BIRMINGHAM STATUTORY CHILD DEATH REVIEW ARRANGEMENTS

Governance arrangements

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Birmingham Child Death Review Arrangements

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Foreword

The death of a child is a devastating loss that affects all those involved. The bereaved parents, siblings, families, friends and professionals who were involved with caring for the child need to be supported with empathy and compassion. Parents, siblings, families and friends need to know what happened to their child and know, wherever possible, that people will learn from what happened.

The United Nations Convention on the Rights of the Child came into force in 1992 and sets out the civil, political, economic, social, health and cultural rights of children. The process of systematically reviewing the deaths of children is 'grounded in respect for the rights of children and their families, with the intention of learning what happened and why, and preventing future child deaths'.

Birmingham City Council, and Birmingham and Solihull Clinical Commissioning Group is committed to supporting families at their time of loss and seeking learning from each and every child death in the City.

Over the next year, and as we work through the transitional arrangements, more collaborative learning will take place across the city.

This plan outlines the revised child death review arrangements for Birmingham following the statutory guidance in Working Together (2018) and the Child Death Review Statutory and Operational Guidance (England, October 2018).

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Section 1: Child Death Reviews

Introduction

The publication of the Working Together to Safeguard Children, July 2018[1], and the detailed Child Death Review Statutory and Operational Guidance (England)[2] set out the new legal requirements for the systematic review of every death of a child under 18 years of age in England, regardless of the cause of death. Working Together (2018) identifies the accountable Child Death Review Partners as the local authorities and any clinical commissioning groups for the local area. In Birmingham this refers to Birmingham City Council and Birmingham and Solihull CCG.

The Operational Guidance builds on the statutory requirements set out in Chapter 5 (Child Death Reviews) of *Working Together to Safeguard Children 2018* and clarifies how individual professionals and organisations across all sectors involved in the child death review process will be required to contribute.

The guidance seeks to:

- improve the experience of bereaved families, and professionals involved in caring for children; and
- ensure that information from the child death review process is systematically captured in every case to enable learning to prevent future deaths ensure local learning is captured and, through the use of National Child Mortality Database, to identify learning at national level to inform changes in policy and practice.

Who is the guidance for?

The statutory guidance identifies that:

- Senior leaders within organisations who commission or provide services to children should follow the procedures set out in the guidance.
- All professionals who care for children and/or have a role in the child death review process should read and follow the guidance so they can respond to each child death appropriately. This includes people working within:
    - Health services (across all sectors: acute, maternity, mental health, primary care and community);
    - Children's social services;
    - Police, including British Transport Police, and Royal Military Police;
    - Coronial services;
    - Education; and
    - Public health.

The Flow Chart in the guidance (Figure 1) illustrates the full process of a child death review. It identifies the responsibility of the local review by professionals involved in the care of the child (Child Death Review Meeting) and the review of an independent multi-agency panel organised by the Child Death review Partners.

[1] The guidance in Chapter 5 is issued under section 16Q of the Children Act 2004.
[2] HM Government, Child Death Review Statutory and Operational Guidance (England), published October 2018.

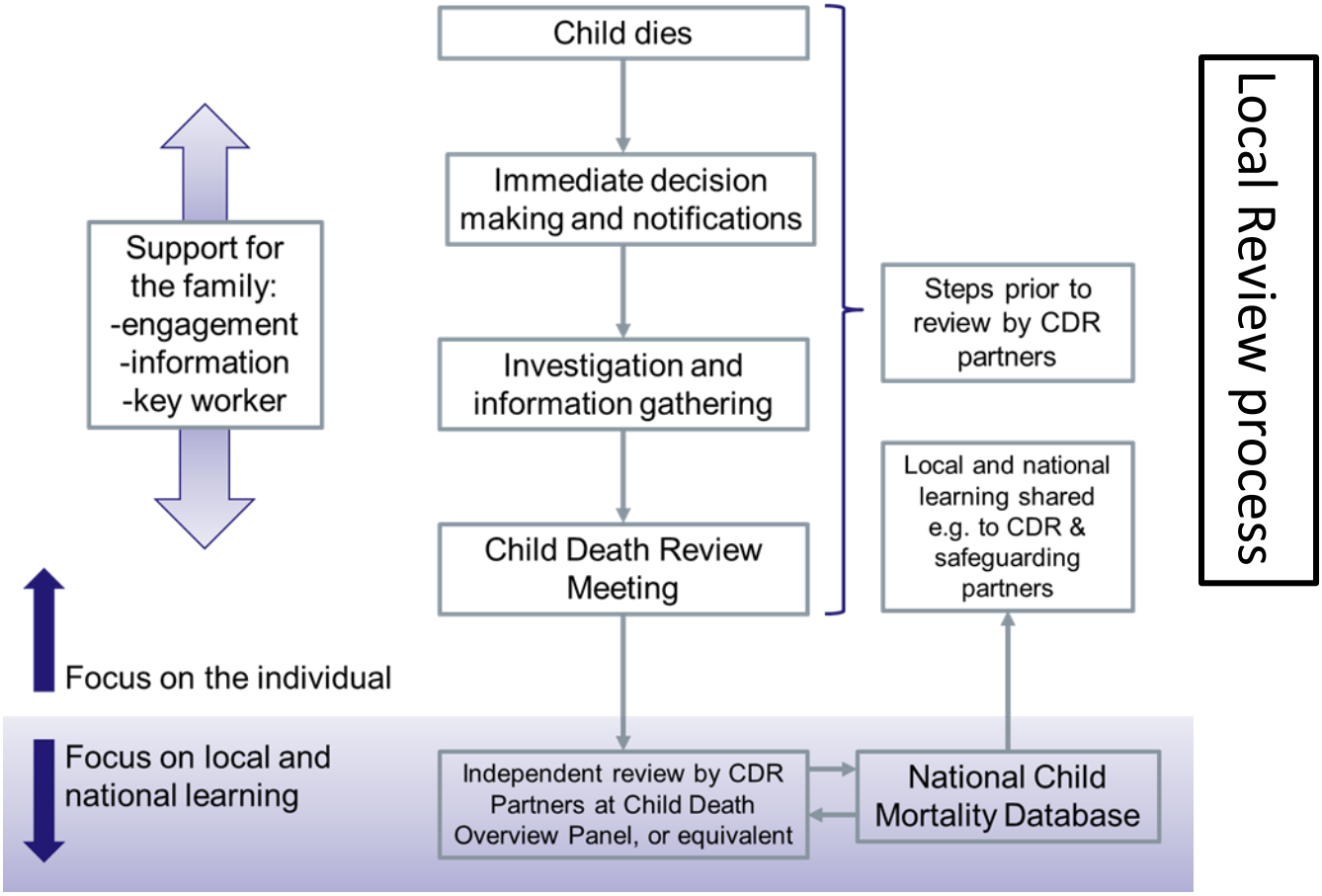


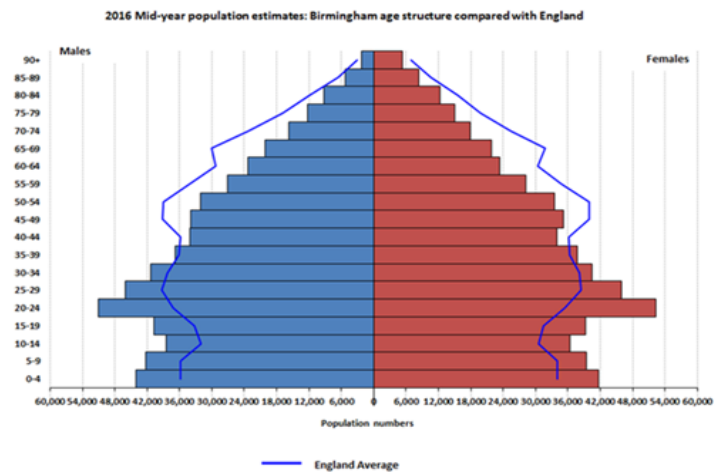
Figure 1

Section 2: Geographical Footprint and local context to our arrangements

The Operational Guidance determines that the geographical footprint of the Child Death Arrangements should cover a population where more than 60 child deaths are reported per year. This is to ensure sufficient numbers of death reviews for reliable lessons to emerge, particularly in groups of rarer deaths. Consideration has also been taken of the boundaries of the City Council and the flows of care for children in the local NHS.

Birmingham and Solihull CCG covers two local authority areas and it has been agreed that the CCG will be the principal partner with Birmingham City Council and an Associate partner with Solihull MBC in it's arrangement with Warwickshire Count Council, Coventry City Council and the two respective CCGs

Birmingham the Local Context

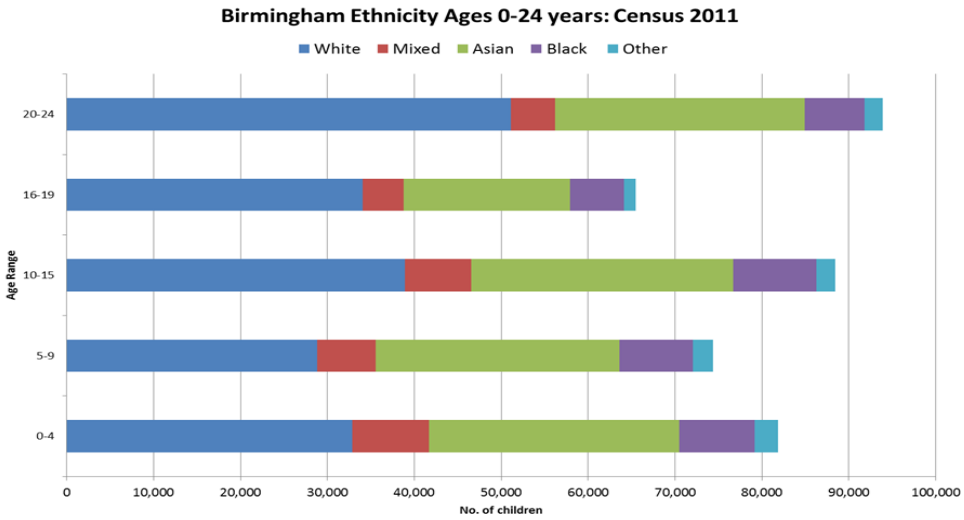


Birmingham is the youngest City in Europe. Figure two compares the population of England (the blue line) with that of Birmingham (the blue male and red female bars). It is clear how Birmingham has more younger (0-34 years) and less older (50+ years) people living in the City.

Figure 2

The Census 2011 reported that 46% of the under 25 year olds in Birmingham were of White ethnicity (Figure 3), compared to 79% in England. The largest ethnic group was Asian, 33% compared to 10% for England.

Figure 3. Birmingham Ethnicity Ages 0-24 years



One of the most significant challenges for children and young people living in Birmingham remains family poverty. Birmingham has high levels of deprivation with 40% of the population living in the 10% most deprived areas of England. The Index of Multiple Deprivation (IMD) is a measure of the relative levels of deprivation at small area levels. Figure 4 shows that this disadvantage is not distributed evenly across the City.

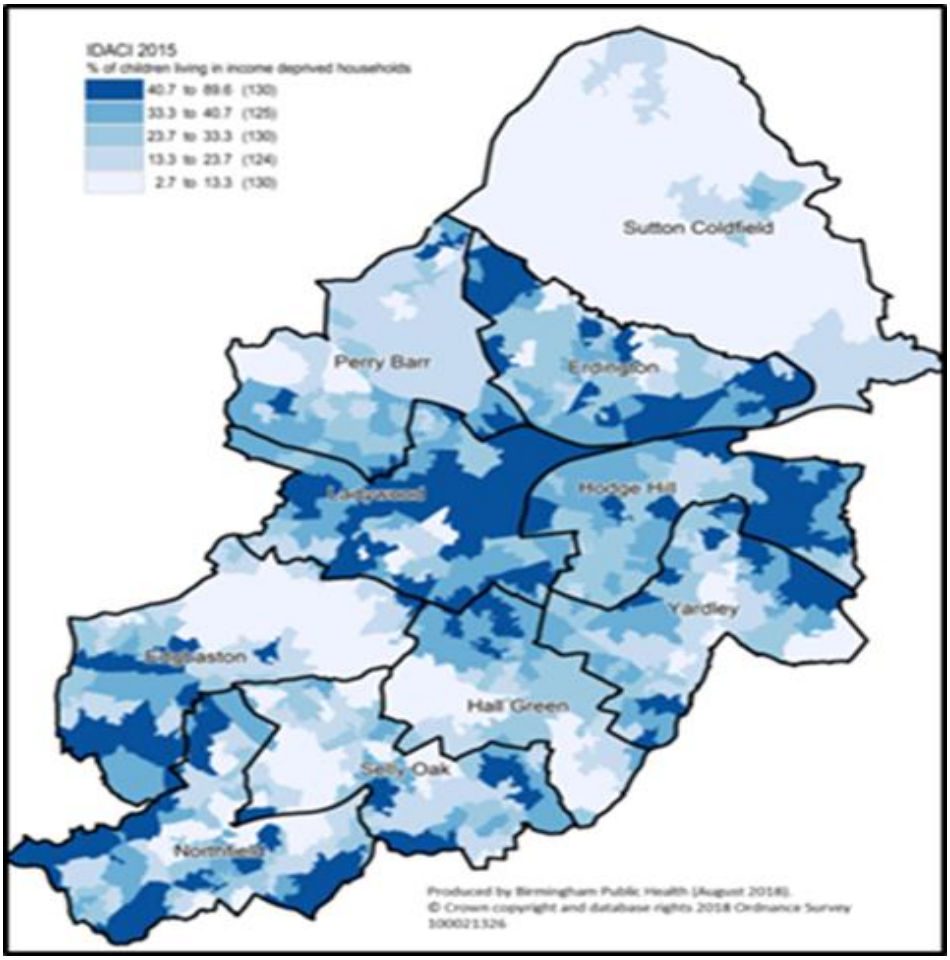
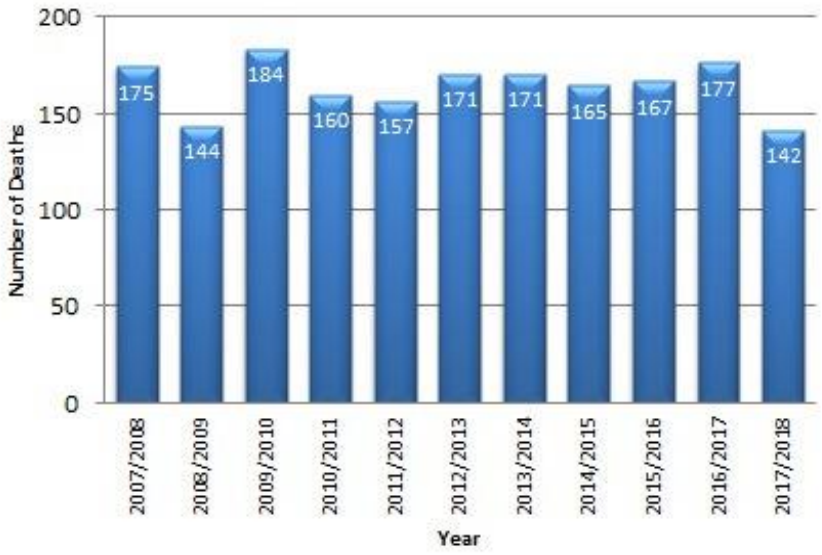


Figure 4

On average Birmingham has 180 child deaths per year and the pattern of deaths has remained similar to previous years (Figure 5).

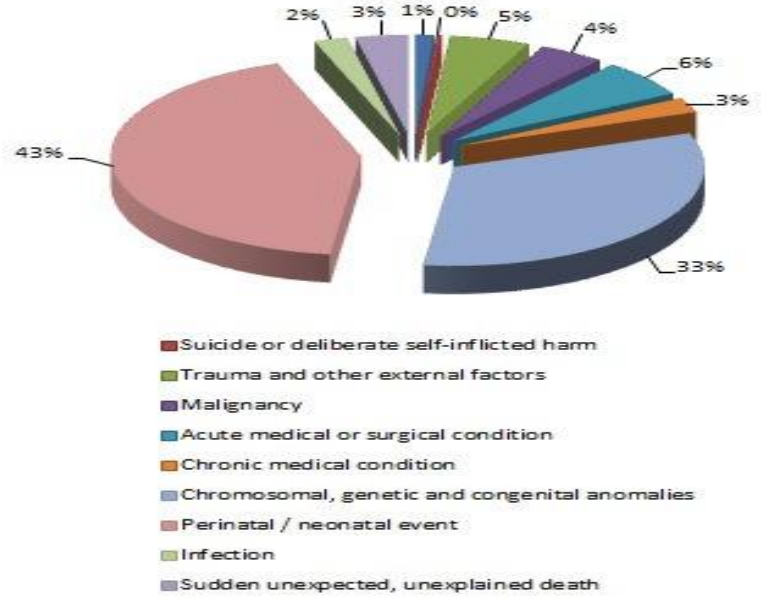
Figure 5 Number of Child Deaths in Birmingham – April 2007 – March 2018.



A child is most vulnerable in the first year of life, the 'infant period' and accounts for 71% of deaths in Birmingham with almost two thirds occurring in the first seven days of life.

Figure 6 shows the pattern of the category of deaths in Birmingham, with 43% being due to events around birth and 33% being due to genetic or congenital anomalies. The cultural diversity of communities in Birmingham is reflected in the patterns of death by age.

Figure 6 Proportion of Child Deaths by Category between 2015/18



Section 3: Responsibilities of the Child Death Review Partners

This section outlines our governance, funding arrangements, workforce and accountability process.

Governance Arrangements

Strategic leadership is shared between Chief Executives of Birmingham City Council and Birmingham and Solihull CCG. The funding of the new arrangements is to be determined and agreed during the transition period.

Monitoring and Reporting

It is expected that the CCG will take the lead around the governance related to monitoring and reporting. The performance and outcome indicators of the Joint Agency Response Health Team and the Birmingham Child Death Partnership Overview Panel should report quarterly to the Quality and Safety Committee of Birmingham and Solihull CCG and be escalated to the Mortality Overview Scrutiny Group as appropriate.

The Child Death Review partners will publish annual reports on:

- What they have done as a result of the child death review arrangements in their area, namely the lessons learnt and resulting actions; and
- How effective the arrangements have been in practice

The Birmingham Child Death Overview Panel Annual Report will be presented to the Quality and Safety Committee and the Mortality Overview Scrutiny Group of the CCG and the Birmingham Health and Wellbeing Board.

Transition Arrangements

Existing Child Death Overview Panel arrangements will continue to oversee the review of new child death until the 30th September 2019, when the new child death arrangements commence on the 1st October 2019. It is expected that the previous arrangements will have concluded any outstanding reviews in excess of 6 months of notification. All information relating to the remaining outstanding will be transferred to the new arrangements. However, given that the footprint has not changed and Birmingham is using the eCDOP case management system this will not be a challenge or risk. Birmingham was one of the early adopters of eCDOP and this system facilitates the reporting of the review data to the National Child Mortality Database.

Workforce and contact arrangements

Figure 1 illustrated the main process of a child death review leading to the Independent review by the Child Death Review Partners. Our child death review partnership will support the local and overview processes using the current administrative resources and identifying Designated Doctor and Nurses.

The CCG Child Death Support Team and the Designated Professionals for Safeguarding, including the doctor and nurse supporting child death reviews will be based on Floor 1, 10 Woodcock Street, Birmingham, B7 4DJ. This will bring together the resources currently in Birmingham and Solihull CCG, Birmingham Community Health Care NHS Trust and Birmingham City Council/Birmingham Childrens Trust under a single management to maximise efficiencies.

Appointment of the Designated Doctor for Child Death

A consistent member of the local and overview panels in the statutory guidance is a Designated Doctor for Child Death. The Designated Doctor for child deaths must be a senior paediatrician, appointed by the Child Death Review Partners, who will take a lead in

co-ordinating responses and health input to the child death review process, across Birmingham.

The descriptor “designated” refers to a dedicated professional with specific roles and responsibilities that are centred on the provision of clinical expertise and strategic advice to the Child Death Review process. The designated role therefore relates to the Birmingham Child Death Overview Panel and not the co-ordinated multi-agency response triggered under certain circumstances of a child’s death, the Joint Agency Response. This is supported via an existing community services service specification that includes the other Designated Doctors for Safeguarding Children on sessional arrangements.

Communications and Notifications

Notifications of a child death will be sent to a dedicated NHSnet email (bsolccg.cdreview@nhs.net). The Birmingham Designated Doctor for Child Death will be contacted on a separate dedicated NHSnet email (bsolccg.cdreview@nhs.net). The Birmingham Joint agency response paediatricians will be contacted as part of an on call system.

Information Sharing

Information-gathering, data flows and agreements with Birmingham and Solihull CCG that link into the Birmingham Child Death Partnership Overview Panel has begun and will be ongoing as we refine our local child death review arrangements.

Local NHS and providers should note that the Child Death Review Partners team may request information from a person or organisation for the purposes of enabling or assisting the review and/ or analysis process. The person or organisation must comply with this statutory request, and if they do not, the child death review partners may take legal action to seek enforcement (see Working Together to Safeguard Children, July 2018, Chapter 5: Child Death Review at page 95).

Engagement and Communication

A plan of engagement with local stakeholder partners involved in local Child Death Reviews or Joint Agency Responses is being prepared as part of an implementation Plan which will conclude by 30 November 2019.

The implementation plan will be managed by a Project Team and will have five initial themes. These are:

i. Agreement of the financial envelope.
ii. Child Death Review Team transfer to a single organisation and site.
iii. Appointment of the Designated Doctor for Child Death Review.
iv. Establishing the Local Child Death review arrangements in each Acute NHS Trust, Community NHS Trust, General Practice, and Voluntary Sector provider.
v. Review of the Health arrangements to support Joint Agency Response to unexpected deaths.
vi. Establish the chair and membership of the Child Death Overview Panel