

CHILD DEATH REVIEW ARRANGEMENTS FOR THE SOUTH WEST PENINSULA.

Introduction

Child Death Review (CDR) partners are Local Authorities and any Clinical Commissioning Groups for the local areas as set out in the Children Act 2004, as amended by the Children and Social Work Act 2017.

Child Death Review partners must make arrangements to review all deaths of children normally resident in the local area and, if they consider it appropriate, for any non-resident child who has died in their area. Child death review partners for two or more local authority areas may combine and agree that their areas be treated as a single area for the purpose of undertaking child death reviews. Child Death Review partners must make arrangements for the analysis of information from all deaths reviewed. (Working Together to Safeguard Children 2018)

Child Death Review partners must publish their arrangements for child death as per the requirement set out in Working Together 2018.

CDR Arrangements

Across the area, local authorities and CCGs have come together to form the child death review arrangements for the South West Peninsula, using the existing Child Death Overview Panel framework.

Purpose of the arrangements

The Child Death Review partners for the South West Peninsula understand that the death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity and also impacts on the wider community.

The partners' intention is to ensure that families experiencing such a tragedy within the South West Peninsula should be met with empathy and compassion. Families should receive clear and sensitive communication in order to understand what happened to their child and know that people will learn from what happened.

The partners fully understand the statutory obligations placed upon them and others. All agencies commissioned by the Partners, and involved in the child death review process, will work together throughout the process. This is for two main reasons:

- 1) To improve the experience of bereaved families, as well as professionals, after the death of a child;
- 2) To ensure that information from the child death review process is systematically captured to enable local learning and, through the planned National Child Mortality Database, to identify learning at the national level, and inform changes in policy and practice at a regional and local level.

The members of the Child Death Overview Panel (CDOP) pledge to ensure that the child and family will remain at the centre of the final discussion. The process of expertly reviewing all children’s deaths within the South West Peninsula will always be grounded in a deep respect for the rights of children and their families, with the intention of facilitating maximum learning in order to prevent future child deaths.

The geographical area and the child death review partners

The area covered is:

- Devon (including Plymouth and Torbay)
- Cornwall and the Isles of Scilly

Partners responsible for Child Death Review across this geographical area are:

- Cornwall Council
- Council of the Isles of Scilly
- Devon County Council
- Plymouth County Council
- Torbay Council
- NHS Devon CCG
- NHS Kernow CCG

Arrangements in place will ensure that all new requirements as set out in child death review: statutory and operational guidance (England) are met, this includes for example the functions of CDOP, panel responsibilities and membership, and a geographical area large enough to ensure the review of a minimum of 60 deaths per year.

Funding arrangements

Child Death Review partners have financial arrangements in place to fund arrangements across the area.

Accountable Officials

Each organisation has named accountable officials for Child Death Review in Plymouth and Torbay these are:

Organisation	Position	Named person
Plymouth City Council	Local Authority Chief Executive	Tracey Lee
Torbay Council	Local Authority Chief Executive	Steve Parrock
NHS Devon CCG	Accountable Officer of the Clinical Commissioning Group	Simon Tapley



Designated Doctor

The Designated Doctor for child deaths across the South West Peninsula is Roger Jenkins

Other sources of information

This document is to be read alongside the South West Peninsula Child Death Review arrangements 2019 flowchart.

Relevant legislation and guidance for child death review is as follows:

Children Act 20014

Children and Social Work act 2017

Working Together to Safeguard Children 2018

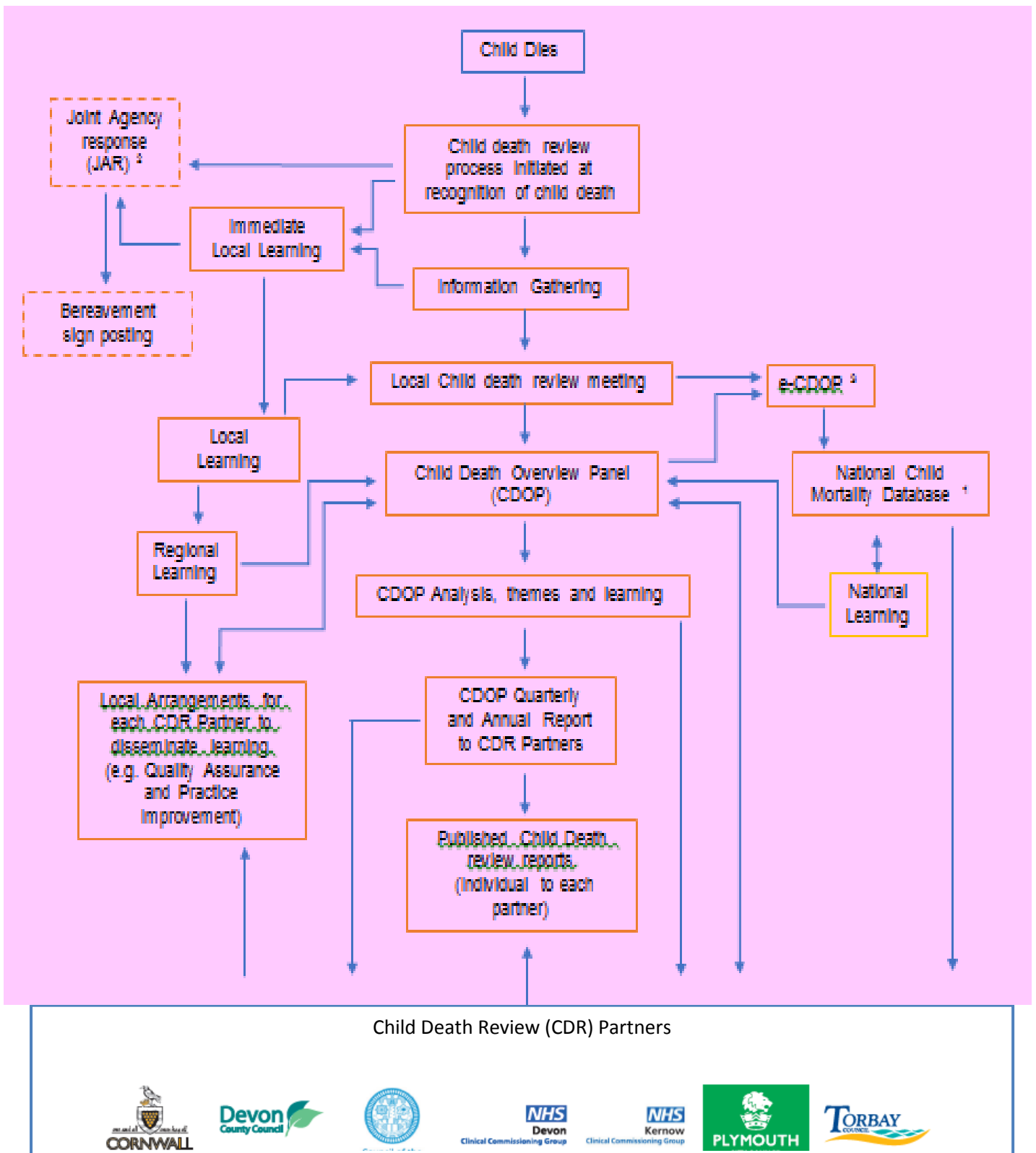
Sudden and Unexpected Death in Infancy and Childhood: multiagency guidelines for care and investigation (2016)

Child death review: statutory and operational guidance (England)

Child death review – Guide for parents and carers:



South West Peninsula Child Death Review Arrangements 2019 Flowchart



Key:

¹ NCMD - The National Child Mortality Database (NCMD) is a repository of data relating to all children’s deaths in England.

² JAR – A coordinated multi-agency response is triggered in certain circumstances. More details [here](#).

³ e-CDOP –Online recording, casework and reporting system for child deaths.