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

2020/21

Introduction

This year's report contains the summary of activity carried out by the County Durham and Darlington Child Death Overview Panel (CDOP) which seeks to drive improvements improve the health, safety and wellbeing of children and young people in County Durham and Darlington.

Child Death Review Process

The child death review process covers children under 18 years of age. A child death review must be carried out for all children regardless of the cause of death.

This includes the death of any live-born baby where a death certificate has been issued. In the event that the birth is not attended by a healthcare professional, child death review partners will carry out initial enquiries to determine whether or not the baby was born alive. If these enquiries determine that the baby was born alive the death must be reviewed.

For the avoidance of doubt, it does not include stillbirths, late foetal loss, or terminations of pregnancy (of any gestation) carried out within the law.

Cases where there is a live birth after a planned termination of pregnancy carried out within the law are not subject to a child death review.

Background to the Child Death Review Process

Since April 2008 all deaths of children up to the age of 18 years, excluding still births and planned terminations are to be reviewed by a Child Death Overview Panel (CDOP) to accommodate the national guidance and statutory requirement set out in Working Together to Safeguard Children 2018.

Child Death Review partners, the Local Authorities and Clinical Commissioning Groups for County Durham and Darlington now hold responsibility for the delivery of the Child Death Review Process as set out in the Children Act 2004, as amended by the Children and Social Work Act 2017. The CDOP is multiagency with differing areas of professional expertise. This process is undertaken locally for all children who are normally resident in County Durham and Darlington.

Child Death Review Process

There are three interrelated processes for reviewing child deaths:

1. Joint Agency Response

A co-ordinated multi-agency response (on-call health professional, police investigator, duty social worker), should be triggered if a child's death:

- is or could be due to external causes;
- is sudden and there is no immediately apparent cause (including SUDI/C);
- occurs in custody, or where the child was detained under the Mental Health Act;
- where the initial circumstances raise any suspicions that the death may not have been natural; *or*
- in the case of a stillbirth where no healthcare professional was in attendance.

2. Child Death Review Meeting

This is the multi-professional meeting chaired by the Designated Paediatrician for Child Deaths and attended by professionals directly involved in the care of that child during life and those involved in the investigation after death. The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved.

3. Child Death Overview Panel

A multi-agency panel set up by CDR partners to review the deaths of all children normally resident in County Durham and Darlington in order to learn lessons and share any findings for the prevention of future deaths.

The collation and sharing of all learning from Child Death Reviews and the CDOP is now managed by the National Child Mortality Database (NCMD) which became operational on 1 April 2019.

National Child Mortality Database

Every child death is heart-breaking. Families, friends and others who knew the child by these events and their lives are changed immeasurably. As a society it is incumbent upon us to learn from these tragedies and to identify ways in which we can change things to reduce the number of children who die in the future. The National Child Mortality Database (NCMD) was set up with this very aim in mind and this report gives a valuable source of information for providers of services, commissioners and policymakers to support evidence-based decision making to improve the health and well-being of children.

Purpose of Child Death Review

The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If the Child Death Overview Panel identify action that be taken by a person or organisation, they must inform them.

In addition, the Child Death Review Partners:

- Must prepare and publish reports on:
  - what they have done as a result of the child death review arrangements in their area, *and*
  - how effective the arrangements have been in practice;
- may request information from a person or organisation for the purposes of enabling or assisting the review and/or analysis process - the person or organisation must comply with the request, and if they do not, the child death review partners may take legal action to seek enforcement
- may make payments directly towards expenditure incurred in connection with arrangements made for child death reviews or analysis of information about deaths reviewed, or by contributing to a fund out of which payments may be made; and may provide staff, goods, services, accommodation or other resources to any person for purposes connected with the child death review or analysis process.

The Child Death Overview Panel

The Child Death Overview Panel (CDOP) is a joint sub-group of Durham Safeguarding Children Partnership and Darlington Safeguarding Partnership. The Child Death Overview Panel meetings are held on a bi-monthly basis and there has been consistent organisational commitment since the Panel was established in 2008 (membership can be found at Appendix 1.

The Panel has two distinct elements:

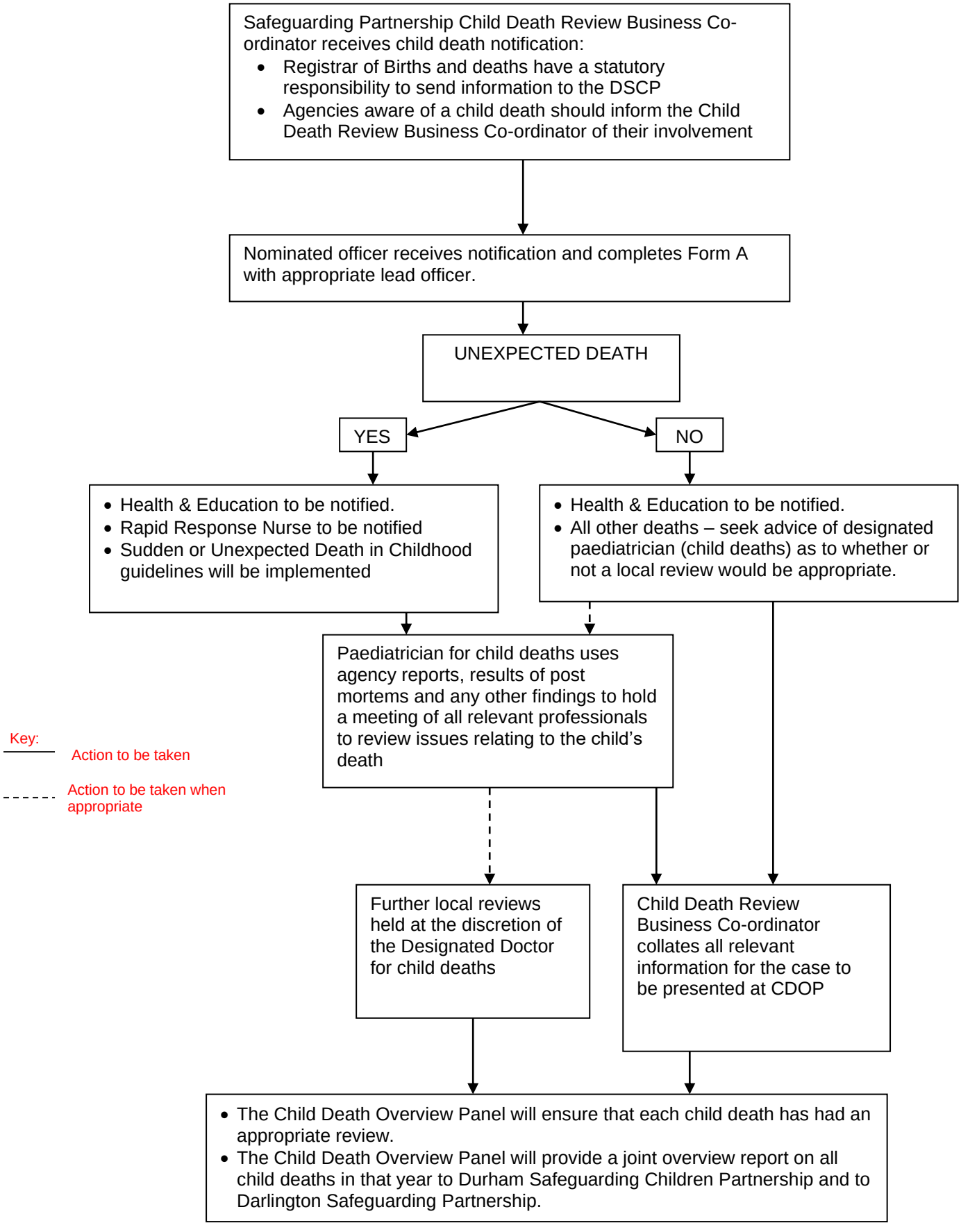
1. **Case reviews**
   The Panel categorise a likely/cause of death, identify any environmental, extrinsic, medical or personal modifiable factors that may have contributed to the death and consider any agency, strategic, regional and/or national recommendations to prevent future deaths.

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

The role of the Designated Doctor (child deaths) is carried out by a Consultant Paediatrician and the Joint Agency 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 Joint Agency Response process augments the local review of all unexpected deaths and ensures that parents are engaged and received appropriate support during the process.

The Child Death Overview Panel is the Director of Public Health to support the identification of key themes that can be raised and progressed by relevant strategic forums such as the Health & Wellbeing Board.

Child Death Review Process Flowchart



Child Death Review Activity

Child Death Review Notifications

18 children living in Durham and 11 children in Darlington died between 1 April 2020 and 31 March 2021.

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

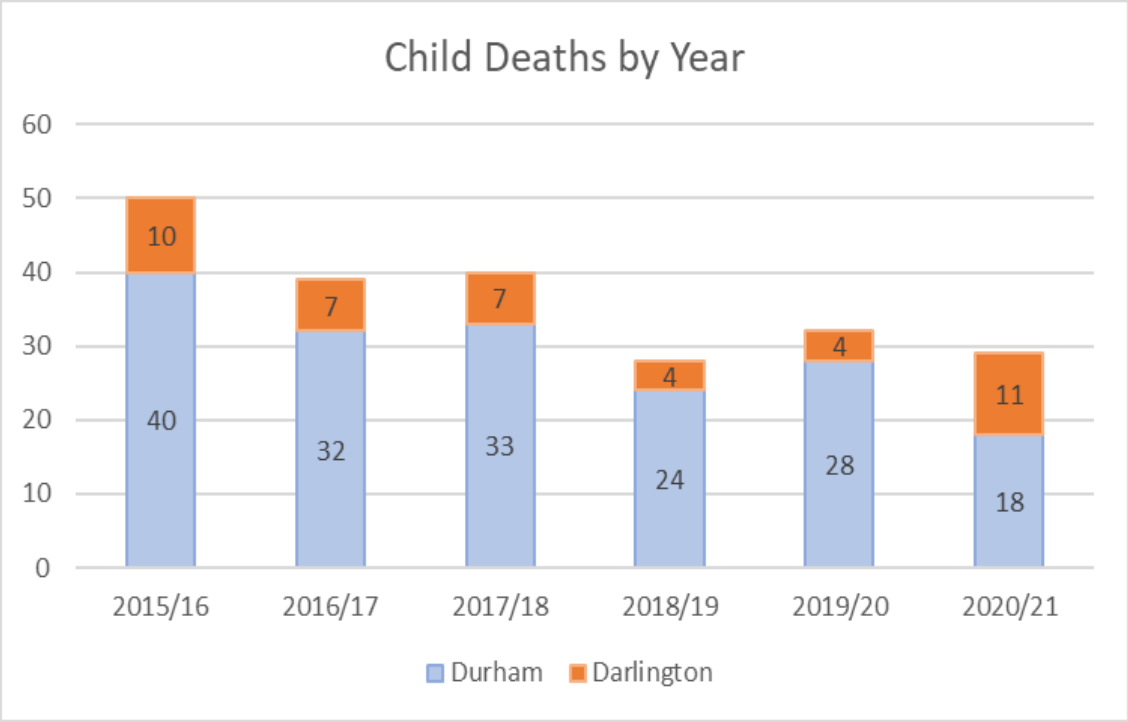
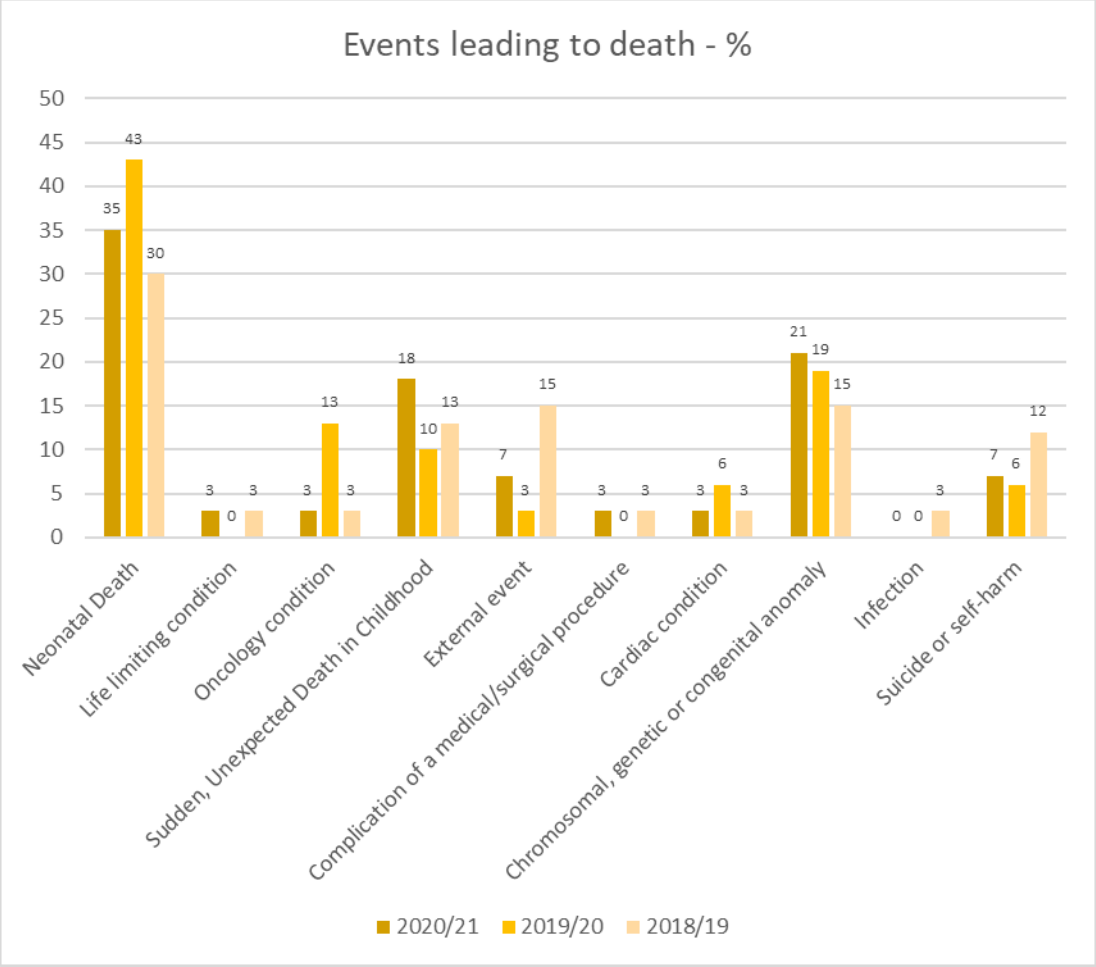


Figure 2: Events leading to death % by year



Child Death Overview Panel Performance

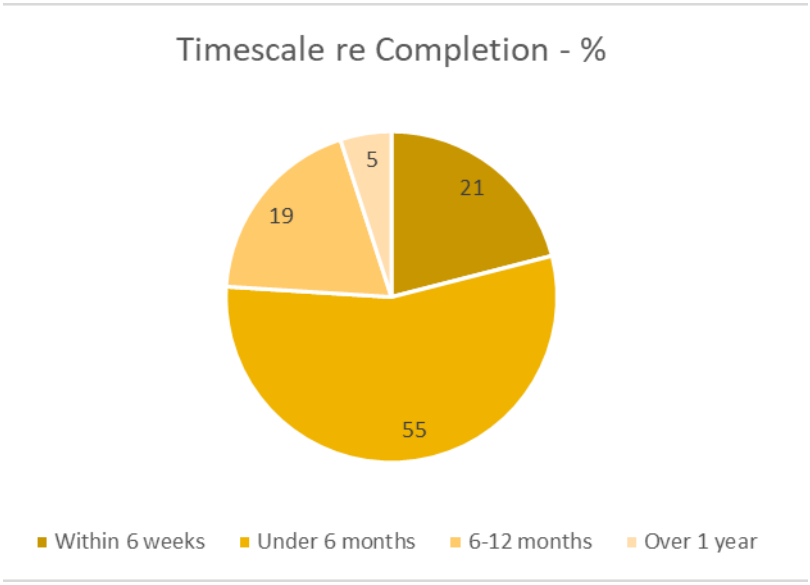
Between April 2020 and March 2021 there were four Child Death Overview Panels in which 43 cases were reviewed.

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.

34 child death reviews are ongoing; 18 of which cannot be completed until other proceedings have been concluded.

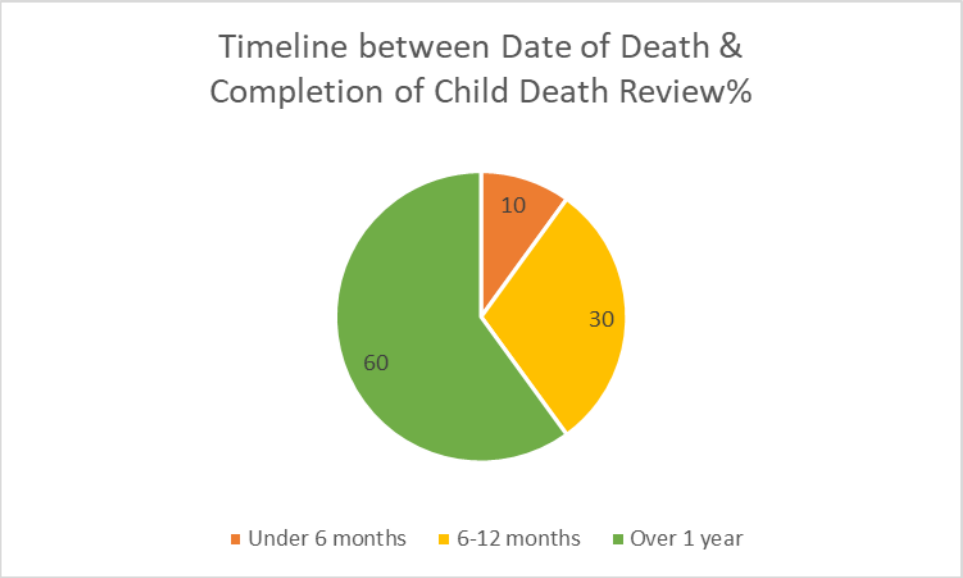
Timescale for Child Death Review Completion

Figure 3: % of CDOP completed cases by time taken between all information being received and completed at the Child Death Overview Panel.



The Child Death Review Statutory & Operational Guidance states that CDOPs should aim to review all children's deaths within six weeks of receiving all information including the results of the Coroner's Inquest. Out of 43 completed reviews, 21% were completed in less than six weeks. This has been compounded following the COVID-19 pandemic throughout 2020-21. A decision was reached that all face to face meetings would be suspended and future Child Death Overview Panel meetings would be held virtually. The Panel considers that this transition has been successful and has not impacted on the quality and discussion at the Panel meetings.

Figure 4: Timeline between Child Death Notification and Completion



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.

Figure 5: Timeline between Child Death Notification and Completion

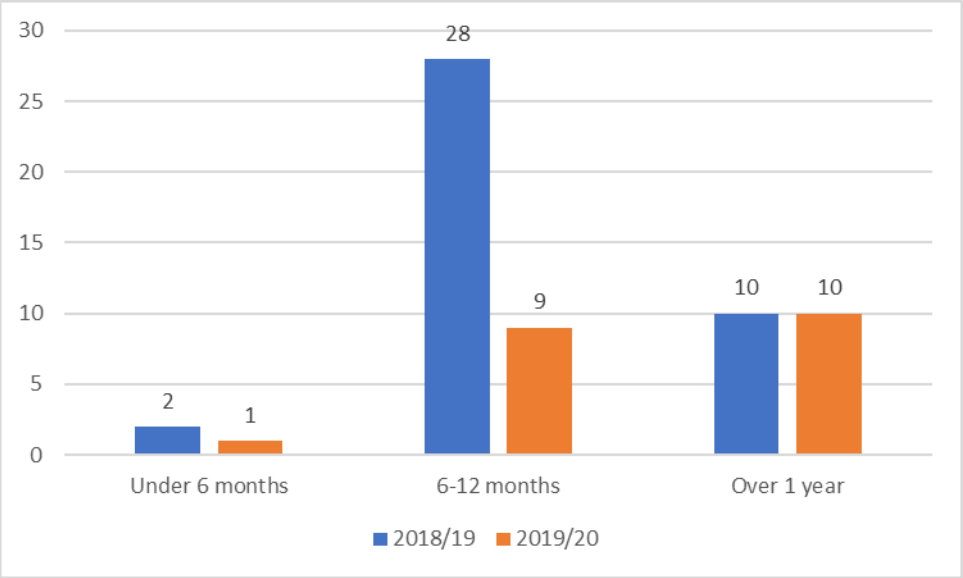
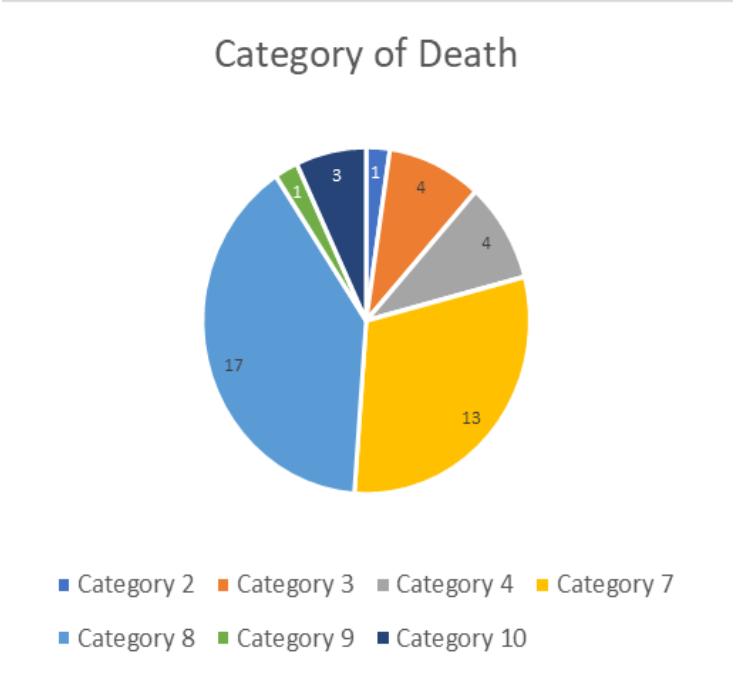


Figure 6: Category of Deaths
Categorisation is nationally determined.

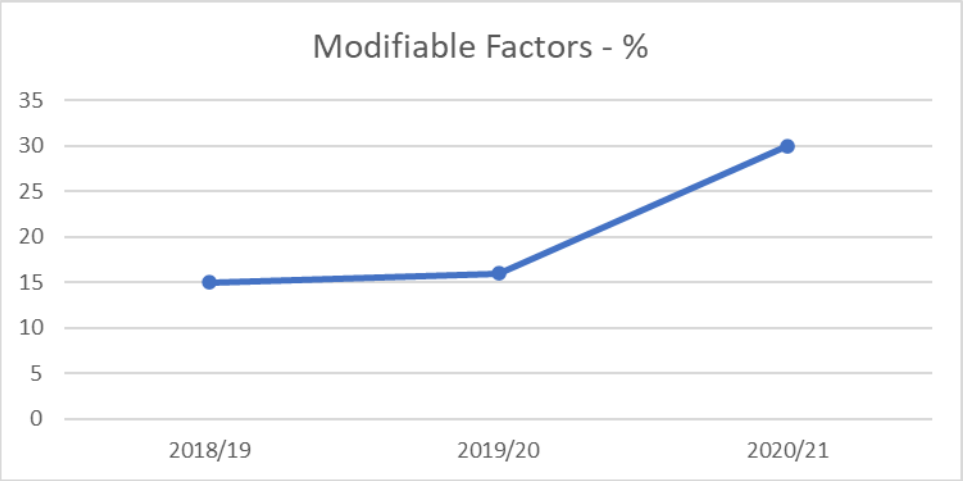
The majority of deaths relate perinatal/neonatal deaths which has consistently been the highest categories since the data has been collected.



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

Chart 7: 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.

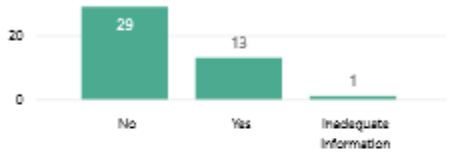


Modifiable factors were identified in 12 deaths (30%) reviewed in 2020-21. Locally this is a significant increase compared to 2019-20. Common modifiable factors identified include maternal BMI; smoking during pregnancy and co-sleeping. **It is therefore, recommended that a Thematic Review of modifiable factors is undertaken during 2021/22**.

Chart 8: Completed Reviews – Modifiable Factors compared with England

Number of cases reviewed 20/21:	% cases with modifiable factors (CDOP):	% cases with modifiable factors (England):
43	30%	34%

Were any modifiable factors identified?



% of cases where modifiable factors were identified by age group

Age group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
0 - 27 days	18	6	33%
28 - 364 days	12	6	50%
1 - 4 years	6	1	17%
5 - 9 years	3	0	0%
10 - 14 years	1	0	0%
15 - 17 years	3	0	0%
Total	43	13	30%

% of cases where modifiable factors were identified by category of death

Primary category of death (CDOP)	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Acute medical or surgical condition	0	0	0%
Chromosomal, genetic and congenital anomalies	13	1	8%
Chronic medical condition	0	0	0%
Deliberately inflicted injury, abuse or neglect	0	0	0%
Infection	1	0	0%
Malignancy	4	0	0%
Perinatal/neonatal event	17	8	47%
Sudden unexpected, unexplained death	3	3	100%
Suicide or deliberate self-inflicted harm	1	0	0%
Trauma and other external factors, including medical/surgical complications/error	4	1	25%
Total	43	13	30%

% of cases where modifiable factors were identified by ethnic group

Ethnic Group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Asian or Asian British	1	0	0%
Black or Black British	1	0	0%
Mixed	1	1	100%
Other	3	2	67%
Unknown	0	0	0%
White	37	10	27%
Total	43	13	30%

Chart 8: Where the child was at the time of the event which led to death

The majority of deaths considered by the Child Death Overview Panel during the reporting period occurred at a Neonatal Unit (33%). This is in line with the number of neonatal deaths completed.

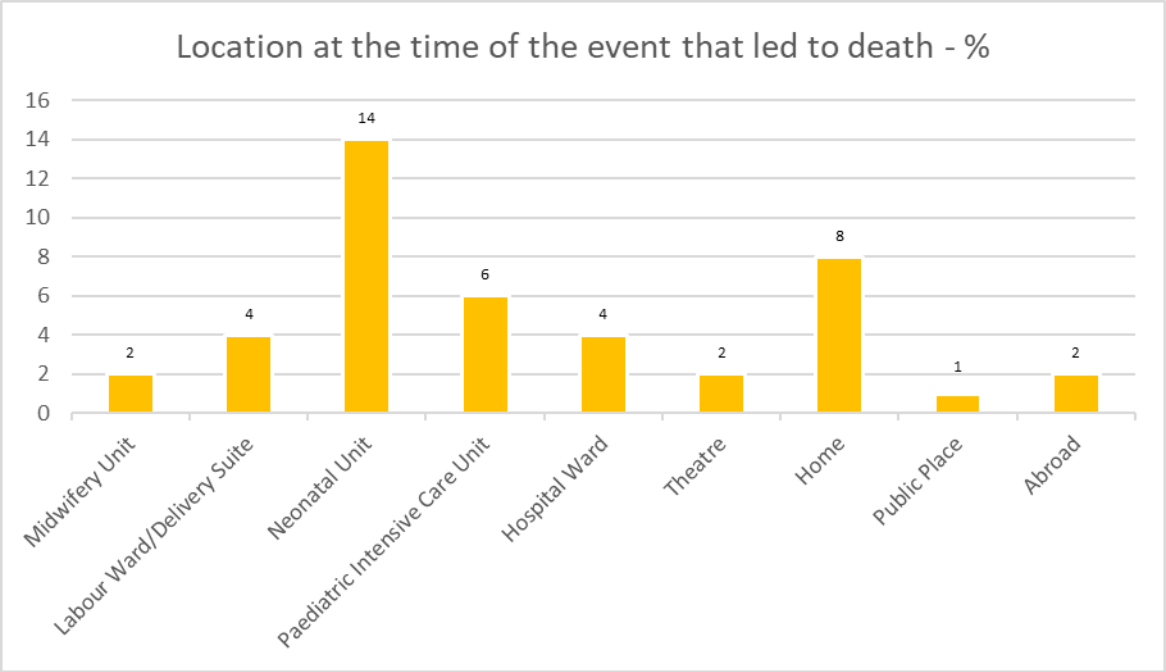


Chart 9: Ages of Children

The deaths of children under one year old (neonatal and post-neonatal) account for around 67% of all child deaths.

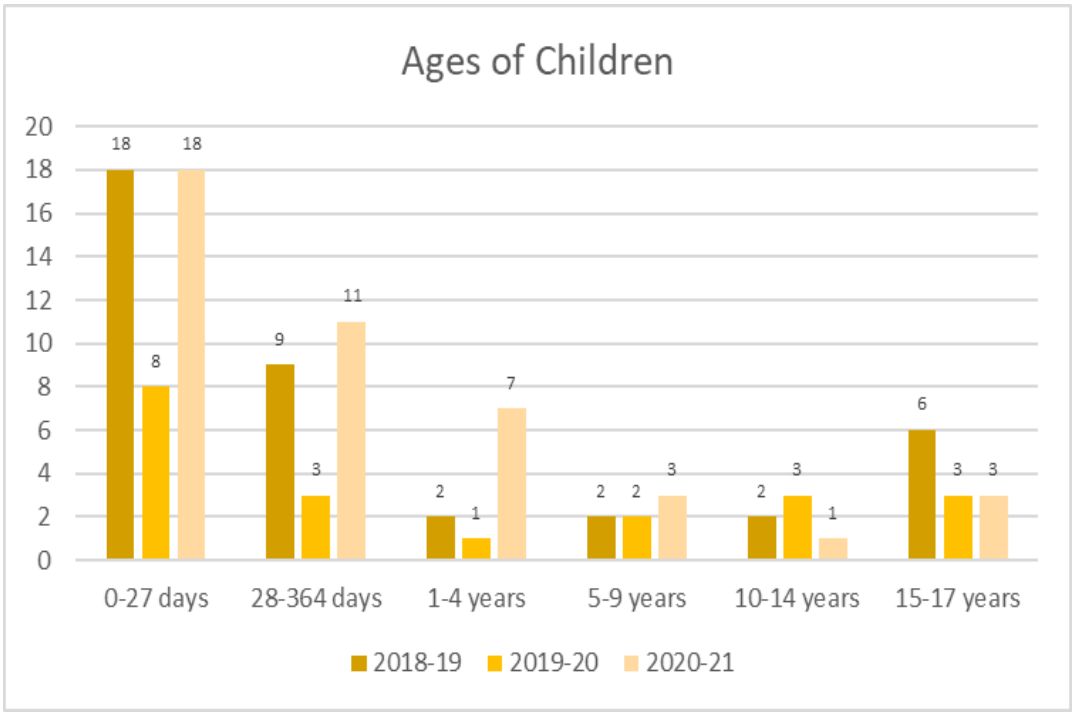
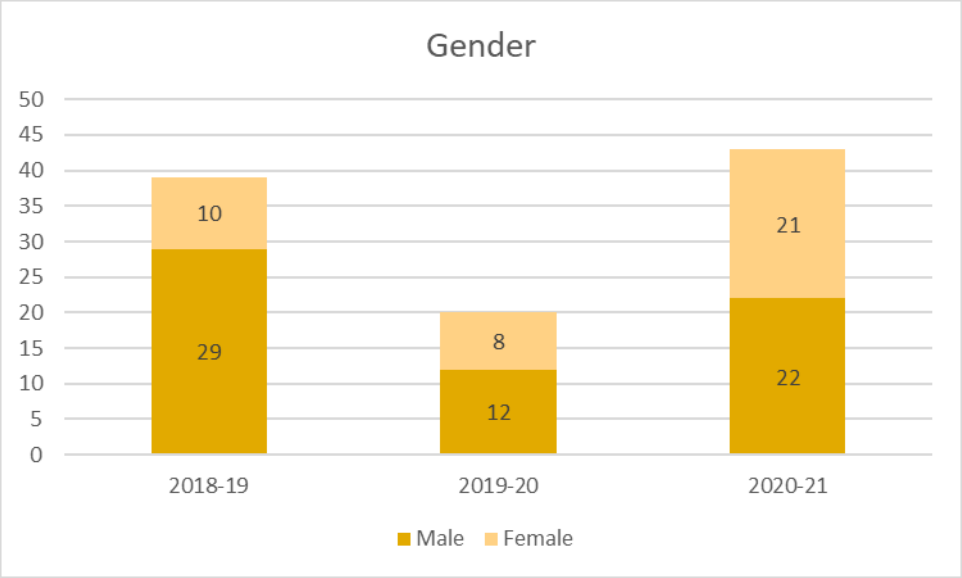


Table 8: Gender

The reporting period demonstrates 51% 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 continues to be fully compliant with Child Death Review Statutory and Operational Guidance launched in October 2018. The revised national Child Death Review reporting templates launched by the DfE in March 2021 have been fully implemented in the Child Death Review process.

County Durham & Darlington Child Death Overview Panel continues to be fully compliant with the data sharing processes launched via the National Child Mortality Database.

County Durham & Darlington Child Death Overview Panel continues to engage with the LeDeR Project and arrangements are in place to share information following a child death where the child has a learning disability.

Analysis of Key Learning

Learning from Child Death Reviews

The aggregated findings from all child deaths informs local strategic planning including the joint strategic needs assessment, on how to best safeguard and promote the welfare of children in the area. This annual report will assist in ensuring that learning from CDOP is shared with partners and informs the wider Durham Safeguarding Children Partnership and Darlington Safeguarding Partnership annual reports

Key Issues & Learning Points from Child Death Reviews completed during 2020/21

The following modifiable factors and key learning points identified from the Child Death Reviews completed during 2020/21 have been condensed into the following concise bullet points to maintain the anonymity of the cases discussed:

- Smoking in the household
- Smoking during pregnancy
- Management of high risk pregnancies
- Co-sleeping and parental alcohol and/or substance misuse

The learning from some of these cases are outlined in the section Developments During 2020/21 and Developments for 2021/22.

Areas of Good Practice

There were a number of cases where it was acknowledged the support and actions taken by professionals involved with a child/young person and their parents/carers was highly commendable and was considered to be over and beyond their roles and responsibilities.

The role of the Rapid Response Service continues to be identified as being a highly invaluable resource, examples included:

- Working together with the Police in the joint investigation of a sudden or unexpected death of a child;
- The Joint Agency Response process in terms of convening a joint Information Sharing and Strategy Meeting which assisted the role of the Team Manager in exploring and clarifying the medical information shared in order to inform the next steps to be taken by Children's Social Care;
- The role of the Joint Agency Response in terms of the sharing of information; co-opting other key agencies to the JAR process; and putting in place mechanisms to identify young people who may/have been affected by the death and to escalate those young people who were considered to have additional vulnerabilities and were a heightened risk in terms of their own safety and wellbeing.

Developments during 2020/21

A review of Sudden Unexpected Death in Infancy in families where the children are considered at risk of significant harm

The 2nd National Panel Review regarding Sudden Infant Deaths published in July 2020 has been considered by CDOP agency representatives and as a result a local workstream has been set up to develop a raising awareness campaign that provides consistent messages regarding safer sleeping. Other developments include the wider engagement by services such as domestic abuse, drug and alcohol and housing services in other key areas of work.

ICON – Parental/Carer advisory programme to reduce potential traumatic head injury in infants

In County Durham we have had an unprecedented number of case reviews where children have been seriously harmed and either died as a result or suffered life changing injuries. Four of the cases in County Durham involved young babies. Children in infancy are especially vulnerable to abuse and neglect, due to their dependency on adults.

ICON as a preventative and evidence based programme, aims to provide advice consisting of a series of brief 'touchpoint' interventions that reinforce the simple message making up the ICON acronym;

"**I**nfant crying is normal, **C**omforting methods can help, **O**kay to walk away,
Never ever shake your baby."

It is hoped that roll out can begin in February 2021 – this may be impacted by the COVID response required by health agencies. However, the members of the task and finish group have committed to identifying their internal SPOCs to train in preparation for roll out. A media campaign will be the responsibility of each organisation.

Born in the Right Place

The regional Clinical Leads for the Neonatal and Maternity Networks had commenced a review of the policy and procedures regarding the advice given to Ambulance Service as to which hospital a mother with threatened pre-term labour is transported to.

Joint Agency Response in respect of Child Death Reviews involving suspected suicide

Formal arrangements have been implemented to co-opt the Public Health Suicide Prevention Co-ordinator to all Joint Agency Response Information Sharing meetings involving a child death where suicide is suspected to be a factor in the death.

Bereavement Support for Children & Young People

The implementation by Harrogate & District NHS FT in the delivery of bereavement training for children and young people has been extended to all staff, as a result of COVID-19, and an external provider has been commissioned to deliver this training.

Understanding Roles & Responsibilities and sharing of Medical Findings to non-medical professionals

Joint training has been delivered by the Police and Designated Doctor for Safeguarding to Paediatric Registrars across the region to raise awareness of communication with other agencies regarding medical findings and the impact that this could have in terms of the information they

share. Further work is ongoing to extend this to other services such as Children's Social Care to raise awareness and have a shared understanding of each other's roles and responsibilities.

Vicarious Trauma
The Durham Safeguarding Children Partnership recognise that working with traumatised children and young people and their families, and the impact of a serious childcare incident, e.g. death of a child open to services, can be emotionally and psychologically difficult for practitioners. As a result a briefing was launched in September 2020 for multi-agency frontline workers to have an understanding of vicarious trauma and how it can impact on their own wellbeing and affect their practice.

Interpretation of Cardiotocography (CTG)
Training has been increased for medical staff regarding the interpretations of CTGs. Further developments are also ongoing to implement a central electronic record for CTGs which is to be launched in early 2021. This will result in the co-ordinator to review CTGs from a central base as part of the "fresh eyes" system which will mean that CTG findings are not reliant on one individual judgement.

Transfer of Babies to Tertiary Centres
Hospital guidelines for the care of babies under 1.5g have been revised which means that babies meeting this criteria will be transferred to a tertiary centre.

North East Ambulance Service Policies & Procedures
More robust mechanisms have been put in place by the Ambulance Service and policies and procedures have been revised to set out clearly the roles and responsibilities and governance arrangements. This process has also been moved to an appropriate directorate and there are more joined up processes and information sharing between the Safeguarding Team and the Patient Experience Team.

Tees, Esk & Wear Valleys NHS FT
Changes have been made to the CAMHS Front End Service to ensure both young people and their parents/carers' voices are heard during the assessment process. The process of triangulation of information has also been strengthened along with the documentation regarding the rationale for decision making.

The Trust has been awarded funding to work together with other agencies across the system to provide support and guidance to aid them when working with young people including those that do not engage with the service.

Public Health Raising Awareness Campaigns – messages given to children and young people
The CDOP considered that Public Health should review the methodology in terms of the information and key messages targeted for children and young people, e.g. mental health, suicide and self-harm, online safety and use of social media; and how these are made available to them to ensure that it has sufficient reach.

Developments for 2021/22

Child Death Thematic Reviews
Greater links to be made with the Public Health Intelligence Team to provide input regarding any themes from the broader child mortality data.

Timescales for completion and receipt of Post Mortem Reports
It has been recognised that the length of time between a child death and receipt of the final post mortem report can have a profound impact on parents and it has been agreed that the timescales for the receipt of post mortem reports would be monitored and where relevant escalated for resolution.

Child Death Reviews vs Child Safeguarding Practice Reviews (formerly Serious Case Reviews)
It has been recognised that the length of time taken to complete a Child Safeguarding Practice Review (formerly Serious Case Review) can have a profound impact on the family and also impacts on the timescale in completing a Child Death Review. As a result, it has been agreed that the links and communication between the Safeguarding Partners and the Child Death Overview Panel would be strengthened in respect of Child Death Reviews where a Child Safeguarding Practice Review has been initiated.

Co-Sleeping, Parental Smoking and Parental Alcohol and/or Substance Misuse
The Child Death Overview Panel to consider a review of the information provided to parents regarding the dangers of co-sleeping whilst under the influence of alcohol and/or substance misuse. As a similar review is ongoing in a different CDOP area, it has been agreed that further enquiries are made in respect of this work to identify opportunities for learning from the work undertaken by that area that could be implemented in County Durham & Darlington.

Child Death Overview Panel Development Session
The Child Death Overview Panel to consider using one scheduled Panel meeting to consider any themes, learning and developments over the last five years to identify and demonstrate the impact of the work of the Child Death Overview Panel.

Appendix 1

CDOP Membership as at 31 March 2019	
Amanda Healy (Chairperson)	Director of Public Health Durham County Council
Jacqui Doherty	Business Manager, Durham Safeguarding Children Partnership
Amanda Hugill	Business Manager, Darlington Safeguarding Partnership
Emma Maynard (Co-ordinator for CDOP)	Durham Safeguarding Children Partnership Officer
Julie Potts	Named Nurse Child Protection Harrogate & District NHS Foundation Trust
Dr Nnenna Cookey	Designated Paediatrician for Child Deaths County Durham CCG
Dr Nicola Cleghorn	Designated Paediatrician for Safeguarding County Durham 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
Chris Bell	Head of Service – Early Intervention & First Contact Darlington Children's Services
Nichola Howard	Named Lead Professional for Safeguarding North East Ambulance Service NHS Foundation Trust
Heather McFarlane	Designated Nurse Safeguarding & Looked After Children County Durham CCG
Karen Agar	Associate Director of Nursing & Governance (Safeguarding) Tees, Esk & Wear Valleys NHS Foundation Trust
	Named GP for Safeguarding Children County Durham CCG

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).