Northamptonshire Safeguarding Children Partnership

Mr David Hemming
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Date: 29.05.2025

Dear Mr Hemming,

RESPONSE TO REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

I am responding on behalf of the Northamptonshire Safeguarding Children Partnership to your report made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, dated 08 April 2025, following the tragic death of Christian Hobbs on 26 December 2017. Specifically, "POINT R – CHILD DEATH OVERVIEW PANEL REVIEW." Northamptonshire Child Death Overview Panel (CDOP) is a Northamptonshire Safeguarding Children Partnership (NSCP) subgroup, and I am the current CDOP chair.

I am unable to comment on why Northamptonshire CDOP agreed that there were no modifiable factors in the review of Christian's death. The CDOP minutes from 12 March 2019, where case Northants498 (Christian Hobbs) was discussed, are brief. The minutes state that case Northants498 was discussed and that CDOP members identified no modifiable factors. As the Report notes, the 'analysis form' is not available, and thus, I cannot determine what information was shared with the Northamptonshire CDOP panel to inform their discussion. Specifically, whether the "…*significant issues on clinical management*" referenced in the Report were shared with CDOP.

I can offer assurance regarding the current child death review process and the operation of Northamptonshire CDOP.

- All CDOP forms and associated communication are now collected, collated and stored appropriately per the General Data Protection Regulation. Ensuring all relevant information is available supports a comprehensive review of the deaths of children and young people in

Northamptonshire.

- The child death review process operates in line with national guidance, ensuring we respond swiftly to national practice changes. The Designated Doctor for Child Deaths, the Child Death Review Coordinator and the CDOP Chair actively maintain their knowledge and skills through CPD and participating in regional CDOP meetings. The Designated Doctor for Child Deaths, the Child Death Review Coordinator have shadowed CDOP meetings in neighbouring authorities to inform the ongoing development of CDOP in Northamptonshire.

- Robust joint agency response (JAR) processes align with the national guidance regarding unexpected deaths in children. The Designated Doctor for Child Deaths, the Child Death Review Coordinator and the CDOP Chair (the CDR Team) display' professional curiosity' regarding unexpected deaths in children and seek further information to inform decision-making. If the CDR team believes organisations don't plan serious incident (SI) investigations, similar processes, and circumstances suggest they are warranted, the team challenges the organisation concerned, escalating to senior leaders for support if needed.

- Where a child or young person dies outside of Northamptonshire, and child death professionals from the area where they died lead the initial JAR process, there is communication with the Northamptonshire CDR team to ensure a thorough process is followed continuously. Northamptonshire CDOP members will have access to the JAR notes to support decision-making regarding whether a death is considered modifiable.

- The CDR team review SI reports and those from similar investigative processes. If they have concerns that the report findings don't reflect the issues associated with the child's death and/or the improvement actions don't sufficiently address the issues identified, the CDR team will seek further information from the organisation. If the team still has concerns, they elevate them through the ICB quality team. When reviewing the deaths of children where there has been an SI investigation, CDOP will identify modifiable factors related to the service provision, which echo those found in the investigation and others CDOP believe to be important. This mirrors practice in other CDOPs I've chaired.

- The CDR team reached a joint decision on when to bring a case to CDOP. Typically, children and young people's deaths are not usually discussed until formal processes, such as serious incident (SI) investigations or inquests, have concluded. Delaying the CDOP panel ensures that the SI investigation reports, and inquest conclusions inform the CDOP discussion. When the CDR team knows that inquests will be delayed, they decide whether to have an initial discussion at CDOP to identify learning. If so, the case will be returned to CDOP for further discussion and ratification.

- At the time of Christian's death, there was no CDR Coordinator in the post. The CDR Coordinator is crucial in ensuring that the family's voices are heard, including their concerns regarding their child's care. The CDR Coordinator advocates for families with

concerns and ensures families have answers to their questions wherever possible.

- The Northamptonshire CDOP panels operate well. All members have an equal voice. If one CDOP member raises a concern or wants to discuss whether factors are modifiable, other members listen, and there is an open and honest discussion.

Northamptonshire CDOP is the third CDOP panel I've chaired or co-chaired and I draw on my experience, alongside the experience of colleagues to ensure we have a cycle of continuous improvement. I am confident what constitutes good practice in reviewing child deaths and committed to enshrining it in Northamptonshire.

Your Sincerely,

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[redacted]

Chair of Northamptonshire Child Death Overview Panel

Deputy Director of Public Health, North Northamptonshire Council

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