

The Child Death Overview Panel

On 1 April 2020, the Public Health Directorate transferred from the Department of Health and Social Care to the Cabinet Office and with it the transfer of responsibility for the review of child deaths in the Isle of Man from the Safeguarding Board.

The deaths of all children resident in the Isle of Man, both expected and unexpected, are currently reviewed by the Isle of Man Child Death Review Partners to identify any learning. Island child death review arrangements have recently been reviewed in line with the revised arrangements published for England in October 2018. As a result, child death review arrangements have been placed on a statutory footing and a full child death review is undertaken for each death on island (and of children normally resident on Island whose death occurs elsewhere) to ensure that local learning is identified and acted upon. It is important to understand that the 'overview reviews' are not, and never have been, intended to be detailed individual case reviews.

The Child Death Review Partners are responsible for ensuring that all the standard reporting forms for each death have been completed by the agencies involved in the death. These forms are then submitted to the Merseyside and Isle of Man Child Death Overview Panel which undertakes the overview reviews. The Isle of Man is a full member of the Merseyside and IoM CDOP. The Director of Public Health is a panel member and chairs the Isle of Man Child Death Review Partners. The findings of the CDOP on Isle of Man cases are then reviewed by the Child Death Review Partners to ensure that local learning is identified and acted upon. In addition, the CDRP receives the aggregate reports of CDOP and also the English National Child Mortality Database and ensures that any transferable learning is acted upon here.

The purpose of the overview is to identify modifiable factors that can be addressed to reduce future risks of child death or (particularly where death was expected) improve services and support available to children and their families.

The Child Death Review Partners will identify cases for consideration of a Safeguarding Board Serious Case Management Review and notify the Independent Chair of the Safeguarding Board.