to an accident and emergency department. Initial meetings between different professionals, such as the police and relevant consulting paediatrician, take place, and parents, carers and if appropriate siblings will be asked questions to establish what has happened.
2. Early response:	Usually within the first week:	All professionals involved will share information about the deceased child or young person. If death occurred away from home, these professionals may visit the place of death. If the child or young person died at home, particularly the child was a baby, a

²¹ See <https://www.rcpath.org/uploads/assets/874ae50e-c754-4933-995a804e0ef728a4/sudden-unexpected-death-in-infancy-and-childhood-2e.pdf>

²² See [Ibid](#) page 6.

		home visit will be conducted. Usually this will be a joint visit by a health professional and a police officer. They will ask questions about what happened before and after the death and take a statement.
3. Later response:	From one week onwards.	This stage may extend over several months: More background information is gathered if required, for example health records, maternity and neonatal notes or other relevant information. The joint agency team will meet together to review the information they have gathered. They will provide information to the coroner for their investigation, and members of the team will visit the bereaved to discuss their conclusions.

Fig. 12 Outline of the three stage JAR process

As per the JAR detailed in the National Operational Guidance, we are aiming to support a sustainable model of JAR across BHR. We are not currently delivering this function in all areas of the BHR system and there is variation in practice between the different system components. Work is underway to ensure that the full multi-agency response (on-call health professional, police investigator, duty social worker), is available for all deaths meeting the national criteria. The JAR is required where the death of a child or young person:

- is or could be due to external causes;
- is sudden and there is no immediately apparent cause (including SUDI/C);
- occurs in custody, or where the child was detained under the Mental Health Act;
- where the initial circumstances raise any suspicions that the death may not have been natural; or
- in the case of a stillbirth where no healthcare professional was in attendance.

The full process for a JAR is set out in the SUDI/C Guidelines²³ but three key areas are set out below:

Conveyance of expired remains and police investigations: If there is an unexplained death of a child at home or in the community, the child should normally be taken to an emergency department rather than a mortuary. In some cases when a child dies at home or in the community, the police may decide that it is not appropriate to move the child's body immediately, for example, because forensic examinations are needed.

See also: the London Ambulance outline process and actions guide on conveyance of deceased remains of CYP in Appendix D and E

Potential Criminal Proceedings: In a criminal investigation, the police are responsible for collecting and collating all relevant information pertaining to the child's death. Practitioners should consult the lead police investigator and the Crown Prosecution Service to ensure that their enquiries do not prejudice any potential criminal proceedings.

²³ See: <https://www.rcpath.org/uploads/assets/874ae50e-c754-4933-995a804e0ef728a4/sudden-unexpected-death-in-infancy-and-childhood-2e.pdf>

If the results of any investigations suggest evidence of abuse or neglect as a possible cause of death, the relevant consultant paediatrician in the CDRM or Designated Doctor for Child Deaths should inform the appropriate Safeguarding Children Partnership and National Child Safeguarding Review Panel immediately.

Local mapping of processes and resources is underway and is a key area of development, particularly with regards to the interface of the BHR CDRP with local Policing, Judicial, Coronial and Safeguarding systems.

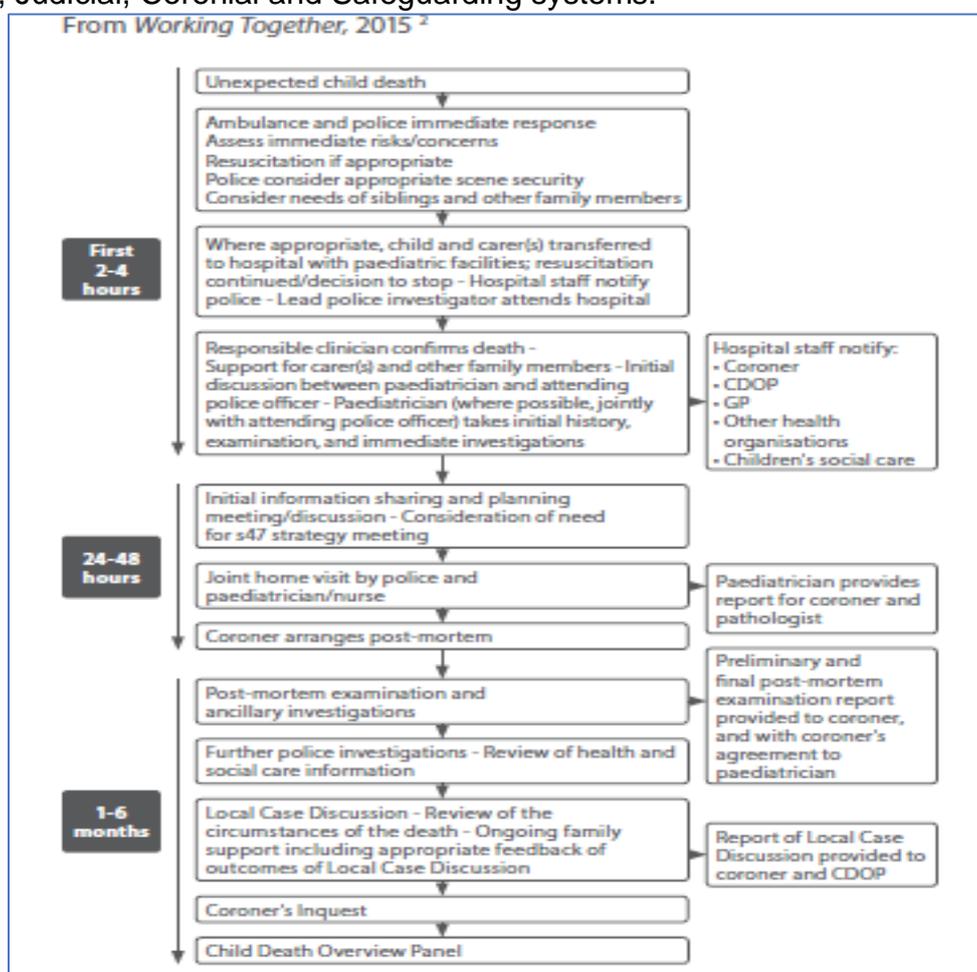


Fig 13 The SUID/C process as cited in the Kennedy Guidelines²⁴.

This mapping exercise is framing the development of a SUDI Protocol and local commissioning discussion aimed at ensuring appropriate resources and expertise are available for all JAR. See figures 9, 11, and 12. above for details on the local process mapping.

14. LeDeR – Learning Disability Mortality Review

LeDeR reviews arise from the recognition that care provided to children and people with learning disabilities can often result in poor care, outcomes and premature death.

²⁴ See <https://www.rcpath.org/uploads/assets/874ae50e-c754-4933-995a804e0ef728a4/sudden-unexpected-death-in-infancy-and-childhood-2e.pdf> page 20

Following on from Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD)²⁵ which reported that seven of the fourteen deaths of young people aged 4-17 years reviewed could have received better care, a National Learning Disability Mortality Review Body and processes was established to learn from mortality reviews of people with learning disabilities and provide a driver to reduce inequalities in care for this population.

LeDeR provides a review process for the deaths of people aged 4 to 74 years with learning disabilities in England.

The programme team aims to support local areas to implement the LeDeR review process and to take forward the lessons learned from individual mortality reviews to make improvements to service provision. The LeDeR programme also collates and shares anonymised information from the review so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

LeDeR – Responsibilities and Age Ranges

Age range	Operational responsibility for delivering LeDeR
4 yrs. to 17 yrs. (to 18 th Birthday 17yrs +364 days)	Child Death Review systems CDOP/CDRM
18 th Birthday onwards	Adult services

Fig. 14 LeDeR Age ranges

LeDeR and CDOP/Child Death Review Meetings (CDRMs):

Working Together to Safeguard Children (2018) and the expanded statutory guidance on Child Death Reviews stresses the requirement to “recognise the need to *specifically recognise and record that a child or young person has learning disabilities, irrespective of any other diagnoses or syndromes that are recognised*”.²⁶ Working Together to Safeguard Children (2018) outlines the process for CDOPs and CDRM (Section 7.1.6 onwards).

Work is underway to ensure that CDRM and CDOP are well placed to deliver on LeDeR reviews and themed panels alongside submission of data to the LeDeR process.

15. Deaths of Non-Resident Children & Out of Borough Deaths

The requirements of the new statutory system are with regards to the deaths of children not normally resident in our area are met through a nuanced local protocol that seeks to balance local and home borough review in a sensitive and timely and flexible manner which meets the many different circumstances that will be faced as the CDR systems operates. In principle, the protocol works through the formal

²⁵ See <http://www.bristol.ac.uk/cipold/>

²⁶ See https://consult.education.gov.uk/child-protection-safeguarding-and-family-law/working-together-to-safeguard-children-revisions-t/supporting_documents/Child_death_review_stat_guidance.pdf page 45.

engagement of the local CDR system with peer systems elsewhere. Starting from the receipt of the notification of the death of a child and the identification of 'non-resident status', the CDRM and the local Designated Doctor for Child Death will alert and advise the home system of the non- resident child.

They will then have a discussion with the home system to quickly ascertain details of the child case history to determine who is best place to lead on the review. The protocol is explicit on a constant review of the case details to understand if the local or home system are the appropriate leads and where they would be best placed to swap roles (lead organisation to the subordinate or vice versa) to deliver the richest and most impactful review possible.

Other key features include formal information sharing between systems, co-ordinated recommendations, and inter agency learning opportunities across different CDR systems.

Cases pertinent to this process would include the deaths of Looked After Children (LAC) living in out of borough residential placements (where they may not be known in detail to their local clinical or social care system), mass mortality incident victims (such as may occur through terrorism related incident), gang related or serious youth violence victims (where territorial considerations of gang activity cross multi-geographical boundaries as with the County Lines agenda), or episodes of care involving tertiary care providers and local district general hospital or systems. The need for a consistent approach to case review in complex systems is clear and the protocol will be reviewed in light of operational requirements and experience on an on-going basis, alongside all other protocols and procedures by the BHR CDR System.

Locally the decision on who is leading or collaborating on a review will be managed at CDRM level with formal notification and where necessary support from the CDOP manager and wider system.

This is largely to ensure the capture of key decisions and relationships in the on-going process to avoid any misunderstandings or crucially, ensure the continuity and transparency of processes for both the review and the required key worker or bereavement support that may result from the case. Clearly the decision made will be discussed and agreed with commissioners in the local or home system to ensure equity of resources available to the review and ensure that the central principle driving this decision is the delivery of high-quality child death review and not the availability or lack of resources. The protocol touches on the need to ensure expert input and it is widely recognised that such expertise may frequently be needed to be sought from other sources to enable high quality reviews. This would be pertinent in areas where particularly deaths were not common and the clinical or social care expertise required was not locally available.

The protocol is explicit on consideration on a case by case basis and the need to consult widely with the multi-agency system. This could include for example coroner's office, education, housing, council services, Health and Wellbeing Board, ambulance

services, or hospices. We would welcome an opportunity to adopt a generic approach but have developed a local policy in the absence of a national or regional protocol.

16. Designated Doctor for Child Death

The Designated Doctors for Child Deaths are commissioned from BHRUT and NELFT. Currently a review is being carried out by BHRUT, NELFT and other providers with a view to identification of variations in work-force structures and processes in place across the different local systems. The aim of this review is to understand the current workforce allocations including job descriptions and roles, banding, whole time equivalent, funding, support and hosting arrangements.

We are actively reviewing the intercollegiate guidance on designated roles to ensure that we have the appropriate amount of specialist provision available to the system, including a succession plan.

17. Commissioning

Work is ongoing within the existing system to ensure that the commissioning of the BHR CDRP processes evolves in line with the organisational and operational changes, such as the need to deliver JAR, connected to the delivery of the local system as it matures. BHR CCGs Children's Commissioning Team have identified a specialist resource in support of this. Further work will follow evolving from local existing public health, clinical and social care commissioning streams to understand and meet the resource and challenges presented by the new system. It is essential the system is sustainable, realises, where possible, any potential efficiencies and utilises existing resources to address the needs of the new system as much as possible.

Areas of interest include the contractual underpinning of the CDR system, clinical quality and safety of local services, bereavement support and key worker functions and the support, supervision and resilience of staff who work directly on or are associated with the CDR process and may be negatively impacted by direct exposure to an environment that is routinely traumatic or distressing.

The death of a child is an obviously tragic occurrence and we need to build a system of support for the bereaved, and the staff who work with them to review the circumstances of their loss.

18. Voice of the Bereaved and the Key Worker Function:

The death of a child is a devastating event to parents, carers, siblings and those around them. Each death represents a huge individual loss, affecting families' carers, siblings and communities. Many bereaved parents, carers and siblings want to offer feedback from this terrible experience to help ensure that lessons are learned and improvements in care are achieved.

Crucially the inclusion of a new statutory function – the Key-Worker, charged with bereavement support, presents a golden opportunity to build a collection of bereavement feedback to inform service improvement into a systematic approach for Child Death Review systems.

Key workers with their on-going support role would be well placed to deliver practical support across the system and provide the bereaved with different opportunities to give feedback at different stages of their bereavement journey. This feedback will be essential in guiding the development of the BHR CDRP as it is established. Initially using the Maternity Bereavement Experience Measure²⁷, for appropriate cases the Key-Worker would be able to collect significant and useful data on the experience of the bereaved.

Work is underway to map the existing support functions across the different providers in the local system. Discussions on how the role is commissioned and with what mix of skills and seniority flowing from the outline of the role in the national operational guidance is ongoing.

Given the diverse and vibrant multi-cultural context of the BHR system it is essential that we have a culturally sensitive and appropriate bereavement offer taking into account the many different taboos and cultural practices associated with different communities and crucially the needs of people with learning or physical disabilities. We are well placed to deliver a standardised resource that meets the needs of the communities we serve that empowers professionals to understand and engage with a diverse range of bereaved parents, carers and siblings.

19. Communications engagement and publishing schedule

Initially with the publication of an outline narrative and plan by 29 June 2019 we aim to continue the process of local communication and engagement that began in 2017 with the publication of the Children Social Work Act and in 2018 with the publication of the Operational Guidance of Child Death Review.

Multi-agency partners in the precursor system, notably the LSCB and the CDOP annual reports, alongside diverse local reports and updates to local governance and commissioning structures have been for some time heralding the changes. We aim to build on this multi-agency working and ensure that with particular regards to the impact of recommendations arising from local processes and the learning or service development opportunities are fully developed. Alongside the local safeguarding partnership as this develops, we are seeking to ensure that there is an appropriate and proportionate scrutiny of local functions.

²⁷ See <http://www.londonscn.nhs.uk/publication/gathering-feedback-from-families-following-the-death-of-their-baby/>

As with the safeguarding partnership, we seek to be transparent, accountable and responsive to ensure that the BHR CDR process constructively challenges and reflects on its effectiveness on an ongoing basis.

We have plans to use both existing maternity bereavement experience measure and the planned wider CYP bereavement experience measure being refined by HLP to ensure we have a robust standardised process for gauging our impact and the level of service experienced by the bereaved.

This will give us vital intelligence on how well we are servicing the needs of those impacted by the death of a child or young person. Alongside the routine publication of CDR system reports and the feed to the NCMD we aim to furnish local governance and quality mechanisms (Health and Wellbeing board, local authority boards/cabinet, local health watch, Trust level board and scrutiny apparatus) with regular thematic reports and updates.

The annual report will be produced in quarter 4, 2019/20. The annual report will be published in accordance with Child Death Review, Statutory and Operational Guidance 2018 and presented at BHR Executive CDR Group, published on BHR CCGs and BHR Local Authorities websites and circulated regionally and nationally as appropriate. The CDOP Manager will lead in the delivery of CDRP annual report, identifying risks, issues and dependencies, considering best practice and ultimately making decisions in the best interest of lessons learnt.

Implementation of the new system presents multiple opportunities for the strengthening of integration, co-location and more effective use of available resources associated with safeguarding and the CDR system. There is an emerging awareness that work is underway to establish the new CDRP across all parts of the professional system and significant work is underway to support both the development of the new system and ensure that the wider borough partnerships with statutory and voluntary and community sector agencies is consolidated.

Initially there is an urgent need to communicate and engage with local system partners to secure and accelerate development of the new CDRP system. The key purposes of the underlying communication and engagement plan are:

- To ensure local system statutory partners, relevant agencies and the wider public are aware of and understand the new requirements for the CDRS
- To ensure their ongoing input into the design and ongoing iteration of the local system
- To strengthen service user input and capture the voice of the bereaved in the new process.
- To capture and share learning across the system that has been identified through ongoing operational safeguarding, local case review and data intelligence.
- To support local system awareness and engagement with the BHR CDRP
- To support the representatives and direct contributions from the Bereaved
- To share resources and learning to drive and improve the quality and delivery of child death review.

20. Next steps:

We have a number of key tasks to deliver in the next three months and beyond. These include but are not limited to:

- Completion of the system and asset mapping underway
- Delivery of the communications and engagement plan – with a focus on wider cross border system links.
- Strengthening of the local community and voluntary sector input into the CDRP
- Maturation of the local bereavement offer to ensure it is appropriate for a diverse and vibrant multi-cultural context
- Refinement of the key worker options across BHR
- Refinement of key metrics, outcomes and outputs from the local system to ensure data flow locally and to the NCMD and prioritisation of local learning from reviews.
- Migration of existing CDOP caseloads and legacy data to the new system
- Continuance, expansion and strengthening of the local eCDOP system and its usage
- Refinement of JAR delivery
- Refinement of BHR CDRP standard operation protocols
- Refinement of the local model for Themed Reviews – an initial focus will be on neonatal and asthma related deaths reflecting the significant volume of the former and complexity of the latter groups.
- Refinement of the local model for themed reviews
- Migration and updating of all local CDOP web resources into a centralised BHR CDRP resource
- Preparation for the national roll-out of Medical Examiners
- Preparation for the CYP Bereavement Experience Measure

Appendix A

Plan to meet the requirements of Working Together to Safeguard Children (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		
<i>This section should include details of ALL the child death review partners for your area. Please add more rows if needed.</i>		
Name of organisation	London Borough of Barking & Dagenham	<input type="checkbox"/> Clinical Commissioning Group <input checked="" type="checkbox"/> Local Authority
Name of contact for child death reviews within organisation	Liz Winnett Business Manager for LSCB and CDOP Barking & Dagenham Safeguarding Children Board Children's Care and Support (Commissioning) Children's Services. London Borough of Barking and Dagenham Ground Floor Central, Barking Town Hall Barking IG11 7LU	
Email address of contact	Email: elizabeth.winnett@lbbd.gov.uk Secure via Egress CDOP: cdop.bdh@nhs.net	
Telephone number of contact	Phone: 0208 227 3578 / 07875 993809	
Name of organisation	London Borough of Havering	<input type="checkbox"/> Clinical Commissioning Group <input checked="" type="checkbox"/> Local Authority
Name of contact for child death reviews within organisation	Gloria Okewale Child Death Overview Panel Coordinator Havering London Borough of Havering Mercury House, Mercury Gardens, Romford, RM1 3SL	

	www.havering.gov.uk
Email address of contact	Email: gloria.okewale@havering.gov.uk cdopadminhavering@nhs.net
Telephone number of contact	Phone: 01708 434 633

Name of organisation	London Borough of Redbridge	<input type="checkbox"/> Clinical Commissioning Group <input checked="" type="checkbox"/> Local Authority
Name of contact for child death reviews within organisation	Jeanette Ford, MSc, BSc, RN, HV. Coordinator to the Redbridge Child Death Overview Panel (CDOP), 3rd Floor Front, Lynton House, 255-259 High Road, Essex. IG1 1NY	
Email address of contact	nem-tr.CDOP@nhs.net CDOP (NORTH EAST LONDON NHS FOUNDATION TRUST) nem-tr.CDOP@nhs.net	
Telephone number of contact	Tel: 0208 708 3455 Administrator, Tina Ramdial 0208 708 5961	

Name of organisation	Barking & Dagenham Clinical Commissioning Group	
Name of contact for child death reviews within organisation	Jacqui Himbury Nurse Director, Barking & Dagenham, Havering & Redbridge CCGs	<input checked="" type="checkbox"/> Clinical Commissioning Group <input type="checkbox"/> Local Authority
Email address of contact	jacqui.himbury@nhs.net	

Telephone number of contact	Tel: 020 3182 2919
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Name of organisation	Havering Clinical Commissioning Group	<input checked="" type="checkbox"/> Clinical Commissioning Group <input type="checkbox"/> Local Authority
Name of contact for child death reviews within organisation	Jacqui Himbury - Nurse Director, Barking & Dagenham, Havering & Redbridge CCGs	
Email address of contact	jacqui.himbury@nhs.net	
Telephone number of contact	Tel: 020 3182 2919	
Name of organisation	Redbridge Clinical Commissioning Group	<input checked="" type="checkbox"/> Clinical Commissioning Group <input type="checkbox"/> Local Authority
Name of contact for child death reviews within organisation	Jacqui Himbury Nurse Director, Barking & Dagenham, Havering & Redbridge CCGs	
Email address of contact	jacqui.himbury@nhs.net	
Telephone number of contact	Tel: 020 3182 2919	
Please indicate the lead CDR partner (NB: this must be one of the organisations listed above)	Barking & Dagenham, Havering & Redbridge Clinical Commissioning Groups (BHR CCGs) (BHR CDOP)	
Please indicate which CDR partner(s) are responsible for	As above	

commissioning the new arrangements if different from above	
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Name of organisation	Redbridge Clinical Commissioning Group	<input checked="" type="checkbox"/> Clinical Commissioning Group <input type="checkbox"/> Local Authority
Name of contact for child death reviews within organisation	Jacqui Himbury Nurse Director, Barking & Dagenham, Havering & Redbridge CCGs	
Email address of contact	jacqui.himbury@nhs.net	
Telephone number of contact	Tel: 020 3182 2919	

Name of organisation	East London Health & Care Partnership (ELHCP) This is the overarching partnership of 7 CCG's in North East London. There will be a Child Death Review (CDR) systems in North East London, BHR and WEC, City & Hackney, Tower Hamlet, Newham and Waltham Forest. This plan is the response from the BHR CDR system.	
Name of contact for child death reviews within organisation	Jane Milligan Accountable Officer for ELHCP	<input checked="" type="checkbox"/> Clinical Commissioning Group <input type="checkbox"/> Local Authority
Email address of contact	Jane.milligan1@nhs.net	
Telephone number of contact	Tel:	

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	BHR CDOP
Name of CDOP Manager / Administrator	CDOP Manager to be appointed
Email address of CDOP	To be confirmed by ITC - Redbridge CCG
Telephone number of CDOP	T: 020 3182 2919
Please list ALL the local authority areas covered by your CDOP	London Borough of Barking & Dagenham London Borough of Havering London Borough of Redbridge
Number of deaths reviewed in total in the 2018/19 year in the areas listed above	London Borough of Barking & Dagenham = 17 London Borough of Havering = 13 London Borough of Redbridge = 32 Total = 62

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

Q1.1 Please give an overview of your local arrangements for reviewing child deaths. *This should include details of the administrative and logistical processes and should give details of the local arrangements for the notification process, information gathering, child death review meetings, frequency of CDOP meetings*

BHR's response to the Children and Social Work Act 2017 requirements for a revised Child Death Review system includes clear details of local systems, processes and arrangements relating to the reformed statutory arrangements.

The Barking & Dagenham, Havering and Redbridge CDOP chairs and Local Safeguarding Children Board (LSCB) chairs agreed to combine the three existing CDOPs and resulting child death review processes into a single arrangement in line with the requirements from "Working Together to Safeguard Children" (2018).

Following discussions at the Executive Child Death Review Group meetings a decision was reached for all 6 partner organisations (BHR CCGs and BHR Local Authorities) to agree to the formal amalgamation of existing CDOPs into a single CDR system.

The geographical agreed local footprint for the CDRP has several advantages and synergies including coterminosity with the emerging Barking & Dagenham, Havering and Redbridge Integrated Care System (BHR) CDR system, Local Maternity System and the Metropolitan Police Service Basic Command Unit (East Area).

A discussion on available resources for the BHR system informed a decision to equally apportion resources in support of two additional new roles to provide coordination and development capacity across BHR. The roles are CDOP Manager (Band 8a) and CDOP Coordinator (Band 5) to support the CDOP. This then raises the compliment of personnel working in the BHR CDR system to 5.

The formal HR processes, (hosting, job matching, recruitment, equalisation of terms and conditions) are still to be completed given the complex nature of the existing workforce. The need to follow the appropriate HR processes to achieve the amalgamation required for the new CDR System has been embraced and is actively being worked through across the new partnership.

As existing users of eCDOP all of the constituent CDOP areas in BHR have already accessed a standardised reporting mechanism for the old CDOP system. The requirements will be addressed through the continued usage of eCDOP, and it newly updated modules for the CDR System, and a developed approach across the CDR partnership to ensure that all partners are aware of the specific requirements and differences arising from the changes in legislation. Specific work is under way to bolster, develop and augment existing provider trust and community mortality and morbidity reviews to embrace the new multi-agency requirement of the CDRM within BHRUT, NELFT and Barts

Health NHS Foundation Trust and the Homerton Hospital Foundation Trust.

At North East London level, Barts Health NHS Foundation Trust and the Homerton Hospital NHS Foundation Trust are both key partnerships with particular regards to both neonatal and trauma caseloads. These Trust while not local are significant partners alongside the neighbouring CDR system covering City and Hackney, Tower Hamlet and Waltham Forest (WELC).

We are committed to ensuring the local systems evolves alongside neighbouring systems including West Essex with an emphasis on continuity of standards, quality and commitment to place the bereaved at the heart of what we do. Alongside this we will ensure that reform of processes and procedures across the CDR partnership allows timely and detailed reporting into the National Child Mortality Database and evolves a shared approach to standardising recommendations arising from the work of partnerships. We will feed this shared approach into local system learning and maintain a clear and productive relation with local provider and commissioning systems.

See section 3, 5, 6, 7, 8 and 9 of the Overview document

Q1.2 Please describe the process that will be followed when a child not resident in your area dies in your area. *This should include how the CDOP in the area of residence will be notified, how decisions will be made about who conducts the review and retains responsibility for the case.*

The requirements with regards to the deaths of children not normally resident in our area are met through a nuanced local protocol that seeks to balance of local and home borough review in a sensitive and timely and flexible manner which meets the many different circumstances that will be faced as the CDR systems operates. In principle the protocol works through the formal engagement of the local CDR system with peer systems elsewhere. Starting from the receipt of the notification of the death of a child and the identification of 'non-resident status', the CDRM and the local Designated Doctor for Child Deaths will alert and advise the home system of the non-resident child. They will then have a discussion with the home system to quick ascertain certain details of the child case history to determine who is best place to lead on the review.

The protocol is explicit on a constant review of the case details to understand if the local or home system are the appropriate leads and where they would be best placed to swap roles (lead to the subordinate or visa a versa) to deliver the richest and impactful review possible. Other key features include formal information sharing between systems, coordinated recommendations, and inter agency learning opportunities across different CDR systems.

Cases pertinent to this process would include the deaths of Looked After Children, where they may not be known in detail to their local clinical or social care system), mass mortality incident victims (such as may occur through terrorism related incident), gang related or serious youth violence victims (where territorial considerations of gang activity cross multi geographical boundaries as with County Lines), or episodes of care involving tertiary care providers and local district general hospital or systems. The need for a consistent approach to case review in complex systems is clear and the protocol will be reviewed in light of operational requirements and experience on an on-going basis, alongside all other protocols and procedures by the BHR CDR System.

Locally the decision on who is leading or collaborating on a review will be managed at CDRM level with formal notification and where necessary support from the CDOP manager and wider system. This is largely to ensure the capture of key decisions and relationships in the on-going process to avoid any misunderstandings or crucially, ensure the continuity and transparency of processes for both the review and the required key worker or bereavement support that may result from the case. Clearly the decision made will be discussed and agreed with commissioners in the local or home system to ensure equity of resources available to the review and ensure that the central principle driving this decision is the delivery of high-quality child death review and not the available or lack of resources. The protocol touches on the need to ensure expert input and it is widely recognised that such expertise may frequently be needed to be sought from other sources to enable high quality reviews. This would be pertinent in areas where particularly deaths were not common and the clinical or social care expertise required was not locally available. The protocol is explicit on consideration on a case by case basis and the need to consult widely with multi-agency system. This could include for example coroner's office, education, housing, council services, health and wellbeing board, ambulance services, or hospices. We would welcome any opportunity to adopt any generic approach but have developed a local policy.

See section 23 of the Overview document

Q1.3 Please describe how you will engage with hospitals in your area to ensure good communication and sharing of information when a child dies. This should include consideration of the notification process, completion of reporting forms and supplementary reporting forms, and whether you support arrangements for child death review meetings through provision of agency reporting forms

The BHR CDR system is explicitly founded on robust, secure shared communication and information sharing principles. As with other systems within London we have benefited in past from the provision of the eCDOP system funded by NHS Digital and supported by the Healthy London Partnership (HLP), which is now in its second year of operation. This system initially funded by HLP/NHSE will be maintained as a local asset to support the new CDR operation. (See below for commitment of continued funding for eCDOP).

The eCDOP case management tool from QES ensures that the CDR process is completely compliant with GDPR requirements and benefits from an automatic link between NCMD and eCDOP which means the data is automatically ported over into NCMD, the data would not have to be entered manually. BHR Local Authorities have been using eCDOP since May 2018.

The BHR CDR system uses eCDOP for all key processes and it is a shared expectation across the partnership that eCDOP will continue to provide a standardised process for all child death reviews, excluding those addressed by the perinatal mortality reporting tool or MBRACE systems. The CDRM systems in the local footprint is expected to use eCDOP as a core notification and case processing tool alongside all local trust specific mechanisms. Through a shared approach to information collection sharing and processing we aim to standardise and strengthen reporting and analysis of CDR related information.

We will ensure that local provider trusts (acute, community and mental health) are supported to use eCDOP as a key part of their CDRM response and where they are not familiar with its operations we are looking to support learning and training opportunities to enable them to quickly utilise its as their core CDRM system.

The hospitals in the locality are Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), (King George Hospital Ilford and Queen's Hospital, Romford) and Barts Health NHS Trust. A Community provider Trust to be considered is North East London Foundation Trust (NELFT), alongside local primary care where practices could in theory be asked to deliver a CDRM function.

Specific CDRM level personnel identified as eCDOP leads:

- BHRUT, the eCDOP link will be Named Midwife, Safeguarding Children, Barking, Havering and Redbridge University Hospitals NHS Trust.
- NELFT, the eCDOP link is still being clarified.
- Barts Health and the Homerton HealthCare Trust NHS Foundation Trust, the eCDOP link is still being clarified.

At CDOP level the CDOP Manager and Panel Co-ordinator will have access to the joint Redbridge, LBBB and Havering eCDOP system. All authorities working within the joint area will access one standard system. This system will be in line with the new Working Together (2018) national statutory guidance, including the new forms and processes. It will also link to National Child Mortality Database (NCMD), and automatically transfer data when required.

This will include the following additional features available in eCDOP: Consolidated Form A, Consolidated Form B, Health Dashboard, Joint Agency Response Process, Designated Doctor User Role and Out of Area deaths.

See section 11 of the Overview document

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

Q2.1 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. Please describe how you will provide information to NCMD. This should include details of how you submit data to NCMD securely and details of any other local analysis you plan to undertake

BHR CCGs have been using the eCDOP case management tool from QES (Quality Education Solutions Ltd) since May 2018. This tool ensures that the process is completely compliant with GDPR requirements and benefits from an automatic link between NCMD and eCDOP which means the data is automatically ported over into NCMD so there would not have to enter any data in manually.

The BHR CDR system has a clear data sharing and information governance basis. It reflects statutory authorities set out in the Children Act Section Under s16M (3) requires Child Death Review Partners to “make arrangements for the analysis of information about deaths reviewed under [s16]. Analysis by the NCMD is considered to be part of a Child Death Review as described in the data flow diagram in the statutory guidance document Working Together to Safeguard Children (2018). This document, together with the Child Death Review Statutory & Operational Guidance document requires Child Death Review Partners to investigate all cases of child death and to request that their CDOP (or equivalent) transfers data to NCMD for further analysis.

The BHR CDR system requires partners to share collated data relating to any case, and ultimately to support the sharing of eCDOP reporting feed into the NCMD, in order that that information can be analysed.

A decision was made for all 6 partner organisations (BHR CCGs and BHR Local Authorities) to agree to the formation and funding equally funding for both system roles (two new roles CDOP Manager post, Band 8a and CDOP Coordinator, Band 5 to support the CDOP) and crucially the shared funding of eCDOP.

From 1st April 2020, QES will require a contract between QES and a lead organisation from Redbridge, LBBD or Havering. BHR CCGs will need them to sign a contract and invoice from 1st April 2020. The national pricing model for eCDOP is based on the number of deaths reviewed which are taken from the last published annual government. A decision has been taken for all 6 partner organisations (BHR CCGs and BHR Local Authorities) to contribute to the funding on an equally split basis, supporting 60-90 deaths reviewed at £9813 per annum. The funding has been agreed on a recurrent basis.

See section 11 of the Overview document and above and Q 7.1 below.

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

Q3.1 Please describe your plans for publication of reports related to this requirement. *This should include details of what reports you plan to publish (if appropriate) and where they will be published*

Initially with the publication of an outline narrative and plan by the 29 June 2019 we aim to continue the process of local communication and engagement that preceded the Children Social Work Act and in 2018.

Multi-agency partners in the precursor system, notably the LSCB and the CDOP annual reports and diverse local reports and updates to local governance and commissioning structures have been for some time heralding the changes with local system leaders and operatives. We aim to build on this multiagency working and ensure that, with particular regards with the impact of recommendations arising from local processes, learning or service development opportunities are fully embraced.

Alongside the local safeguarding partnership as they are developed, we are seeking to ensure that there is an appropriate and proportionate scrutiny of local functions. As with the local BHR safeguarding partnership system we seek to be transparent, accountable and responsive to ensure that the BHR CDR process constructively challenges and reflects on its effectiveness on an ongoing basis.

We have plans to use both existing maternity bereavement experience measure and the planned wider CYP bereavement experience measure to ensure we have a robust standardised process for gauging our impact and the level of service experienced by the bereaved.

This will give us vital intelligence on how well we are servicing the needs of those impacted by the death of a child or young person. Alongside the routine publication of CDR system reports and the feed to the PMRT, LeDeR process and NCMD we aim to furnish local governance and quality mechanisms (Health and Wellbeing board, local authority boards/cabinet, local health watch, Trust level board and scrutiny apparatus) with regular thematic reports and updates.

The CDOP annual report will be produced in quarter 4, 2019/20 year. The annual year will be published in accordance with Child Death Review, Statutory and Operational Guidance 2018 and presented at BHR Executive CDR Group, published on BHR CCGs and BHR Local Authorities websites and circulated regionally and nationally as appropriate. CDOP Chair and Manager will lead in the delivery of CDR partners' annual report, identifying risks, issues and dependencies, considering best practice and ultimately making decisions in the best interest of lessons learnt.

See section 9 to 12 and 19 of the Overview document

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

Q4.1 Please give details of the agencies and job roles of the individuals on your CDOP. *This should include details of core members and any members that are co-opted for specific discussions / themed panel meetings*

The CDOP is a multi-professional panel whose core membership should include senior representatives from the following agencies or roles:

Chair: Nurse Director, Barking & Dagenham, Havering & Redbridge CCGs

- Public Health - Director of Public Health for Barking and Dagenham
- Designated Doctor for Child Deaths (and a hospital clinician if the Designated Doctor is a community doctor or vice versa); Consultant Paediatrician
- Local Authority - Commissioning Director for Children's Care and Support
- Metropolitan Police; Super Intendant, Metropolitan East Basic Command Unit
- CCG Safeguarding (Designated Doctor or Nurse) - Designated Nurse for Safeguarding and LAC Redbridge CCG
- Primary Care (Named GP or Health Visitor) – Named GP for Safeguarding B&D and Havering CCGs
- Nursing and/or midwifery - Named Midwife, Safeguarding Children, Barking, Havering and Redbridge University Hospitals NHS Trust
- Nursing and/or midwifery - Lead Named Nurse for Safeguarding Children Barts Health
- Lay representation and independent scrutiny (TBC)
- Additional professionals should be considered on a case-by-case basis, for example from: coroner's office, education, housing, council services, health and wellbeing board, ambulance services, or hospices as required.

In addition to the core membership, relevant experts from health and other agencies, including where appropriate neighbouring CDR systems (WELC or West Essex) or tertiary centres (Royal London, Great Ormand Street Hospital, Evelina Children's Hospital) should be invited as necessary to inform discussions. (TBC)

See section 5, 7 and Appendices of the Overview document

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

Q5.1 Please give details of this role in your local area. *This should include which organisation the role is employed within and the number of working hours for the post. Please also include a job description if available.*

Designated Doctor for Child Deaths (and a hospital clinician if the Designated Doctor is a community doctor or vice versa); Consultant Paediatrician Specialist Community Paediatric Services.

Currently a review is being carried out by NELFT with a view to identify variations in work force structures and processes. To understand the current workforce a mapping exercise was completed including job role, banding, WTE, funding and hosting arrangements. Associate Director Safeguarding & LAC NELFT will provide an update when available.

See section 16 of the Overview document

Q5.2 Please describe the process for notifying the Designated Doctor for Child Deaths when a death occurs. *This should include details of who is responsible for carrying out the notification and how this occurs (e.g. email / telephone via the CDOP admin team).*

Local providers alert the Designated Doctor for Child Death. The eCDOP system is then used to notify the Designated Doctor for Child Death when a death occurs with the sharing of Form As. Locally we anticipate a need for support in the early stages of notification and immediate decision making at CDRM level and we are supporting the provider trusts to develop robust notification flow at the initial stages of the CDRM. The CDOP Manager will be responsible for ensuring there is good liaison between the Acute Trust and CDOP. It is recognised as the CDRM and CDOP processes achieve maturity this interface will become 'second nature' but initially this will be a key focus for support from the existing CDOP. We will establish a specific CDOP level email address that will be monitored daily to ensure all deaths are captured when they occur.

See section 9, 10 and 16 of the Overview document

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

Q6.1 Please give details on where the information for child death reviews in your area can be publicly accessed. *The information publicly available should include who the accountable officials are (the local authority chief executive and the accountable officer of the clinical commissioning group), which local authority and clinical commissioning group partners are involved, what geographical area is covered and who the designated doctor for child deaths is*

Child death review partners will publicise information on the arrangements for child death reviews in the BHR Locality which will be publicly accessed on BHR CCGs and the BHR Local Authorities websites. This will include details of the accountable officers, which local authority and clinical commissioning group partners are involved, what geographical area is covered and who the designated doctor for child deaths is. Alongside this we will publish reviews and reports and material including the national bereavement resource and key third sector materials

aimed at supporting members of the public or professionals impacted upon by the death of a child (including Lullaby, SANDS, PAPHYRUS, SAMARITANS, Child Death Helpline, Child Bereavement UK, Royal College of GPs, Royal College of Physicians, LeDeR).

See section 19 of the Overview document

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

Q7.1. Please give details on how the CDR process in your area is being funded? This might include mention of funding coming from LA, CCG and Health Care Trusts.

See above. A decision was made for all 6 partner organisations (BHR CCGs and BHR Local Authorities) to agree to the formation and funding equally funding for both system roles (two new roles CDOP Manager post, Band 8a and CDOP Coordinator, Band 5 to support the CDOP) and crucially the shared funding of eCDOP.

From 1st April 2020, QES will require a contract between QES and a lead organisation from Redbridge, LBBD or Havering. BHR CCGs will need them to sign a contract and invoice from 1st April 2020. The national pricing model for eCDOP is based on the number of deaths reviewed which are taken from the last published annual government. See above for details of the BHR Partnership commitment to continuance of eCDOP funding.

Alongside these costs an ongoing conversation between commissioners and providers will provide the BHR CDR systems with a nuance and detailed view commissioning requirements to deliver the new systems. As we monitor the development of process and capacity to deliver the new model of review we will conduct detailed analyses of both opportunity cost and available resource for a developed and mature CDR system. It is anticipated that at this point in time we not realise sufficient cost savings or efficiencies, but as the new paradigm matures we will identify sufficient areas where standardisation will enable a high standard of quality of service and potentially new opportunities for both prevention of child death and support for the bereaved. These will naturally generate system level savings leaving aside the moral imperative of prevention of harm to child and support for bereaved families, carers, sibling and peer groups and communities.

See section 4 to 8 and 17 of the Overview document and Question 2.1 above.

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.

Q1.1 Please describe how you have ensured that all staff within the child death review process have read and follow the operational guidance. This should include methods of dissemination of the guidance and any training / awareness raising sessions that have been provided

We have had a rigorous process of communication, learning and training opportunities across the health and social care professional groups. These will continue as a key feature of the local CDR and wider safeguarding systems. Key initial opportunities based on assessment of priority needs and roles in the system have included:

- 'The Child Death Review Statutory and Operational Guidance' (2018) has been disseminated by email to the relevant teams regarding child death review process.
- Local implementation group has generated and cascaded updates and briefing in support of the systems

Future plans include:

- Awareness raising sessions, road shows seminars and engagement with key teams in the local healthcare system.
- The eCDOP Panel coordinator will provide training, advice and support on CDR processes guidance and eCDOP to new and existing staff in relevant internal and external agencies as required.
- Alongside these safeguarding child partnership we will look at developing multi-agency facing briefing and awareness raising materials.

See section 4 to 11 and 19 of the Overview document

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.

Q2.1 Please describe your process for assuring that relevant organisations have appointed a key worker in the event of a child death. *This should include details of the responsibilities of that post*

Following on from the decision to proceed with the BHR CDR model we have sought assurance from all local providers that they are well placed to deliver on the requirement for key worker role and have or are developing a detailed understanding of the support and 'voice of the bereaved' functions of the role.

Discussions on the commissioning arrangement for the role and options for sustainable models of provision are being actively explored.

The role will reflect the responsibilities of the Key Worker job description referenced in 'The Child Death Review Statutory and Operational Guidance (England) October 2018' page 40 and Appendix 5' Support for the bereaved'.

BHRUT are developing plans for the key worker function to support the existing Trust CDOP Coordinator in the future performance of the Lead Health Professional role the Key Worker's role is to act as a single point of contact with the bereaved family for the duration of the

death review process. This role is separate to bereavement support and will primarily be a signposting role as well as a first point of contact for the family and conduit for them with the organisations reviewing (and potentially investigating) the child's death.

This includes the post holder being a reliable and readily accessible point of contact for the family after the death, help coordinate the family and professionals as required and be able to provide information on the child death review process and the course of any investigations pertain to the child, including liaising with the coroner's officer and any police family liaison officer. Represent the 'voice' of the parents at professional meetings, ensure that their questions are effectively addressed, and to provide feedback to the family afterwards; and signpost to expert bereavement support if required.

See section 4 to 10, 17 and 18 of the Overview document

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

Q3.1 Please describe your process for notifying LEDER of the death of a child with a learning disability. This should include details of who is responsible for making the notification and how it occurs (e.g. telephone / email)

It is expected that all CDRM and CDOP secretariat and related staff are LeDeR trained. With the support of the local LeDeR inspection and review system we will ensure that local CDR system case review of child and young people with learning disabilities follows the LeDeR requirements that feed into the Bristol analysis form (Form C). we are aiming to deliver case review within the BHR CDR systems from 0 to 18 and are exploring how best to support LeDeR case review for transitional age ranges (potentially 13 plus) with colleagues in Adult services who hold the current case load from 18 years plus. We aim to develop a nuanced response to transitional cases and are actively exploring who is best placed to deliver case review against the NHS 10 Year Plan requirement for the development of a coherent 0 to 25 service offer.

LeDeR & family engagement: LeDeR review places a lot of emphasises on engaging with parents, carers, siblings, peer groups and community. They should be given the opportunity to participate in the review process and to comment about the care that was provided to the deceased. Alongside the many professional (statutory and third sector agencies) potentially involved in delivering care should be involved in the overall LeDeR review.

The LeDeR Team and CDR system will work closely to ensure LeDeR representation in all LD death review meetings.

Key Contacts for LeDeR in BHR include:

Disability Mortality Review Programme
Beatrice Kivengea LeDeR Programme Officer
North East London CCGs
Beatrice.Kivengea@nhs.net

020 3688 2001

Ruth Blackburn Associate Director Safeguarding & LAC NELFT
Tel: 0300 555 1201 x 52613
Mobile phone: 07772020337

NELFT LeDeR process



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NAL.pdf

See section 14 of the Overview document

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

Q4.1 Please describe your model for JAR. *This should include details of who the lead health professional will be (e.g. nurse / health visitor / paediatrician), details of who attends when a home visit is required and the times between which the JAR is available e.g. is there an on-call element? Please also include details of the estimated number of deaths requiring a JAR in your area each year.*

As per the Joint Agency Response detailed in the National Operational Guidance, we are aiming to support a sustainable model of JAR across BHR. We are not currently delivering this function in all areas of the BHR system and there is variation in practice between the different system components

See section 14 of the Overview document

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

Q5.1 Please describe how the child death review meeting will be convened for the following groups:

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

The BHR CDRP has been formed in response to the Children and Social Work Act 2017 requirements for a revised Child Death Review system include clear details of local systems, processes and arrangements relating to the reformed statutory arrangements.

This is one of the stages of the review process that precedes the independent multi-agency panel (CDOP) arranged by CDR partners. This meeting should be a multi-professional meeting where all matters relating to an individual child's death are discussed (similar to the Rapid Response Meeting). The CDRM should be attended by professionals who were directly involved in the care of the child during his or her life, and any professionals involved in the investigation into his or her death. The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved, and should not be limited to medical staff. If not attending, especially for expected deaths, professionals need to formally report to the CDRM Chair. The professionals involved in the child's care and investigation of the death from health services, social care, police, education and public health may need to be released to attend the relevant CDRM for ALL deaths and not just unexpected.

The BHRUT process will be followed for children who die in hospitals, Children who die in the community if brought into BHRUT and Children whose deaths trigger a joint agency response. Decision making regarding the process that require further may need to be discussed with health practitioners and agreed with the commissioners. The process should be considered on a case-by-case basis. For deaths of babies in the midwifery unit, most commonly delivery Suite, and in the Neonatal Intensive Unit, NICU, the child death review meeting will be managed by the PMRT.

See section 4 to 13 of the Overview document

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

Q6.1 Please give details of when you will produce your annual report and where it will be published

Initially with the publication of an outline narrative and plan by the 29 June 2019 we aim to continue the process of local communication and engagement that begin in 2017 with the publication of the Children Social Work Act and in 2018 with the publication of the Operation guidance of Child Death Review. Multi-agency partners in the precursor system, notably the LSCB and the CDOP annual reports and diverse local reports and updates to local governance and commissioning structures have been for some time heralding the changes. We aim to build on this multiagency working and ensure that with particular regards with the impact of recommendations arising from local processes and the learning or service development opportunities are fully developed. Alongside the local safeguarding partnership as they are developed we are seeking to ensure that there is an appropriate and proportionate scrutiny of local functions. As with the safeguarding partnerships we seek to be transparent, accountable and responsive to ensure that the BHR CDR process constructively challenges and reflects on its effectiveness on an ongoing basis. We have plans to use both existing maternity bereavement experience measure and the planned wider CYP bereavement experience measure to ensure we have a robust standardised process for gauging our impact and the level of service experienced by the bereaved. This will give us vital intelligence on how well we are servicing the needs of those impacted by the death of a child or young person. Alongside the routine publication of CDR system reports and the feed to the NCMD we aim to furnish local governance and quality mechanisms

(Health and Wellbeing board, local authority boards/cabinet, local health watch, Trust level board and scrutiny apparatus) with regular thematic reports and updates.

The annual report will be produced in quarter 4, 2019/20 year. The annual year will be published in accordance with Child Death Review, Statutory and Operational Guidance 2018 and presented at BHR Executive CDR Group, published on BHR CCGs and BHR Local Authorities websites and circulated regionally and nationally as appropriate. The CDOP Chair and Manager will lead in the delivery of CDR partners' annual report, identifying risks, issues and dependencies, considering best practice and ultimately making decisions in the best interest of lessons learnt.

See section 19 of the Overview document

Appendix B: CDRISG Terms of reference



**Barking and Dagenham,
Havering and Redbridge**
Clinical Commissioning Groups

Terms of Reference

Child Death Review Implementation Steering Group

Purpose:

To provide assurance to the Barking & Dagenham, Havering and Redbridge Child Death Partners that all commissioned, contracted services or relevant organisations have quality assured systems in place to meet the new Child Death Review requirements as per the Children and Social Work Act (2017) and subsequent statutory guidance which sets out reforms to the existing child death review processes in England and to alert the governing bodies of any areas of risk and to monitor those risks.

To ensure that BHR Child Death Partners and partner organisation fulfil all legislative requirements and expectations on individual services as there are a number of significant changes from responsibility shifting from Local Safeguarding Children Boards (LSCBs) to a joint partnership of local authorities and clinical commissioning groups (CCGs), named Child Death Review Partners (CDRP); the establishment of a minimum geographical footprint for each CDRP; and changes to the review mechanism and family support functions. These changes must be implemented by 29th September 2019 and each local CDRP must publish plans of how they intend to configure and resource themselves to meet these new requirements by **29th June 2019**.

In addition, the National Child Mortality Database (NCMD), a national programme which will collect and report on data of all child deaths across England will go live on **1st April 2019**. From this date, CDRPs, through their local Child Death Overview Panels (CDOPs), the multi-agency panel established by each CDRP to review the deaths of children normally resident in their area, must supply data to NCMD on all open and new cases; the Child Death Review partners have agreed the new model for the CDR process will go live on **1st April 2019** and require plans for the assurance required.

Scope of Group

To ensure that all organisations has robust plans and processes in place to meet the new requirements with regards to the Child Death Review requirements to ensure all targets are met:

- Enable all designated professionals to work together and fully participate in decision making
- Discuss how best to configure services locally to meet these requirements

- Provides an update on the progress across the Child Death Review service to date to Executive Child Death Review Group

Objectives:

Early 2018, the decision was made by the three LSCB's to combine the existing CDOPs and child death review process into single arrangements in line with the requirements from 'Working Together to Safeguard Children (2018).

- To support the development of a new Child Death Review model
- Aim for a deadline for 1st April 2019 to move the new Child Death Review arrangements
- Arrange the 1st combined CDOP, planned for 19 April 2019
- To receive evidence of organisational transitional plans to implement the new Child Death Review requirements and combined CDOP with any working policy documents to confirm compliance which outlines the challenges and considerations
- To monitor the recommendations and action plans from relevant organisations

Redbridge CCG current positions – as presented at the HLP East London Child Death Review Workshop, 25.02.19 by Sue Nichols, CDR Implementation Steering Group Clinical lead and Designated Nurse for Safeguarding and LAC Redbridge CCG



CDR Update Paper
(2) Presentation 25 C

David McKinlay has provided the below update:

The requirements for the National Child Mortality Database are available on the DHSC website at: <https://www.gov.uk/government/publications/child-death-reviews-forms-for-reporting-child-deaths/national-child-mortality-database-transitional-arrangements>

Key Dates – 2019

January – May 2019

Identify potential models and consult locally

May – June 2019

Governance sign-off of recommended model

July – September 2019

Communicate and embed chosen model

20th & 29th March 2019 – NHS England are running two webinars centred on the new child death review requirements which will take place between 12.00-14.00. To register, please contact NHS England at England.cypalignment@nhs.net.

1st April 2019 – National Child Mortality Database goes live. Department of Health & Social Care transitional arrangements outline that from this date, any new child deaths or any open cases

(those not yet reviewed by a child death overview panel) of children who died before that date should be added to the NCMD. The data collection requirements for reviewing child death will also change on this date.

29th June 2019 – All Child Death Review Partners in England must publish their plans to meet the new requirements and send to NHS England at England.cypalignment@nhs.net.

29th September 2019 – All Child Death Review Partners in England must complete the transition to the new arrangements. After this date they must be compliant with the new statutory requirements.

Membership:

Project Lead – Chair
Clinical Lead - Designated Doctor for Safeguarding
Clinical Lead - Designated Nurse for Safeguarding
Designated Doctor for Safeguarding Children
Named Doctor, BHURT
Designated Nurse for Safeguarding Children and LAC
Named Midwife, Safeguarding Children
Public Health
LAS
Police
Clinical Specialist Safeguarding
Safeguarding & Quality Assurance

Appendix C Child Death Review Implementation Steering Group Membership

(Correct as of 8.03.19)

NAME	ROLE	CONTACT
Dr Sarah Luke	LUKE, Dr Sarah _ Clinical Lead Consultant Paediatrician Specialist Community Paediatric Services – NELFT	drsarah.luke@nhs.net
Sue Nichols	Clinical Lead Designated Nurse for Safeguarding and LAC Redbridge CCG	suenichols@nhs.net
Janet Powell	CDR Project Manager –Interim	Janet.powell9@nhs.net
Justine Yearwood	Deputy rep of Ruth Blackburn Justine Yearwood Named Nurse Safeguarding Children	Justine.yearwood2@nelft.nhs.uk
Stephen Hynes	Deputy rep of Daniela Capasso and Kathryn Halford Stephen Hynes Named Nurse, Safeguarding Children	stephen.hynes@nhs.net
Ginika Achokwu (nee Nwafor- Iwundu)	Deputy rep of Alan Taylor	Ginika.Nwafor-Iwundu@lond-amb.nhs.uk
Maxine Blackledge	met.pnn.police.uk	Maxine.Blackledge@met.pnn.police.uk
Junaid solebo	Named Doctor, BHURT	junaid.solebo@bhrhospitals.nhs.uk
Ronan fox	Joint Children's Commissioner Barking & Dagenham CCG	ronan.fox@nhs.net
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Kathryn Halford	Named Nurse	kathryn.halford@nhs.net

Daniela Capasso	Named Midwife, Safeguarding Children	Daniela.Capasso@bhrhospitals.nhs.uk);
Alan Taylor	Head of Safeguarding & Prevent at the London Ambulance Service	Alan.Taylor@lond-amb.nhs.uk
Mark Ansell	Director of Public Health	Mark.Ansell@havering.gov.uk
Gloria Okewale	Deputy rep of Mark Ansell Gloria Okewale Child Death Overview Panel Coordinator Havering	gloria.okewale@havering.gov.uk
Gladys Xavier	Director of public health	Gladys.Xavier@redbridge.gov.uk
Matthew Cole	Director of public health at LBBD	Matthew.Cole@lbbd.gov.uk
Winter Ian Not attending	Independent Chair ISCB	Ian.Winter@lbbd.gov.uk
Teresa DeVito	Deputy rep of Ian Winter Teresa DeVito Head of Service - Safeguarding & Quality Assurance	Teresa.Devito@lbbd.gov.uk
Brian Boxall No response	Independent Chair ISCB	brian.boxall@havering.gov.uk
John Goldup No response	Independent Chair ISCB	John.Goldup@redbridge.gov.uk
Vicky Gatley	Designated Clinical Officer	victoria.gatley@nhs.net
Daniel Devitt	Childrens Commissioner BHR CCGs	Daniel.Devitt@nhs.net
Lay representatives TBC		

Frequency of Meetings:

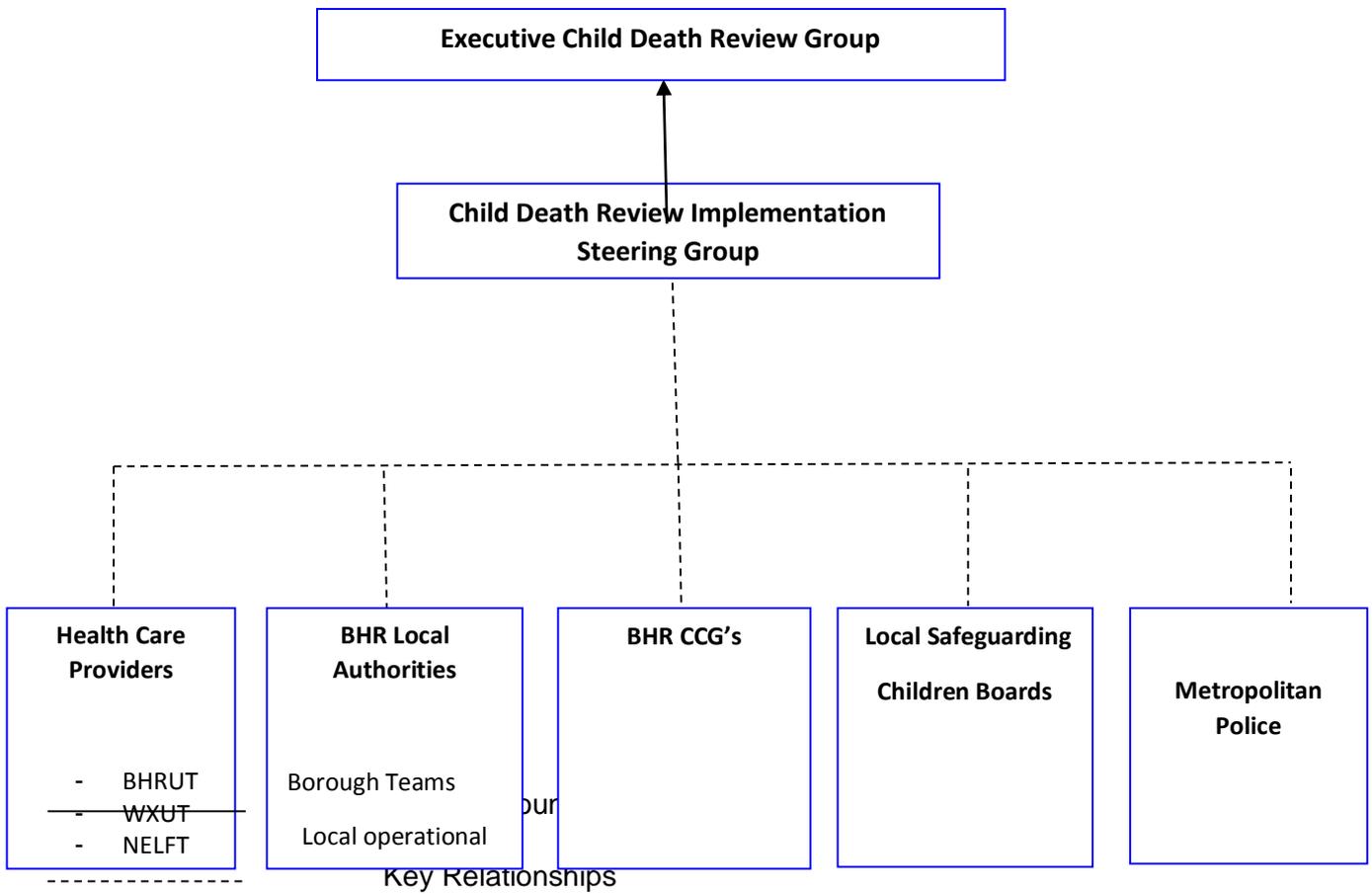
Three weekly and as required

Accountability:

- To the Child Death Review Partners

Key relationships:

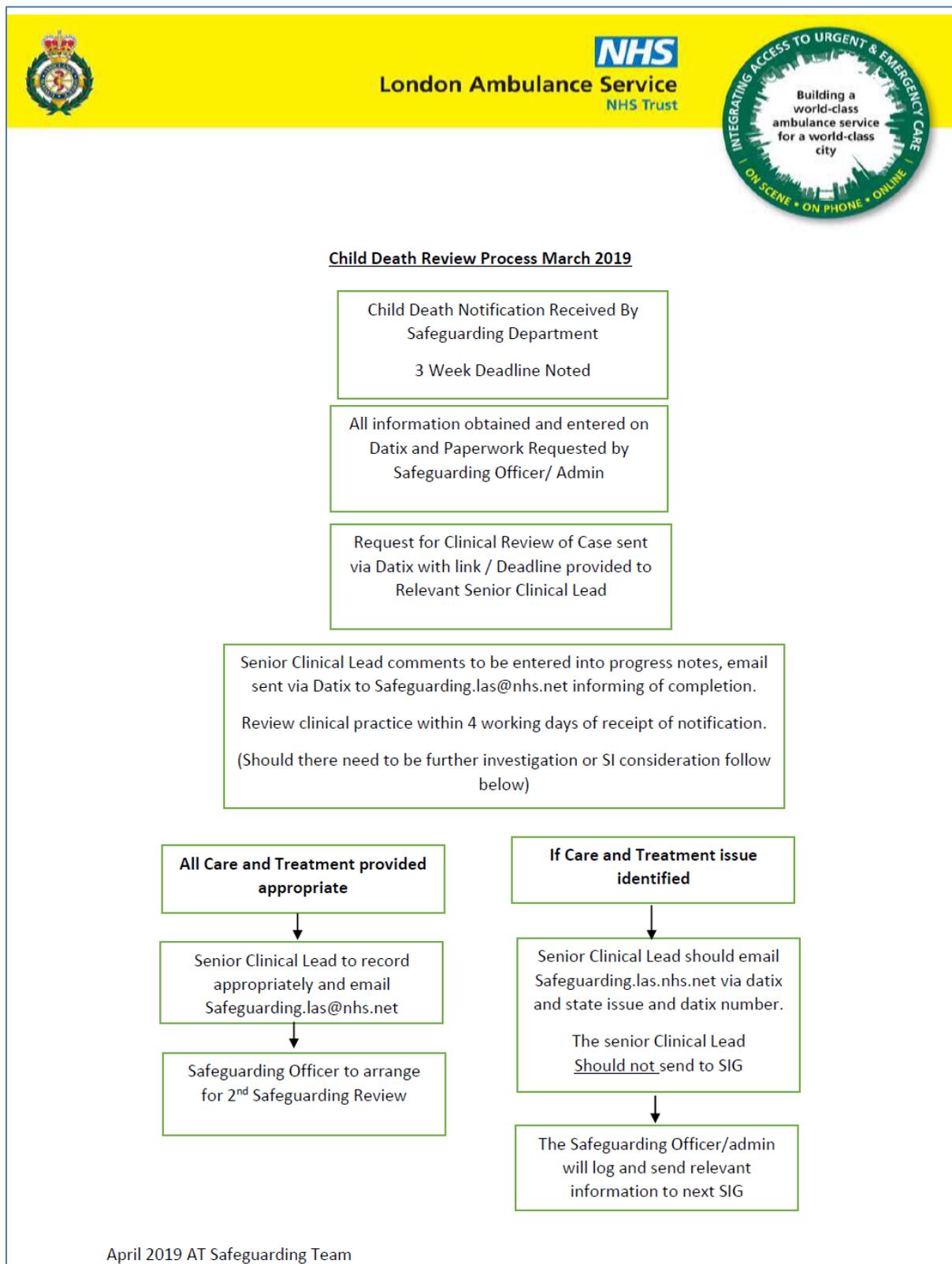
- Local Safeguarding Children Boards
- Local Authorities - Public Health
- LAS
- Police
- Executive Child Death Review Group
- BHRUT and Barts Health NHS Trust, Health Whipps Cross site
- North East London Foundation Trust



Appendix D: BHR CDRP Executive Group Membership

NAME	ROLE	CONTACT
John Goldup	Independent Chair Redbridge LSCB	John.Goldup@redbridge.gov.uk
Ian Winter	Independent Chair Barking and Dagenham LSCB	Ian.Winter@lbbd.gov.uk
Brian Boxall	Independent Chair Havering LSCB	brian.boxall@haverling.gov.uk
Mark Ansell	Director of Public Health London Borough of Havering	Mark.Ansell@haverling.gov.uk
Gladys Xavier	Director of Public Health London Borough of Redbridge	Gladys.Xavier@redbridge.gov.uk
Matthew Cole	Director of Public Health Barking & Dagenham	Matthew.Cole@lbbd.gov.uk
Jacqui Himbury	Nurse Director Barking & Dagenham, Havering & Redbridge Clinical Commissioning Groups & Chair BHR CDR Executive Group	jacqui.himbury@nhs.net

Appendix E: London Ambulance Service Outline Child Death Review Process



Appendix F: LAS Actions following the death of a child (under 18) in the community.



Actions following the death of a child (under 18) in the community

In all cases where a child has been verified deceased by the ambulance service the Emergency Bed Service (EBS) must be informed who will complete the child death notification (Form A)

