Isle of Man Government

Reiltys Ellan Vannin

CHILDREN AND YOUNG PERSONS (AMENDMENT) BILL 2019

EXPLANATORY NOTES

These Notes have been produced for the assistance of Members with the approval of the Member in charge of the Bill, Mr D Ashford MHK.

INTRODUCTION

1. These explanatory notes relate to the Children and Young Persons (Amendment) Bill 2019 ("the Bill"). They have been prepared by the Department of Health and Social Care ("the Department") in order to assist readers of the Bill. They do not form part of the Bill and have not been endorsed by the House of Keys.

2. The notes need to be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill.

BACKGROUND

3. This Bill will amend the Children and Young Persons Act 2001 ("the Act") to make provision for the review of child deaths that occur on the Island and for the analysis of information regarding such deaths.

4. The statutory requirement for the review of child deaths was originally included in the Safeguarding Act 2018, a proposed function of the Safeguarding Board being to review such information as may be prescribed in relation to deaths of children in the Island and in such circumstances as may be prescribed.

5. The review of child deaths and the analysis and collection of information in relation to such deaths has wider public health considerations that go beyond safeguarding alone, therefore it is proposed that such functions, rather than sit under the auspices of the Safeguarding Board, do so instead under Public Health.

6. Thus, the Children and Young Persons (Amendment) Bill 2019 (Bill) is proposing to insert a new Part 7A into the Act and make consequential amendments to sections 8(4) and 9(1) of the Safeguarding Act 2018.

7. The Bill has been the subject of a limited consultation exercise with stakeholders which elicited a positive response.

8. In the opinion of the Member moving the Bill its provisions are compatible with the Convention rights within the meaning of the Human Rights Act 2001.

FINANCIAL EFFECTS OF THE BILL

9. The Bill potentially has financial implications as it requires the child death review partners to make arrangements with a body outside of the Island with regard to the analysis of information about child deaths on the Island. It is anticipated and the intention is that arrangements will be made with Merseyside Child Death Overview Panel and that the annual cost of such arrangements to the Island will be circa £10,000.

10. An Impact Assessment of the Bill has been prepared by the Department and it is attached as Appendix 1 to these Notes.

CLAUSE BY CLAUSE NOTES

Clause 1

11. This clause gives the short title to the Act which will, if enacted, result from the Bill.

Clause 2

12. This clause provides for the commencement of the Bill by an appointed day order to be made by the Council of Ministers. It is anticipated that an appointed day order to bring

the Bill into operation will be laid before the same sitting of Tynwald Court at which Royal Assent is announced.

Clause 3

13. This clause introduces the amendments to be made to the Act.

Clause 4

14. This clause inserts a new clause 68A (interpretation) into the Act to define the child death review partners for the purposes of Part 7A (child death reviews).

Clause 5

15. This clause inserts a new clause 68B (child death reviews) into the Act to require arrangements to be made for the review of child deaths and the analysis of information in respect of such deaths.

16. The purpose of a review is to identify matters relevant to the welfare of children, to public health and safety on the Island and to consider whether it would be appropriate for action to be taken. Where it is appropriate for action to be taken a recommendation can be made to a person and that person must either comply or explain why they propose not to do so.

17. Regarding the analysis of information clause 68B(8) will require the child death review partners to make arrangements with a body outside of the Island.

18. English guidance states that a Child Death Overview Panel should review 60 child deaths per year to identify any potential public health or safeguarding issues which may be effecting children. The Island has approximately 4/5 child deaths per year. Therefore to keep in line with current best practice, it is anticipated, and the intention is, that arrangements will be made with the Merseyside Child Death Overview Panel.

Clause 6

19. This clause inserts a new clause 68C (information) into the Act to deal with the supply of information to enable the child death review partners to carry out their functions and the purpose for which that information may be used.

Clause 7

20. This clause inserts a new clause 68D (funding) into the Act to make provision for funding and the provision of resource in connection with the functions of the child death review partners.

Clause 8

21. This clause inserts a new clause 68E (guidance) into the Act empowering the child death review partners to have such regard as they consider appropriate to guidance issued by the Secretary of State in England under corresponding provisions.

Clause 9

22. This clause makes consequential amendments to sections 8(4)(b) and 9(1) of the Safeguarding Act 2018. The amendments are required given the proposed insertion of Part 7A (child death reviews) into the Act.

Appendix 1

DEPARTMENT: **Health and Social Care**		
IMPACT ASSESSMENT **FOR A CHILDREN AND YOUNG PERSONS (AMENDMENT) BILL 2019**		
Stage: 12 – Council approval to introduce legislation into Branches	**Version:** 4	**Date: 03/09/19**
Related Publications: Children and Young Persons (Amendment) Bill 2019 (V03), Explanatory Memorandum, Stakeholder Consultation documentation on the draft Bill, Treasury paper.		
Responsible Officer: Sarah Kewley **Email Address:** Sarah.Kewley@gov.im		**Telephone:** 642627

SUMMARY: INTERVENTION AND OPTIONS
Briefly summarise the proposal's purpose and the intended effects

1. The Department of Health and Social Care (**Department**) is proposing to amend the Children and Young Persons Act 2001 (**Act**) to make provision for the review of child deaths that occur on the Island and for the analysis of information regarding such deaths.

2. Provision regarding the review of child deaths and the analysis of information regarding such deaths is currently provided for in sections 8(4) and 9(1)(b) of the Safeguarding Act 2018.

3. Under section 8(4) of the Safeguarding Act 2018 the functions of the Safeguarding

Board include:

a) to undertake case management reviews (regulations would prescribe when and their extent); and
b) to review information in relation to child deaths (regulations would prescribe when and their extent).

4. Further, under section 9(1)(b) of the Safeguarding Act 2018 the Safeguarding Board would have a statutory duty to establish a Child Death Overview Panel, the anticipated functions of that Panel, as set out in regulations, would have been to collect and analyse information regarding the death of a child but where no abuse was known or suspected.

5. The review of child deaths and the analysis and collection of information in relation to such deaths has wider public health considerations that go beyond safeguarding alone, therefore it is proposed that such functions, rather than sit under the auspices of the Safeguarding Board, do so instead under Public Health.

6. Thus, the Children and Young Persons (Amendment) Bill 2019 (**Bill**) is proposing to insert a new Part 7A into the Act and make consequential amendments to sections 8(4) and 9(1) of the Safeguarding Act 2018.

7. Summary of the provisions of the Bill:

   a) require the child death review partners (as defined) to make arrangements for the review of each child death on the Island to ensure that all deaths of children normally resident in the Isle of Man are reviewed;

   b) allow the child death review partners discretion to make arrangements for the review of a death in the Island of a child not normally resident here;

   c) require the child death review partners to make arrangements for the analysis of information regarding child deaths;

   d) the purpose of such reviews is to identify matters relevant to the welfare of children or to public health and safety on the Island;

   e) where child death review partners decide, that as a result of the review, action must be taken, the relevant person must be informed. That person must either take such action or if they choose not to do so, give reasons to the child death review partners for that decision;

   f) require the child death review partners to make arrangements for the analysis of information. Such arrangements must include making arrangements with a body outside the Island.

   g) require the child death review partners to publish a report regarding the arrangements made for the review of child deaths on the Island, the analysis of information regarding child deaths and the effectiveness of such arrangements. Reports must be laid before Tynwald at such intervals as considered appropriate.

What are the options that have been considered

1. **Option One – Maintain the status quo**

   Subject to regulations being made under the Safeguarding Act 2018, the Safeguarding Board would retain responsibility for conducting case management reviews into child deaths and reviewing information in relation to such deaths.

2. **Option Two - Amend the Children and Young Persons Act 2001**

   The second option considered was to amend the Children and Young Persons Act 2001 to make provision for the review of child deaths on the Island and for the analysis of information relating to child deaths. Responsibility for such matters would effectively fall within the remit of Public Health.

Link to Government Strategic Plan

The Programme for Government 2016-2021, as one of the 5 main themes, includes a Healthy and Safe Island, one of the outcomes of which is to improve the quality of life for children, young people and families at risk. At a policy level this Government is committed to providing safeguards for people who cannot protect themselves.

Link to Department Aims and Objectives

To protect vulnerable people, providing safeguards for people who cannot protect themselves.

Responsible Departmental Member

Kerry Sharpe MLC

Ministerial sign off

I have read the Impact Assessment and I am satisfied that the balance between the benefit and any costs is the right one in the circumstances.

Signed by the Minister

Date:

SUMMARY: ANALYSIS AND EVIDENCE

IMPACT OF PROPOSAL

Resource Issues - Financial (including manpower) [Note C]

Statement

Making arrangements regarding the review of child deaths on the Island

No additional funding is needed in terms of reviewing child deaths on the Island; this already occurs and resource has been allocated accordingly.

The current membership of the Child Death Overview Panel consists of the Director of Public Health (Chair), the designated nurse for child safeguarding, the designated doctor for child safeguarding, representatives of the constabulary, the Department of Education, Sport and Culture and the Children and Families Division. The time commitment of each member is covered within their existing positions.

Administrative support for the Panel is undertaken by the Healthcare Public Health Business Manager (EO grade), support absorbed by Public Health on a good will basis.

Making arrangements regarding the analysis of information of child deaths on the Island

As referred to above, the insertion of clause 68B(8) into the Act will require the child death review partners to make arrangements with a body outside of the Island with regard to the analysis of information about child deaths on the Island.

The arrangements that the child death review partners make will carry cost implications. It is anticipated, and the intention is, that arrangements will be made with the Merseyside CDOP.

English guidance states that a CDOP should review 60 child deaths per year to identify any potential public health or safeguarding issues which may be effecting children. The Island has approximately 4/5 child deaths per year therefore to keep in line with current best practice, arrangements for the analysis of information about child deaths will need to be made with the Merseyside CDOP.

Based on the current total cost of the Merseyside CDOP, the cost to the Island of becoming a part of it would be £10,246 each year; this figure has been confirmed by Merseyside CDOP. The model used by the Merseyside CDOP is as follows:

a) a flat rate of £5,000 is payable, from each local authority Safeguarding Children Board; and

b) a further cost is payable based upon population size, for the Island this would be £5,246, from Isle of Man Government.

Likely Financial Costs

The annual cost will be £10,246.

It is noted that the cost is dependent upon the total cost of the Merseyside Child Death Overview Panel and is therefore subject to change.

Likely Financial Benefits

Not known at this stage.

If the proposal introduces provisions that will require another Department, Board, Office or Body to take on additional work or responsibility please ensure that they have been consulted with early on in your considerations. Please provide a brief statement as to who they are and the consultation that has taken place.

The newly inserted clause 68A (Interpretation) defines "child death review partners", which comprises the Departments of Education, Sport and Culture, Health and Social Care and Home Affairs and the Constabulary.

Given that the Chief Executives/Chief Constable (as the case maybe) of each of the above mentioned bodies is an ex-officio member of the Safeguarding Board, it is not anticipated that there will be any substantive amount of additional work or responsibility. Further, the Bill has been the subject of a stakeholder consultation, whereby those bodies have been consulted.

Are there any costs or benefits that are not financial i.e. social

Best practice states that child death reviews '*should cover a child population such that they typically review at least 60 child deaths each year. Reviewing at least 60 deaths each year will better enable thematic learning in order to identify potential safeguarding or local health issues that could be modified in order to protect children from harm and, ultimately, save lives'*. [1]

The Island currently reviews 4/5 child deaths per year. There is no link with a body outside of the Island therefore, best practice isn't being followed. Without such a link there is the potential risk of missing important issues which could lead to unnecessary child deaths.

Which Business sectors/organisations will be impacted, if any, and has any direct consultation taken place?

[1] Child Death Review Statutory and Operational Guidance (England) (October 2018) page 35

In accordance with the direction of the Council of Minister's Legislation Sub-Committee the Bill has been the subject of a 2 week stakeholder consultation.

Given that provisions regarding the review of child deaths and the analysis of information in respect of such deaths had previously been considered as part of the key stakeholder consultation and public consultation on the Safeguarding Bill in July/August 2017, the Department did not consider it wise or necessary to publically consult again on this issue.

The proposed Bill was discussed at the March 2019 meeting of the Safeguarding Board and with the current CDOP members. All parties support the proposals.

Does the proposal comply with privacy law? Please provide a brief statement as to any issue of privacy or security of personal information.

The proposed amendments to the Children and Young Persons Act 2001 comply with privacy law. The information that the child death review partners requests from a person/body may only be used for the purpose of enabling or assisting the partners in the performance of their functions.

Has Treasury Concurrence been given for the preferred option [Note G]

At a Treasury meeting held on 28 August 2019 Treasury concurred with the Department submitting the Bill to the Council of Ministers for its introduction into the Branches.

Key Assumptions / Sensitivities / Risks [Note H]

The Department's intention is to have the Bill introduced into the House of Keys on 22 October 2019. To meet this target the Department is dependent upon the approval of the Council of Ministers.

Approximate date for legislation to be implemented if known

On the assumption that the Bill is introduced into the Branches on 22 October 2019 and progresses through the House of Keys and the Legislative Council as anticipated, Royal Assent should be announced in March/April 2020.

SUMMARY: CONSULTATION

Consultation in line with Government standard consultation process

In accordance with the direction of the Council of Minister's Legislation Sub-Committee the Bill has been the subject of a 2 week stakeholder consultation.

Given that provisions regarding the review of child deaths and the analysis of information in respect of such deaths had previously been considered as part of the key stakeholder consultation and public consultation on the Safeguarding Bill in July/August 2017, the Department did not consider it wise or necessary to publically consult again on this issue.

Date

Stakeholder consultation: 2 May – 16 May 2019

NB. To allow the High Bailiff to consider the Bill and to discuss its provisions with Public Health and the Attorney General's Chambers, an extension was agreed to 25 June 2019.

Summary of Responses:

Constabulary

- Gary Roberts, Chief Constable:

  The Constabulary supports the proposed legislation and queried whether consultation had been undertaken with the Coroner.

- Stephen Maddocks, Superintendent Operations:

  Highlighted the timing and juncture at which the Board becomes involved, it can't be before any other process (criminal or coronial process for example) but needs to be as timely as it can be after all the processes having been complete.

  Raised the issue of dynamic working in the event there were a series of deaths (a new drug or social media driven craze for example) so learning and prevention could be undertaken quickly to make every effort to prevent further deaths.

  Identified that care would be needed when reporting on or publishing reports to have cognisance of the fact we are a small Island and anonymising the information could be tricky.

  Additionally raised the point regarding the involvement of the Coroner in the consultation process.

  Made the observation that it is a good piece of legislation that must be used timely and correctly with an eye on why it is being brought in at all times.

Department of Home Affairs

Noted some consequential amendments arising from the Regulation of Care Act 2013 and a number of provisions in the Children and Young Persons Act 2001 that need to be repealed as a consequence.

Suggested that consideration should be given as to whether it would be better and more appropriate for the Island to issue its own guidance which describes the process

to be adopted here rather than merely have regard for guidance issued by a UK Secretary of State.

Also whether consideration could be given to adopting the UK model with regard to the sensitive handling of such cases from immediate aftermath to conclusion of inquiry by process of having other parts of the UK model adopted, for instance issuing suitable guidance for bereaved parties as to how the review process will operate, make decisions and subsequently report.

High Bailiff

Following a meeting with the Director of Public Health and the Chief Legislative Drafter the High Bailiff has no difficulties with the Bill proceeding.

EVIDENCE BASE

Children Act 2004 (Act of Parliament)

Child Death Review, Statutory and Operational Guidance (England) October 2018