City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Department of Children's Services
Aiming High for Children

Strategic Director's Office
Margaret McMillan Tower
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[redacted]

Private & Confidential
Mr R Mahmood
HM Assistant Coroner for West Yorkshire
Western Coroner Area

5 September 2023

Dear Mr Mahmood

Response to Regulation 28: REPORT TO PREVENT FUTURE DEATHS
Date of Regulation 28: 3rd August 2023

I am writing to respond to the Regulation 28: Report to Prevent Future Death following the inquest into the tragic death of Leah.

We have reviewed your report and the findings of your inquest into Leah's death. In this, you did not identify actions or omissions on the part of individuals or teams within the Council which contributed to Leah's death. You did however express concern that Bradford Council appeared not to have a system or process in place which allowed us to have an overview of deaths where different Council teams had been involved with a child or young person.

Having taken time to look into the concerns, I am able to reassure you that following Leah's death we do now have strengthened processes to make sure that we have organisational oversight where we have more than one team involved and a child dies. We acknowledge that our staff who gave evidence at the inquest did not share the arrangements that have been put in place since Leah's death.

We recognise that Children Services were facing a number of challenges in 2020, though efforts were being made both then, and since to continually improve. Although we are far from complacent, the changes we have put in place, especially since November 2021, mean that our systems and processes are now more robust. We will continue to learn and improve.

Having looked into the matters raised in the Regulation 28 report, there are now clear processes in place from 2021 that ensure an individual (the Director of Children's Services) and appropriate teams have an overview of a child's death. This has been supported by revised and new processes that ensure information is collected and shared across all parts of Children's Services and continues to be in place following the operation of the Trust. These processes and the quality of the information collected will enable lessons to be learned in future.

Specific changes implemented since Leah's death are:

Individual/Team Oversight of Child Deaths

The Children's Services Departmental Management Team (DMT) now maintain a risk register to ensure their oversight of any serious incidents or significant events and that current progress is made on identified actions, and that lessons learned are acted on. At the DMT meeting the circumstances of the incident is discussed between the Director of Children Services (DCS) and the Assistant Directors (ADs) within Children Services. Where appropriate, actions are agreed, including the team that will coordinate a response. The child remains on the risk register until the actions have been resolved. This change means that the DCS as an individual and the appropriate team asked to coordinate the actions, have oversight and responsibility for those actions.

Notification Processes and within Council Coordination

There have been improvements to the notification process following the death of a child since 2019. Children's Services Review Guidance (2022) has been produced and this includes a new form and improved processes that systematically collects information within children services when a child has died. This form also seeks to identify systemic issues, key lines of enquiry and provides recommendations. This is coordinated by the Council's Education Safeguarding Team.

The Serious Incident or Significant Events Guidance, Form and processes, were further developed and implemented in 2020. These processes are used when there is a death of any child, including where abuse or neglect are thought to have contributed to the child's death. This also includes death by suspected suicide. One of the key changes to the form was the requirement for the relevant Head of Service (HoS) to set out the actions to be taken and for the relevant Assistant Director to give a view about any additional actions need to be taken. This is sent to the DCS to review and is then discussed on Departmental Management Team as outlined earlier. This makes sure that senior leaders in Children's Services are sighted and reviewing information and decisions about a significant or serious event quickly. This change was put in place in November 2021. Since the establishment of the Bradford Children and Families Trust in April 2023, the guidance and notification process continues to operate along similar lines with senior leaders in the Trust being aware of significant or serious events whilst ensuring that the DCS is informed quickly so that this can be reviewed and considered by the Children's DMT.

Although there was not a single review by Bradford Council there were contemporaneous partnerships reviews that included Bradford Council resulting in recommendations of suicide prevention training led by the multi-agency suicide prevention group.

In terms of wider partnership working, following Leah's death, the Bradford Safeguarding Children Board Chair reviewed the information in line with government guidance, and concluded that there was no obvious safeguarding, abuse or neglect issue that would warrant a Rapid Review. Individual agencies did their own internal reviews to inform this. This was noted by the case review subgroup on the on the 25.07.2019.

Leah's death was then referred (as the Safeguarding Board recommended) to the Child Death Overview Panel. As you will know, the role of the Child Death Overview Panel (CDOP) is to analyse the information obtained in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths. The CDOP can also to make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children. Although, the Child Death Overview Panel (CDOP) are not able to review Leah's death until all the relevant legal processes have been completed, the CDOP identified that there had been two deaths by suicide in the year that Leah died and produced a report in 2022 that outlined six recommendations to prevent suicide. These recommendations were implemented. Bradford council also has a council wide suicide prevention group (SPG) and the terms of reference for this group were updated in 2021. This group is responsible for district wide suicide prevention training.

I acknowledge again that these changes were not reflected fully in the evidence given to the Inquest and can assure that the right processes are in place to enable us to learn from such cases in the future. The DCS is the single point of oversight with their DMT to ensure that we have oversight and learn any lessons that arise.

Yours sincerely

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Strategic Director
Children's Services