The Child Death Review Process for County Durham and Darlington Annual Report

2018/19

Introduction

This is the 8th Annual Report of County Durham and Darlington Child Death Overview Panel (CDOP) and reflects the activity from 1 April 2018 to 31 March 2019.

The process of reviewing child deaths was established in April 2008 as outlined in Chapter 5 of Working Together to Safeguard Children 2015. It is the responsibility of Local Safeguarding Children Boards (LSCBs) to ensure that a review of every death of a child normally resident in their area in undertaken by a CDOP.

The overall purpose of County Durham and Darlington CDOP is to undertake a comprehensive and multi-disciplinary review of child deaths, in order to better understand how and why children in County Durham and Darlington die and use our findings to take action to prevent other deaths and improve the health, safety and wellbeing of children and young people in County Durham and Darlington.

Background to the Child Death Review Process

Working Together to Safeguard Children describes the process to be followed when a child dies in the Local Safeguarding Children Board (LSCB) area covered by a Child Death Overview Panel. The LSCB functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

a) collecting and analysing information about each death with a view to identifying:
   i. any case giving rise to the need for a review mentioned in regulation 5(1)(e);
   ii. any matters of concern affecting the safety and welfare of children in the area of the authority;
   iii. any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; *and*

b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

There are two interrelated processes for reviewing child deaths:

1. **Rapid Response** by a group of key professionals who come together for the purpose of enquiring into and evaluating each **unexpected death; *and***
2. An overview of **all deaths** up to the age of 18 years (excluding both those babies that are stillborn and planned terminations of pregnancy carried out within the law) in Durham and Darlington areas, undertaken by a panel.

The Child Death Overview Panel

A Child Death Overview Panel (CDOP) was jointly established by County Durham Local Safeguarding Children Board and Darlington Safeguarding Children Board. The Child Death Overview Panel is a sub-committee of both Durham and Darlington LSCBs. It is responsible for reviewing the available information on all child deaths and is accountable to the LSCB Chair.

The Panel has two distinct elements:

1. **Case reviews**
   The Panel categorise a likely/cause of death, identify any environmental, extrinsic, medical or personal modifiable factors that may have contributed to the death and consider any agency, Board, regional and/or national recommendations to prevent future deaths.

2. **Business**
   The Panel considers the business arising from case reviews and the other responsibilities and statutory functions of CDOP.

The disclosure of information about a deceased child is to enable the LSCBs to carry out its statutory functions relating to child deaths. The LSCBs use the findings from all child deaths, to inform local strategic planning on how best to safeguard and promote the welfare of children in County Durham and Darlington.

The CDOP must make a decision about whether or not a death was modifiable. Government guidance defines those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

The role of the Designated Doctor (child deaths) is carried out by a Consultant Paediatrician and the Rapid Response process is carried out by a team of senior nurses to manage and deliver the process for sudden and unexpected deaths. This ensures their active involvement at the onset of the review process in line with government guidance. The rapid review process augments the local review of all unexpected deaths and ensures that parents are engaged and received appropriate support during the process. The Rapid Response senior nurse also provides support to families following the expected death of a child, if invited to do so by the consultant paediatrician caring for the child.

The registrars of births and deaths are required by the Children and Young Persons Act 2008 to supply LSCBs with information which they have about the deaths of persons aged under 18 years.

The Child Death Review Process

Child Death Overview Panel
The CDOP has a fixed core membership with flexibility to co-opt other relevant professionals as and when appropriate. See Appendix 1.

The CDOP considers all outstanding reviews and collates actions and learning from Child Death Reviews into an action plan which is reviewed and updated at each CDOP meeting. This process increases accountability and provides written evidence of progress and completed actions with the facility to monitor deadlines. Experience has shown that over time it is possible to identify recurrent themes or issues.

Rapid Response
The national arrangements for a joint agency "rapid response" to unexpected child deaths and a review of all child deaths are a major step forward in helping to ensure that each bereaved family receives a thorough yet sensitive investigation of their child's death and that professionals from all agencies will respond appropriately when a child dies unexpectedly. A joint agency approach has been in place in County Durham and Darlington since October 2009.

Nursing Service
A senior nurse/manager provides in-depth specialist expertise in the field of unexpected child deaths and respond quickly to the unexplained death of a child and undertake reviews/investigations that are highly sensitive. In addition a key component of the role is to provide bereavement support for parents.

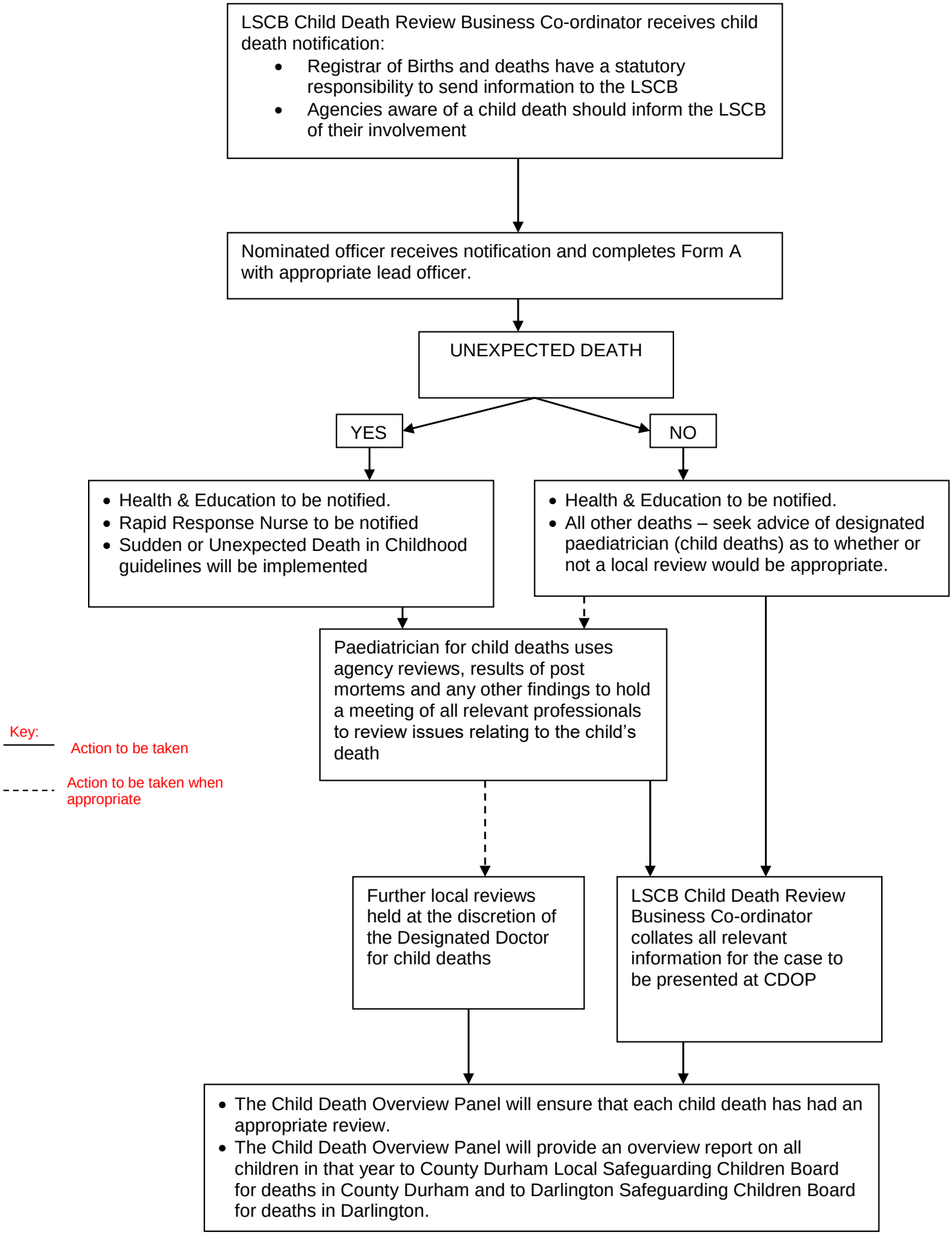
The post-holder provides the majority of hours for the service. However, this is supplemented with a small team of dedicated nurses to provide a round the clock service seven days a week including bank holidays. They are available to respond rapidly within a timely and flexible manner.

Local Case Discussions
For most unexpected deaths a local case discussion takes place at the discretion of the Designated Doctor for Child Deaths. Local Case Discussions are convened when the results of the post-mortem and other tests are known and when all the information has been gathered, including return of all requested Agency Report Forms (Form B). This will enable a discussion of all the issues and may give the best opportunity to identify the possible cause of death and any contributory factors. All agencies involved with the child and family before and at the time of their death are invited to the meeting.

The main purpose of the meeting is for sharing information to identify the cause of death and/or those factors that may have contributed to the death which includes modifiable factors and then to plan the future care for the family. Potential lessons to be learned may also be identified by this process.

After the meeting, the Designated Doctor will prepare a summary of the issues discussed, including any factors thought to have contributed to the child's death, lessons to be learned and action points. This summary will be forwarded to Durham/Darlington LSCB for consideration at the Child Death Overview Panel. Analysis Proforma will usually be completed after discussion at the Child Death Overview Panel.

Child Death Review Process

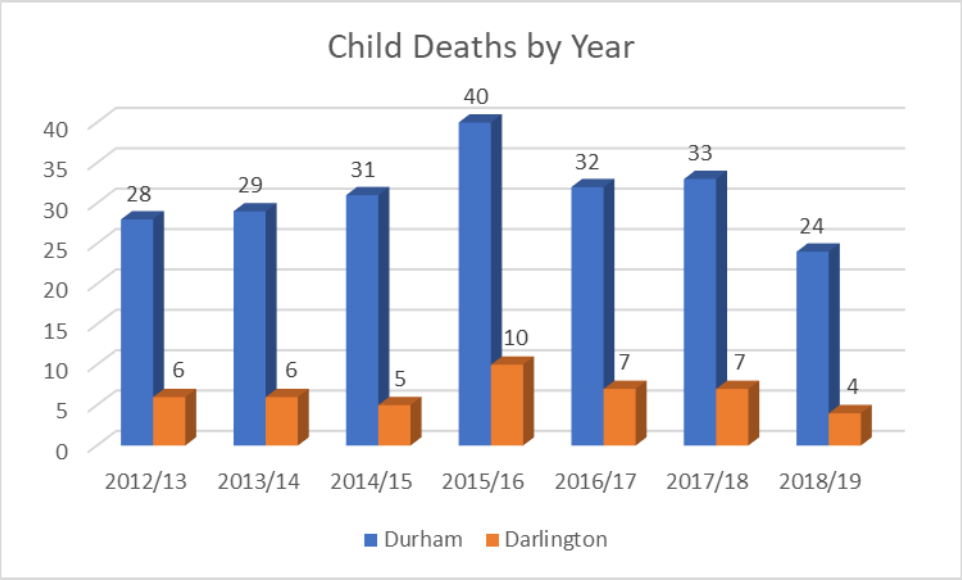


Child Death Review Activity

Child Death Review Notifications

24 children living in Durham and 4 children in Darlington died between 1 April 2018 and 31 March 2019.

Figure 1: The number of child deaths by Local Authority by year



Unexpected Child Deaths

An **unexpected death** is **defined** as the **death** of an infant or **child** (less than 18 years old) which was not anticipated as a significant possibility 24 hours before the **death** or where there was a similarly **unexpected** collapse or incident leading to or precipitating the events which led to the **death**.

Table 1: Rapid Response Activity

2014/15	2015/16	2016/17	2017/18	2018/19
25	25	20	21	20

Child Death Overview Panel Performance

Between April 2018 and March 2019 there were four Child Death Overview Panels in which 39 cases were reviewed.

The Panel does not review cases until all information is gathered and other processes have been completed such as Serious Incident Reviews, Root Cause Analysis, criminal proceedings and Serious Case Reviews. At each Child Death Overview Panel, the Designated Doctor for Child Deaths presents the circumstances of each death to the multi-agency panel. The case is reviewed in detail and recommendations/actions logged for monitoring purposes.

Of the 39 cases reviewed in 2018/19 the following table details the time period in which death occurred:

Number of deaths which occurred in 2015/16	Number of deaths which occurred in 2016/17	Number of deaths which occurred in 2017/18	Number of deaths which occurred in 2018/19
1	7	29	2

The CDOP determined out of the 39 cases reviewed there were modifiable factors in four deaths.

A statutory function of the CDOP is to identify and refer cases of concern to the relevant Local Safeguarding Children Board. There was one case referred by CDOP for consideration of a Serious Case Review which was not progressed. It is of note that there are other means of making a referral for a Serious Case Review before the formal CDOP process.

Timescale for Child Death Review Completion

Out of 39 completed reviews, 5% were completed in less than six months. There has been a 50% increase in the number of reviews completed between 8-11 months. Possible reasons for those taking longer than six months to complete include 18 cases subject to other proceedings. The Child Death Overview Panel has agreed to not complete a Child Death Review until all relevant information has been received. A monitoring system has been built into the Child Death Database to specifically identify the reasons for this as well as an escalation process to address agency report forms not submitted within a timely manner.

35 child death reviews have not yet been reviewed; one from 2014/15, two from 2016/17, eight from 2017/18 and 24 from 2018/19. These cases will continue to be monitored and regular updates provided to the CDOP throughout 2019/20.

Figure 2: Timeline between Child Death Notification and Completion

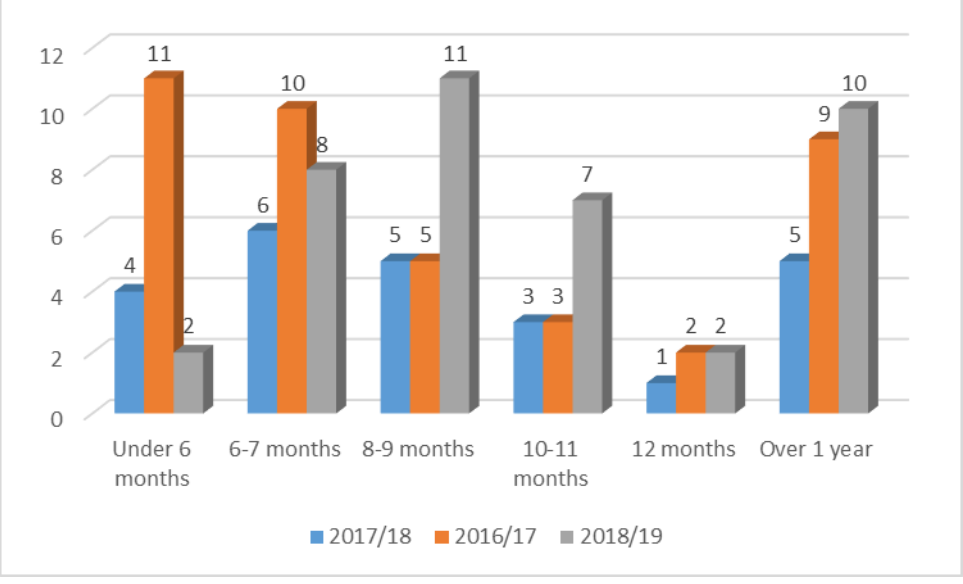
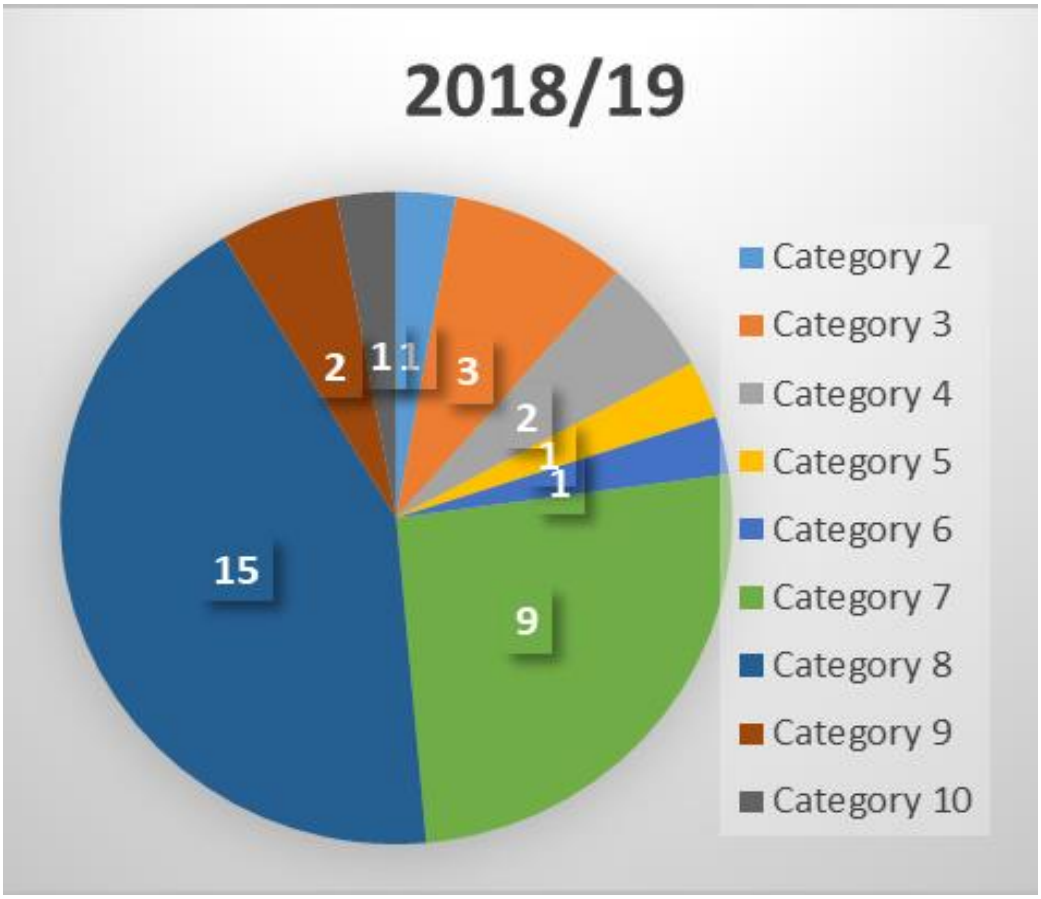


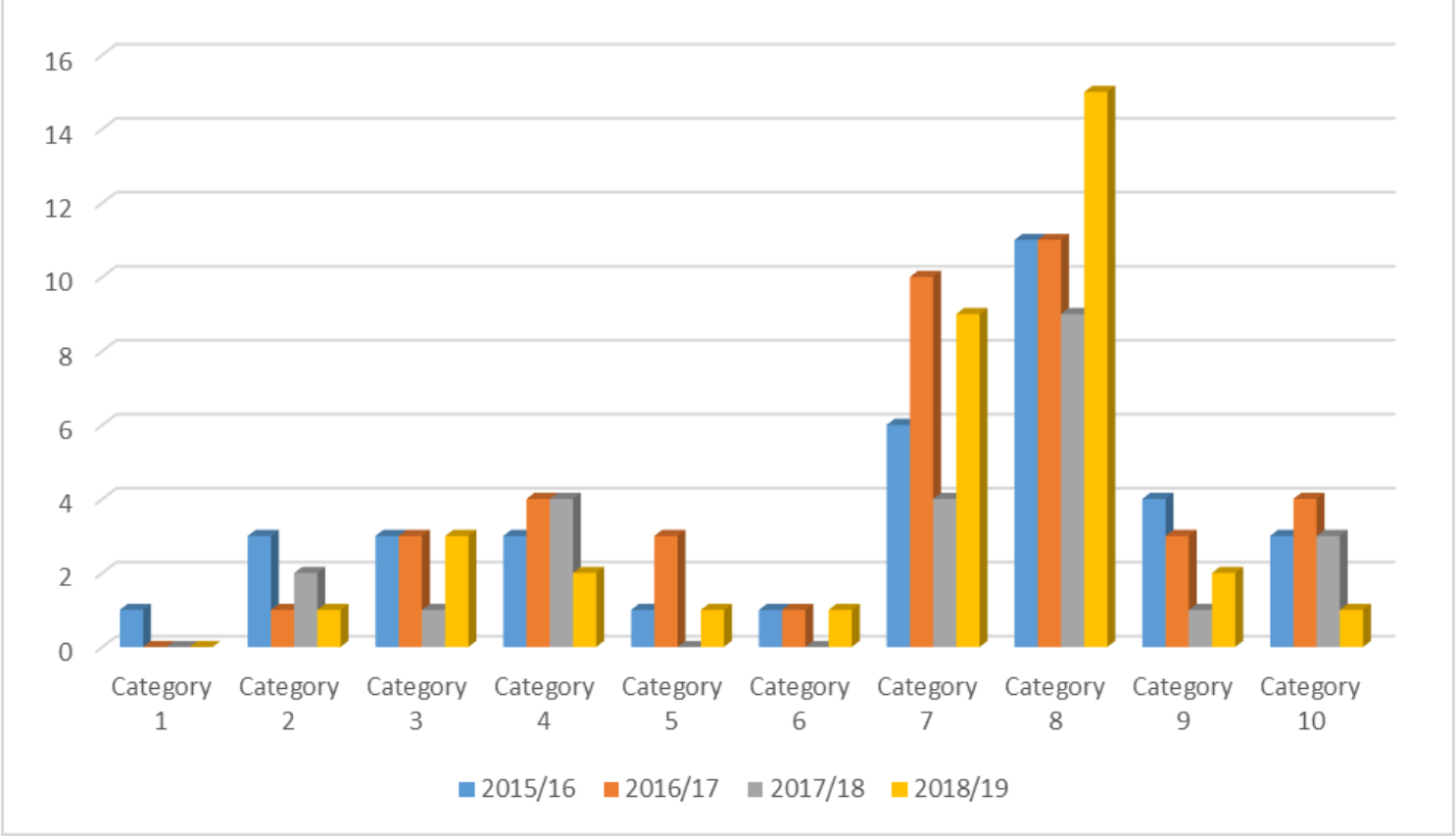
Figure 3: Category of Deaths
Categorisation is nationally determined and a glossary regarding the categorisation is found at Appendix 2.

The majority of deaths relate to life limiting conditions and perinatal/neonatal deaths which has consistently been the highest categories since the data has been collected. In this reporting period the CDOP determined that there were potentially modifiable factors three cases of sudden unexpected, unexplained deaths and two cases categorised as suicide or deliberate self-harm.



Category 2	Suicide or deliberate self-inflicted harm	**Category 9**	Infection
Category 3	Trauma and other external factors	**Category 10**	Sudden unexpected, unexplained death
Category 4	Malignancy		
Category 7	Chromosomal, genetic and congenital anomalies		
Category 8	Perinatal/neonatal event		

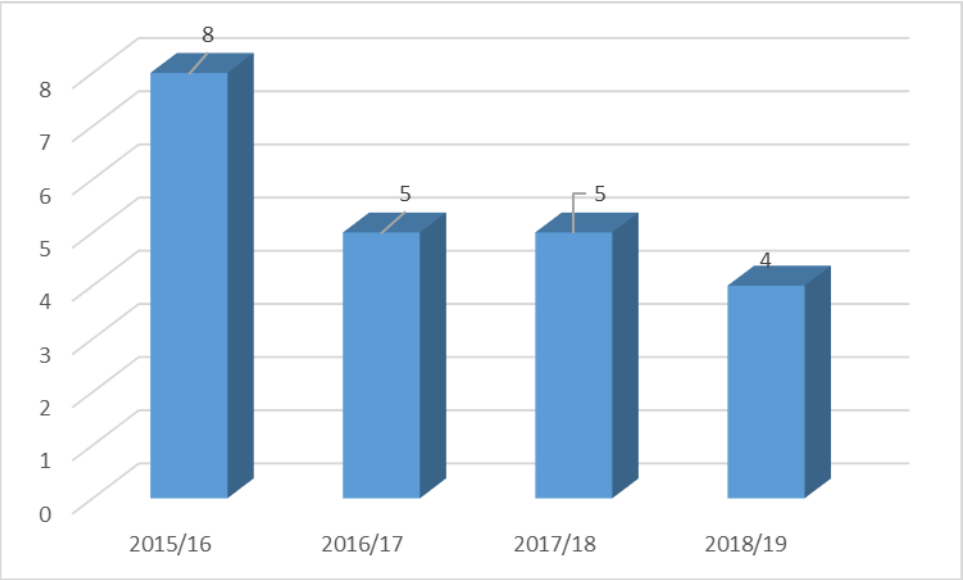
Chart 3: Category of Deaths (comparison with previous years)



Category 1	Deliberate inflicted injury, abuse or neglect	**Category 6**	Chronic medical condition
Category 2	Suicide or deliberate self-inflicted harm	**Category 7**	Chromosomal, genetic and congenital anomalies
Category 3	Trauma and other external factors	**Category 8**	Perinatal/neonatal event
Category 4	Malignancy	**Category 9**	Infection
Category 5	Acute medical or surgical condition	**Category 10**	Sudden unexpected, unexplained death

Chart 4: Modifiable Factors

Modifiable factors are factors that may have contributed to the death of the child and which, by means of locally or nationally achievable interventions could be modified to reduce the risk of future deaths.



Modifiable factors were identified in 4 deaths (10%) reviewed in 2018-19. Locally this is a slight decrease compared to 2017-18. Parental smoking in the household and smoking during pregnancy were identified as being modifiable factors.

Contributory Factors

The following findings relate to the child death reviews completed during the reporting period:

Child's Needs,

- 18 health factors were identified which was determined to provide a complete and sufficient explanation for the death.

Family and Environment,

- There were two cases where smoking during pregnancy was identified as to having contributed to the vulnerability, ill-health or death of the child
- There was one case where parental substance misuse was identified as to having contributed to the vulnerability, ill-health or death of the child.
- There was one case where the child's mental health and emotional wellbeing was identified as to having contributed to the vulnerability, ill-health or death of the child.
- There was one case where co-sleeping was identified as to having contributed to the vulnerability, ill-health or death of the child.

Service Provision,

- There were two cases where access to health care and prior surgical intervention was determined to provide a complete and sufficient explanation for the death.
- There was one case where access to health care was identified as to having contributed to the vulnerability, ill-health or death of the child.

Chart 5: Where the child was at the time of death

The majority of deaths considered by the Child Death Overview Panel during the reporting period occurred at hospital (67%); there were modifiable factors identified in two of these cases.

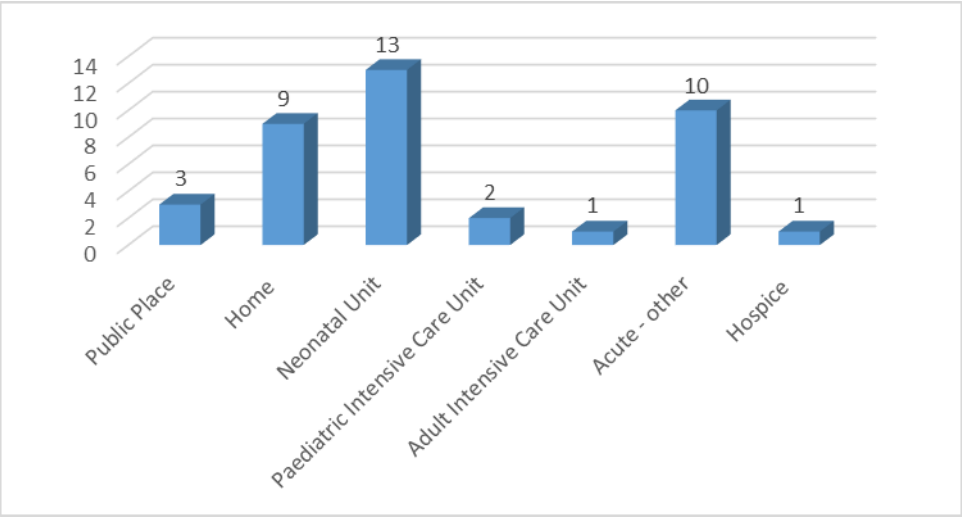


Chart 6: Ages of Children

The deaths of children under one year old (neonatal and post-neonatal) account for around 69% of all child deaths.

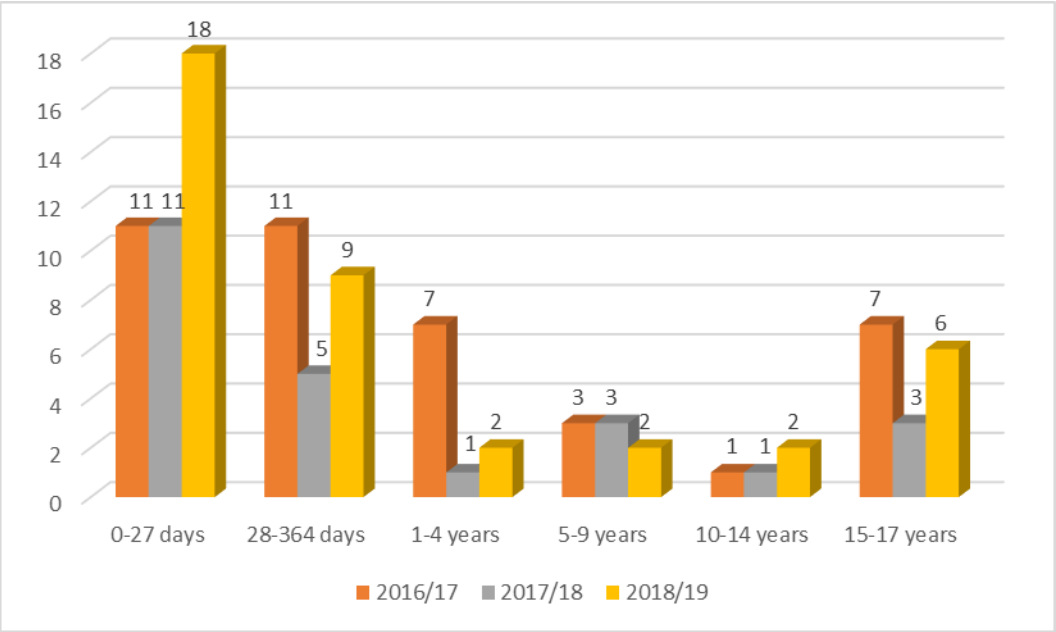
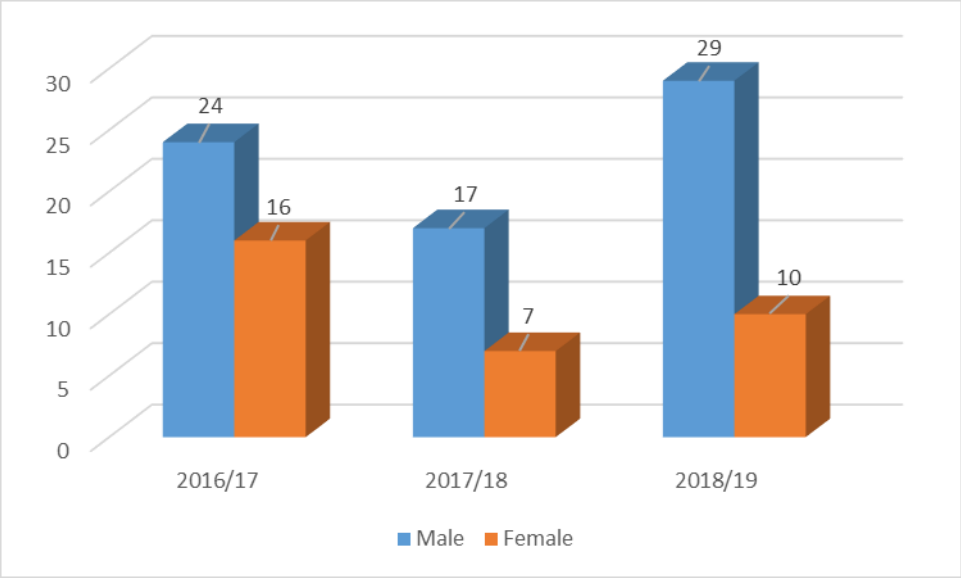


Table 7: Gender

The reporting period demonstrates 74% of completed cases being in relation to male deaths which is slightly higher than last year.



National and Regional Information

The Child Death Overview Panel has been reviewed and is compliant with new Working Together to Safeguard Children guidance 2018. Membership has been reviewed to include a GP at each meeting, and lay member engagement during thematic reviews.

To ensure robust scrutiny and challenge, Public Health England has agreed to work across four CDOPs in the north East of England, undertaking thematic reviews of: suicide and deliberate self-harm; sudden unexpected deaths; trauma and neonatal deaths.

Also, County Durham and Darlington CDOPs will share joint learning with Tees Valley CDOP via twice yearly challenge review meetings

Analysis of Key Learning

Key Issues & Learning Points from Child Death Reviews completed during 2018/19

Babies with life limiting conditions
There is a need to ensure that relevant teams within Tertiary Services, District and Community Health Services are involved in discharge planning and Health Care Plans to ensure that the family receive support during the antenatal and postnatal period and that documentation is shared across all services. There is regional Neonatal Care Comfort Bundle checklist available that would improve communication across all Health sectors.

Accidental Deaths
As part of Primary Care and routine visits by the Health Visiting Service consideration to be given to reinforcing safety outdoors as well as safety indoors.

One case was subject to a Serious Case Review which highlighted issues regarding the hazardous risks of paracetamol overdose and the need to understand the increasingly digital lives that children lead. Work is underway jointly with Public Health and the Safe Durham Partnership to consider ways of improving public awareness and methods of promoting healthy and positive online use.

Children with Chronic Medical Conditions
There was a failure to recognise a critical and acute illness in a child with an underlying chronic and complex condition. In terms of learning, consideration should be given to implementing the Difficulty Airway Society Extubation guidelines. There was also a delay in the child receiving oxygen therapy prior to admission to hospital and assurances have been sought from the CCG in terms of the issues identified for Primary Care and the Ambulance Service.

Neonatal Deaths
There were similar themes identified from a previous External Review of Maternity Services in terms of paediatric input in the management of a high risk mother and delivery of her baby and this will be subject of a Regional Thematic Review of Neonatal Deaths. In the meantime, a Standard Operating Procedure has been developed regarding the involvement of a Consultant Paediatrician which will be subject of the Thematic Review to ensure that it is fit for purpose.

Areas of Good Practice

There was early action taken in the management a high risk mother and delivery of her baby in terms of prompt transfer to a Tertiary Centre and subsequent interventions.

The 0-19 Service has commissioned specialist training for Health Visitors and School Nurses in respect of bereavement support with a view of providing support to the siblings who have experienced the loss of a family member. This is being supported by Public Health.

It was considered to be good practice that the Rapid Response Team and Designated Paediatrician strive to ensure that parents are kept informed at all stages of the investigation after an unexpected death and have the opportunity to ask questions and raise issues that can be considered at the case discussion.
The Rapid Response Nurse and Designated Paediatrician jointly meet with parents where appropriate to share the findings from the post mortem.

Developments during 2018/19

Training

Training continues to be delivered to individual staff groups in order to raise awareness regarding the Child Death Review process and the roles, responsibilities and expectations in respect of those requested to provide information.

Joint training has been delivered by the Police and Rapid Response Manager as part of the national training for Detective Inspectors regarding the Child Death Review process in County Durham.

Harrogate & District NHS Foundation Trust have secured funding to train up to 10 staff from the 0-19 in bereavement support for children and young people. It is envisaged that those trained will offer bereavement support for any child or young person who are struggling with a loss of a family member.

CDOP Identified Developments for 2019/20

1. **Regional Thematic Review –**
   - Suicide or deliberate self-inflicted harm – July 2019
   - Sudden & Unexpected Deaths in Infancy – October 2019
   - Trauma Deaths – December 2019**
   - Neonatal Deaths – March 2020

2. **Continuation of Service Provision for Child Death Review Administration for Unexpected Deaths 2019/20**
   A Service Level Agreement is ongoing between County Durham & Darlington NHS Foundation Trust and Durham LSCB for administration support to the Designated Doctor and Rapid Response Team for unexpected deaths and Local Case Discussions as this provides the benefit of seamless continuity.

3. **To operate effectively under the new Working Together guidance**

Appendix 1

CDOP Membership as at 31 March 2018	
Gill O'Neill (Chairperson)	Deputy Director of Public Health Durham County Council
Jacqui Doherty	Business Manager, Durham LSCB
Amanda Hugill	Business Manager, Darlington SCB
Emma Maynard	Admin Co-ordinator, Durham LSCB
Claire Wallace	Deputy Head of Safeguarding Harrogate & District NHS Foundation Trust
Dr Nnenna Cookey	Designated Paediatrician for Child Deaths County Durham & Darlington NHS Foundation Trust
Dr Nicola Cleghorn	Designated Paediatrician for Safeguarding North Durham, DDES & Darlington CCG
Catherine Hodgkiss	Rapid Response Manager County Durham & Darlington NHS Foundation Trust
Anne Holt	Associate Director of Nursing – Family Health County Durham & Darlington NHS Foundation Trust
Detective Superintendent Dave Ashton	Force Lead for Safeguarding Durham Constabulary
Chris Ring	Strategic Manager – Safeguarding & Professional Practice Durham Children & Young People's Service
Yvonne Coates	Head of First Contact & Locality Services Darlington Children's Services
Karen Arkle	Named Lead Professional for Safeguarding Children North East Ambulance Service NHS Foundation Trust
Heather McFarlane	Designated Nurse Safeguarding & Looked After Children North Durham, DDES & Darlington CCGs
Karen Agar	Associate Director of Nursing & Governance Tees, Esk & Wear Valleys NHS Foundation Trust

Appendix 2 – Glossary re Child Death Categorisation

Name & description of category
Deliberately inflicted injury, abuse or neglect This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.
Suicide or deliberate self-inflicted harm This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.
Trauma and other external factors This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. **Excludes** Deliberately inflected injury, abuse or neglect. (category 1).
Malignancy Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.
Acute medical or surgical condition For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.
Chronic medical condition For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.
Chromosomal, genetic and congenital anomalies Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease,cystic fibrosis, and other congenital anomalies including cardiac.
Perinatal/neonatal event Death ultimately related to perinatal events, eg sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).
Infection Any primary infection (ie, not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.
Sudden unexpected, unexplained death Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).