Rotherham Metropolitan Borough Council

BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	11th December 2024
	LEAD OFFICER:	Alex Hawley Consultant in Public Health, ASCH&PH 01709 255846
	TITLE:	Changes to arrangements for Rotherham's Child Death Overview Panel

1. Background

1.1 Child Death Overview Panels (CDOPs) have been in existence in England since 2008, and fulfil a statutory function to review every child death (with the exception of stillbirths and planned terminations) of a child resident within their area. A child death is any death - from a neonatal death (regardless of gestational age) up to a death on the day before a child's eighteenth birthday.

1.2 The Children Act 2004 remains the statutory basis for child death reviews. Specifically, sections 16M to 16Q set out the requirements to carry out child death reviews. This is currently underpinned by three key pieces of related guidance.

1. **Working Together** (2023)
2. **Child Death Review: Statutory and Operational guidance** (2018)
3. **Sudden unexpected death in infancy and childhood. Multi-agency guidelines for care and investigation** (Royal College of Pathologists) - 2016. This covers conduct of a joint agency response to an unexpected death, but does not currently have a statutory basis per se.

1.3 The most significant change in the legislation and guidance came in 2018, which moved the primary responsibility for child death reviews from the safeguarding partners to the 'Child Death Review' partners – the local authority and CCG (as was – now ICB). At the time, Rotherham CDOP chose to remain under the aegis of the Safeguarding Children Partnership (RSCP).

1.4 The new guidance also set up a recommended minimum footprint for the operation of a CDOP: being of sufficient population size to result in a minimum of 60 child deaths per year. As a result of this a South Yorkshire CDOP (SYCDOP) was established (with an expected number of deaths each year likely to be at or above 100), but only for the purposes of conducting thematic reviews and producing a South Yorkshire annual report. For pragmatic and efficiency reasons, the conduct of CDOP case reviews remained at the place level.

1.5 A local review of the governance arrangements for Rotherham CDOP has recently been conducted, at the instigation of the Independent Chair of RSCP, which has concluded that RSCP is no longer the most appropriate place for CDOP to be reporting, and has instead recommended that it sit under the Health and Wellbeing Board.

1.6 In parallel, at South Yorkshire level there has been a re-evaluation of the SYCDOP, and a decision taken to discontinue its operation under the guise of an overview panel, but to

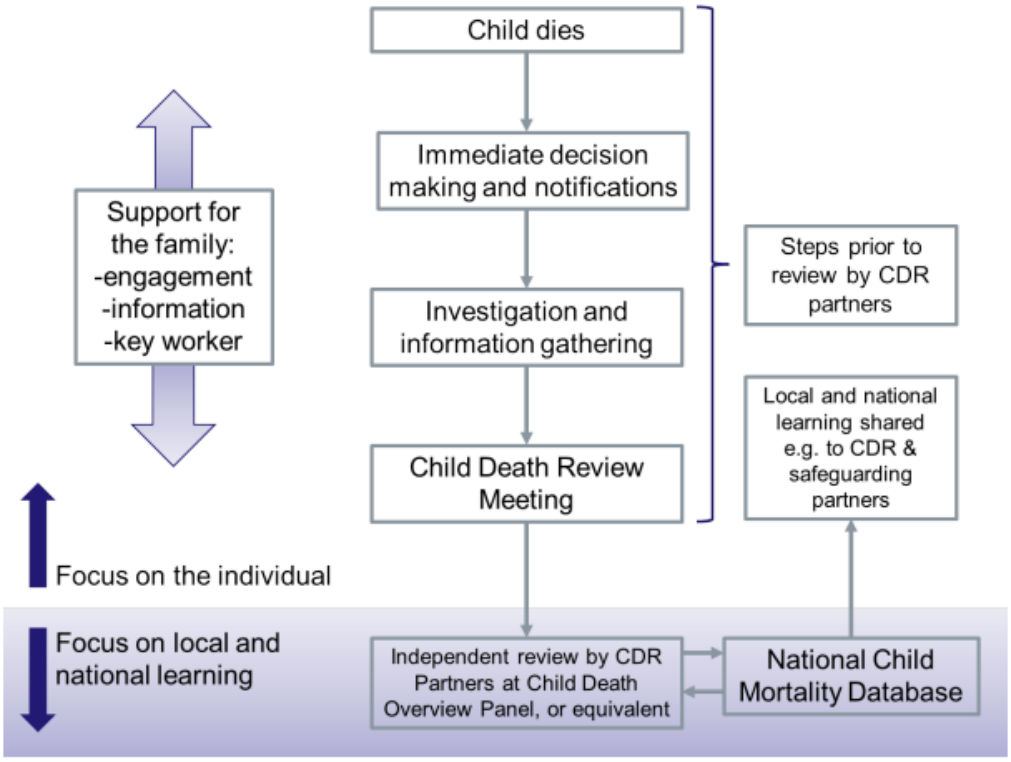
	continue as a less formally constituted network for information and best practice sharing, and some continued combined reporting. In reality, this was a pragmatic recognition of the way it was largely operating in recent years in any case.
2. Key Issues	
	Governance changes
2.1	The local review of the governance arrangements for Rotherham's CDOP has come to a different conclusion to the decision that was taken immediately following the guidance changes in 2018. The decision to move away from the Safeguarding Partnership in favour of the Health and Wellbeing Board is entirely consistent with that guidance, however, which leaves it in the hands of the local child death review partners (the ICB and the local authority) to determine what works best locally. It also reflects the reality that the largest part of the learning from child deaths is generally within the health sphere.
2.2	Changes to the arrangements at South Yorkshire level, with the relegation of the SYCDOP group to a networking community of interest group also mean that stronger local reporting arrangements will be required. The reporting arrangements at South Yorkshire level have not been timely in recent years, with the 2022-23 annual report (appended for information) not being finalised until May this year, and the 2023-24 annual report still in preparation at this time (expected imminently).
2.3	It is expected that some combined South Yorkshire reporting will continue to take place via the network group using aggregated data provided by the National Child Mortality Database, but at each place there will be a need for enhanced local reporting to compensate for the subregional changes.
2.4	From 2024-25 Rotherham CDOP will now produce its own annual report, which will cover numbers of notifications, numbers of deaths reviewed, numbers of cases outstanding, key learning, any emerging themes (locally and nationally) and key activity carried out or instigated by the panel. This report will continue to report on financial year, and will be brought to the Health and Wellbeing Board for sign-off and publication at the most appropriate time, following its compilation. This is likely to be in quarter 2.
2.5	Alongside this new annual reporting arrangement with the Health and Wellbeing Board, CDOP will retain a dotted line relationship with RSCP, providing updates where relevant, and sharing its annual reporting for information. Despite the preponderance of public health and healthcare learning, the safeguarding context is still frequently an important aspect of individual case discussions, and the safeguarding teams at the Trust, the ICB and the local authority are key members of the panel.
	Service impacts
2.6	The governance changes mean that concomitant changes in the administrative and management resources for CDOP are required. Up until recently, administrative support for CDOP processes have been provided through the RSCP business support function. These have worked alongside the administration of other child death review processes, for which there is an existing dedicated administrative resource located in the Trust's Safeguarding team.
2.7	It is proposed to augment this Trust resource in order to provide a single consolidated resource for child death review and CDOP administration and management within a single team.
2.8	To achieve this, funds will be transferred from RMBC to the Trust to fund an additional 1/5 of the administrative role at the Trust and an additional 1/10 of the Lead Nurse role,

	in order to provide capacity for the administration and management of CDOP respectively. Additionally, the funds identified for the annual renewal of the eCDOP software licence (held by Barnsley on behalf of the whole of South Yorkshire) will also be transferred to this enhanced function within TRFT.
2.9	Pressures within the Safeguarding administration team have made this a reality in recent times with the trust team providing additional support to the CDOP function. This is due in large part to goodwill and additional effort from the Lead Nurse for Child Death Review and the Administrative Support for Child Death Review at the Trust to cover both their own administrative requirements for child death review in the hospital, and also provide the management and administration support to CDOP itself.
2.10	In fact, there has also been a concerted effort by this team and indeed by the whole panel over the last eighteen months to bring down a considerable backlog of cases that were due to be reviewed. A huge amount of credit is due in particular to Sharon Pagdin, TRFT's Lead Nurse for Child Death Review, who has a pivotal role in all of CDOP's processes. Her knowledge, dedication and skill have been invaluable, both in addressing this backlog and in making Rotherham's CDOP an effective and respected panel. She is about to retire from her post, but she leaves the panel in a healthy position.
	Learning from panel reviews
2.11	The main function of CDOP is to learn from child deaths, and take whatever actions that learning suggests would help to prevent future child deaths. By and large, the panel operates in a self-sufficient way in this respect, and has been successful in disseminating learning and implementing actions. Nevertheless, it is likely that there will be occasional circumstances, outside the normal reporting pattern, where help is sought from the Board or a particular system issue needs to be escalated.
2.12	As an example, in general, the view of the panel is sufficient to agree, discharge and follow up actions to be taken by the independent Chair on behalf of CDOP, but there may be occasions when the nature of the particular action requires some external endorsement, and in such cases the approval of the Health and Wellbeing Board may be sought on an exceptional basis.
	<u>A current example</u>
2.13	Some recent cases have come to the panel where significant levels of poverty were evident in the housing conditions of the family included within the panel documentation. Analysis carried out by the National Child Mortality Database shows that each decile of increased deprivation is associated with a 10% increase in risk of child death. At the individual case level, a direct mechanism by which poverty and deprivation contributes to a death is not always apparent, but such factors are often present, and it seems with increasing frequency. Following a particular recently reviewed case with some extreme conditions of overcrowding and other aspects of poor housing conditions, the panel asked the Chair to write a letter to the Housing Minister, in order to express our concern. In this instance, guidance is sought given the political aspect of the proposed action.
2.14	The Board's approval of such a letter is sought and advice on the process for carrying this out in the most appropriate and acceptable manner. This will include consideration of whether the letter should come from the Chair of CDOP, or indeed should come from the Health and Wellbeing Board itself, or jointly signed.
3. Key Actions and Timelines	
3.1	Board agrees its new role as principal line of reporting and governance for Rotherham's CDOP from this point onwards (December 2024).

3.2	Funding to transfer to TRFT to augment current child death review resource to provide a consolidated child death review and CDOP resource for administration and management of the panel. To occur as soon as can be achieved.
3.3	Further South Yorkshire CDOP annual report (for 2023-24) to be received by the Board as soon as it is finalised (being compiled on behalf of South Yorkshire by Doncaster's CDOP).
3.4	Rotherham annual report for 2024-25 to be presented to the Board for sign-off – expected to be in the summer of 2025, and at a similar date on a yearly basis thereafter. A brief summary of CDOP activity since 2022-23 is included as an appendix to this report for information.
3.5	Specific matters for consideration, advice, decision or escalation to come to the Board on an exceptional ad hoc basis.
4. Recommendations	
4.1	That the Health and Wellbeing Board agree to become the responsible governing body for Rotherham's CDOP from this point onwards.
4.2	That the Board note the changes in local and regional arrangements for administration of child death review and CDOP functions and for related networking and information and best practice sharing.
4.3	That the Board note the general principle of self-sufficiency of CDOP for the majority of actions it commissions and carries out, and is assured that CDOP will exceptionally seek approval from the Board, where this is deemed necessary and helpful.
4.4	That the Board agree the proposed action of CDOP to write to the Housing Minister (or similar) regarding its concerns arising from poor social and housing conditions associated with deprivation and poverty, and the associated increased child mortality risks, and advise on how this action is best discharged.

APPENDIX A

Diagrammatic representation of child death review processes, from 'Child Death Review: Statutory and Operational guidance (2018)'



APPENDIX B
Summary of Rotherham CDOP activity since April 2023

Activity in 2023-24

Having completed only 7 child death reviews in the year 2022-23, there was a considerable uplift in performance in this financial year.

Number of panels: 6
Number of cases reviewed: 18

Notable activity:

- Multi-agency safe sleep procedures socialised and taken to the RSCP for upload to Rotherham's Tri-X procedures online website
- Local audits of safe sleep undertaken by the Trust reviewed.
- Concerns about the NHS Healthier Together website escalated to the National Child Mortality Database (NCMD). A number of cases were reviewed where there was insufficient information available for parents of children with additional needs, e.g. to provide guidance on vigilance for and response to complications of a particular condition. NCMD has raised this with NHSE.
- Escalated potential value of point-of-care testing for Group A Streptococcus infections with UKHSA.
- Road traffic awareness (especially for children with additional needs) raised via Senior School Leaders' Forum
- Second Rotherham CDOP Learning Webinar staged in October 2023. Webinar was themed around water safety and preventing child drownings, with presentations from the Senior Coroner, national campaign bodies, and a local parent. Well attended from Rotherham and further afield; well evaluated; resulted in a resource pack shared with schools, and agreed approach between Places Leisure and a national charity about providing swimming tuition for children with learning difficulties in Rotherham.

2024-25 activity to date (April – November)

Number of panels: 6 (including 2 additional unprogrammed panels to address backlog)
Number of cases reviewed: 20 (+ 3 planned in November)

Notable activity:

- Confirm regulations (via RoSPA) in respect of seatbelts and child restraints in nonstandard vehicles, specifically a conversion to a motorhome.
- Decision to write to Housing Minister re poverty and housing and other conditions contributing to infant mortality risk.
- Safety of drawing pins – contact with RoSPA re product safety, and with local child settings in respect of fixings for noticeboards.

Reducing the backlog of outstanding cases for review

	Jan 23	March 23	April 23	June 23	August 23	Dec 23	May 24
Current child death cases as of month end	34	34	35	35	35	32	23
Number of cases **within** one year timescale			-	16	16	11	12
Number cases **out of** one year timescale	-	-	-	19	19	19	11

There is no official target time frame for a child death to complete its progression through the various child death review processes, but Rotherham CDOP uses a threshold of 12 months for monitoring performance in this respect. The table illustrates that using this threshold, the backlog of cases was as high as 19 in June 2023. By May 2024 it was down to 11, and as of late October 2024, the number of cases outstanding for more than a year was down to 7.

Four of these seven outstanding cases are due to external factors outside the control of the panel – one is subject to a criminal investigation, and three are the subject of inquests. The remaining three were programmed to be heard at the November 2024 panel, meaning that the backlog has now been largely eliminated.