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

2016-2017

Introduction

This is the 6th Annual Report of County Durham and Darlington Child Death Overview Panel (CDOP) and reflects the activity from 1 April 2016 to 31 March 2017.

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 has been in place since May 2008. The previous Designated Doctor retired in December 2015 and the post was successfully filled by an equally experienced Paediatrician who commenced this role from January 2016.

A Rapid Response process has been in place since August 2009 with a team of senior nurses to manage and deliver the rapid response to 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.

A very good working relationship has been established with the Coroner for County Durham and Darlington. Meetings have taken place with the Coroner accordingly. 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 has been appointed since October 2009 to provide 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.

The role of the rapid response nurse encompasses:
- Ensuring notification to the coroner.
- Early and continuing multi-agency liaison.
- Detailed and thorough history taking, including a careful review of the 24 hours preceding death and production of detailed reports following each death.
- Make immediate enquiries into and evaluate the reasons for and circumstances of death.
- Collection of relevant information about the circumstances of the death, including clinical details, analysing it and compiling a report for the pathologist carrying out the post mortem examination.
- Undertake home visits as appropriate jointly with the police.
- Maintain contact at regular intervals with family members and other professionals who have ongoing responsibilities for other family members, to ensure they are informed and kept up to date with information about the child's death.
- Attend police briefings to jointly update colleagues.
- Together with the designated doctor for child deaths give feedback to parents on the findings from local case discussion.
- Arrange bereavement support for the family following the conclusion of the child death investigation.

Durham and Darlington are one of only a few LSCBs that have been able to establish a robust rapid response process. This is funded by the Clinical Commissioning Group.

The contact telephone number for the rapid response service is **01388 455126**. This telephone number will automatically connect to the nurse on call.

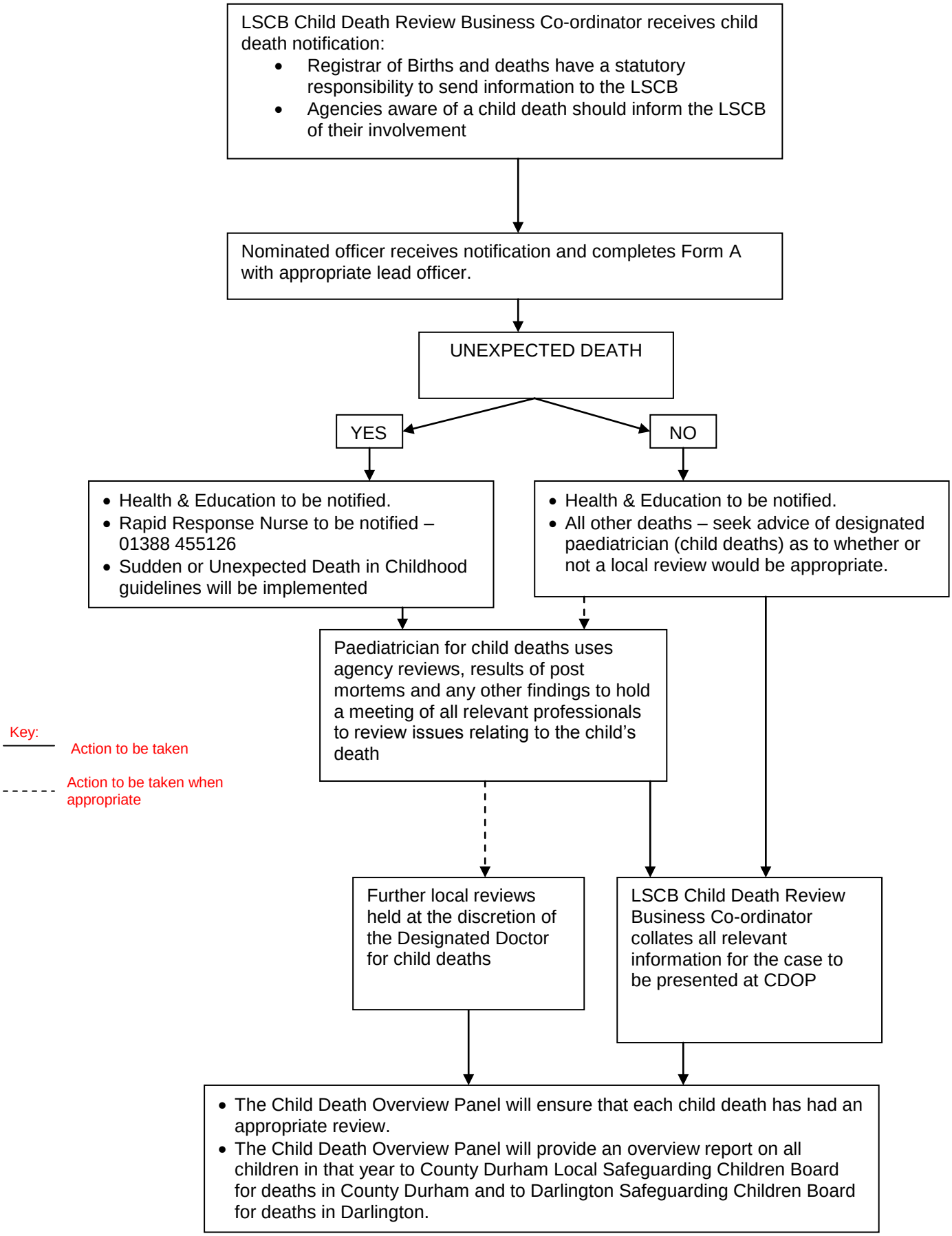
Local Case Discussions

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. To facilitate GPs being involved in the process, the meetings are held at GP's surgeries where practicable.

At this meeting all relevant information concerning the circumstances of the death, the child's history and subsequent investigations should be reviewed. 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

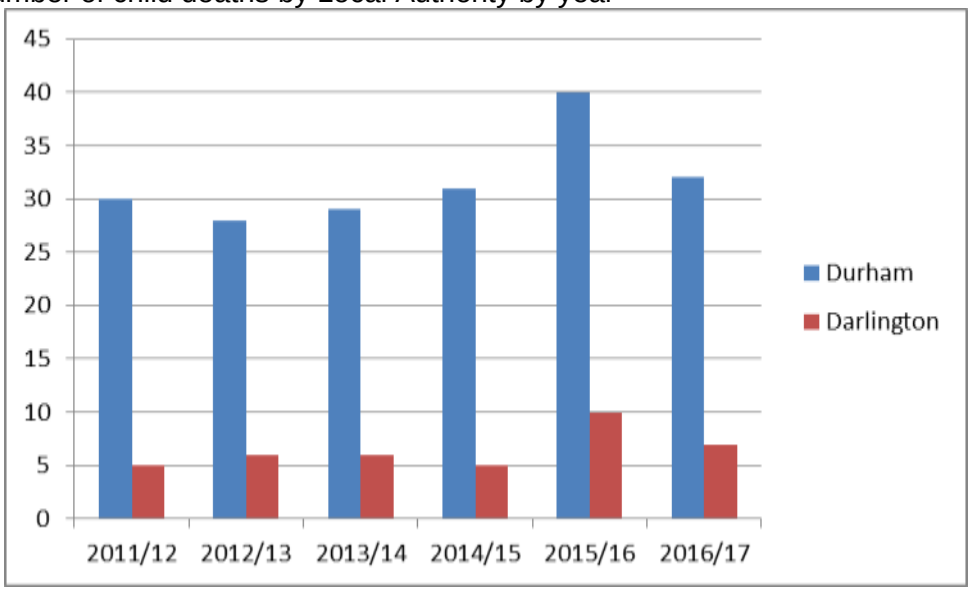


Child Death Review Activity

Child Death Review Notifications

32 children living in Durham and 7 children in Darlington died between 1 April 2016 and 31 March 2017. It is not possible to comment further on the analysis of this data until those deaths have been reviewed and compared against national data.

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

2013/14	2014/15	2015/16	2016/17
19	25	25	20

Child Death Overview Panel Performance

Between April 2016 and March 2017 there were five Child Death Overview Panels in which 40 cases were reviewed. The Panel does not normally 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 40 cases reviewed in 2016/17 the following table details the time period in which death occurred:

Number of deaths which occurred in 2014/15	Number of deaths which occurred in 2015/16	Number of deaths which occurred in 2016/17
4	26	10

The CDOP determined out of the 40 cases reviewed there were modifiable factors in five 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 40 completed reviews, 28% were completed in less than six months. This is a 3% increase compared to 2015/16, and is in line with national statistics for year ending March 2016. Possible reasons for those taking longer than six months to complete include the timing of the final post mortem report, timing of the Local Case Discussion or deaths subject to other processes such as Serious Case Reviews, criminal and coronial proceedings, and agency report forms (Form Bs) not being completed timely by agencies where the child was known to their service. 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.

32 child death reviews have not yet been reviewed; one from 2014/15, three from 2015/16 and 28 from 2016/17 will be brought forward to 2017/18.

Chart 1: Timeline between Child Death Notification and Completion

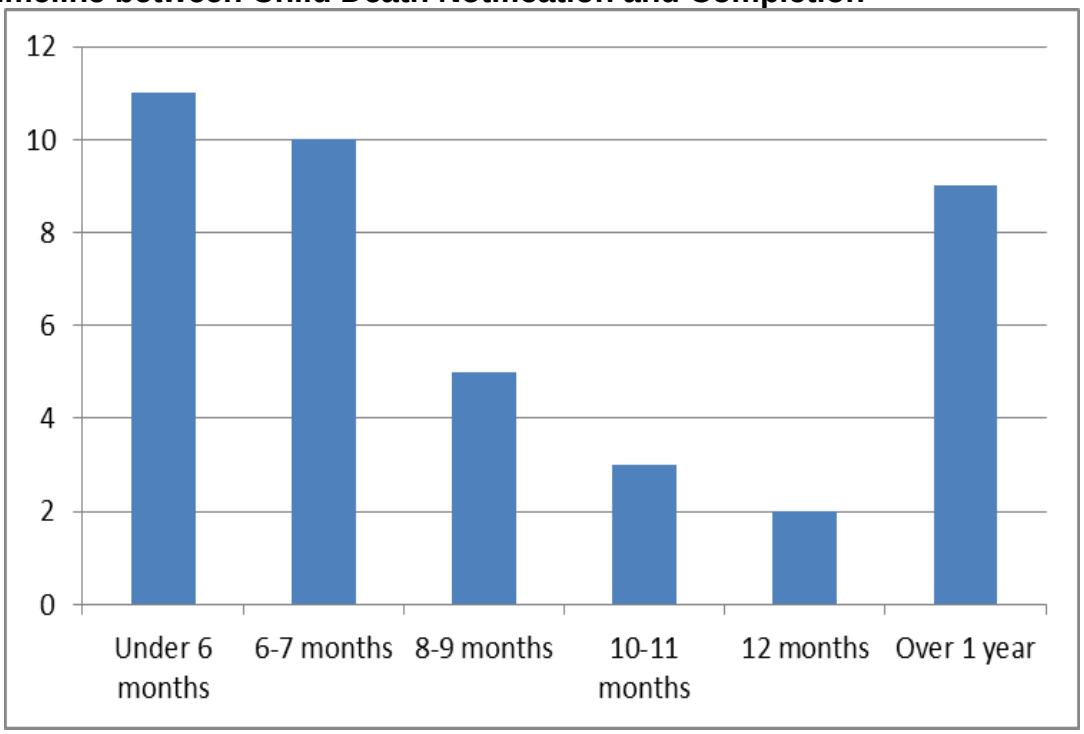


Chart 2: Category of Deaths

Categorisation is nationally determined and feed into a national data return to DfE. 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. This is within parameters of the national statistics for year ending March 2016. In this reporting period the CDOP determined that there were potentially modifiable factors in two perinatal/neonatal events; one chromosomal, genetic and congenital anomalies; and two cases of sudden unexpected, unexplained deaths.

2016/17

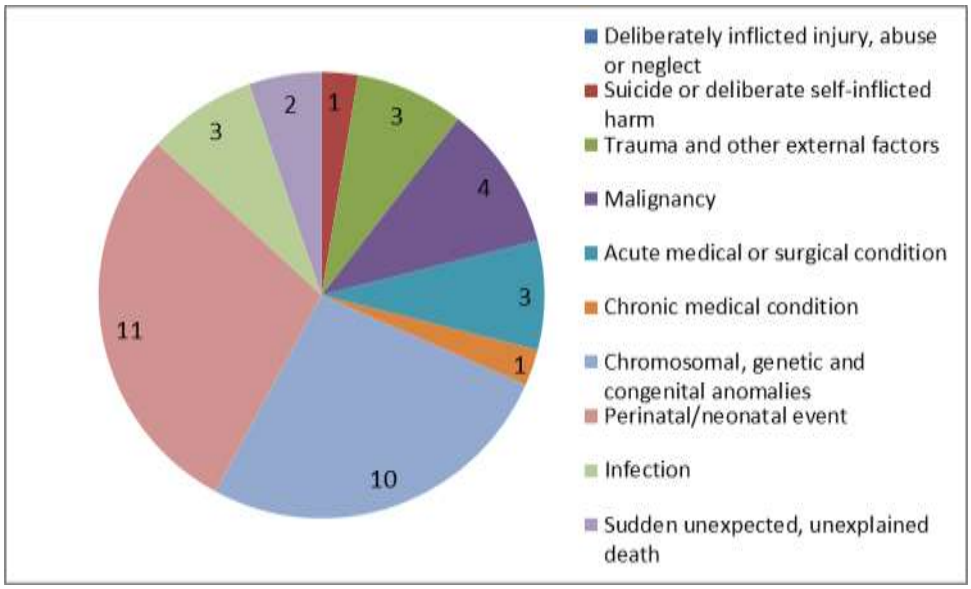
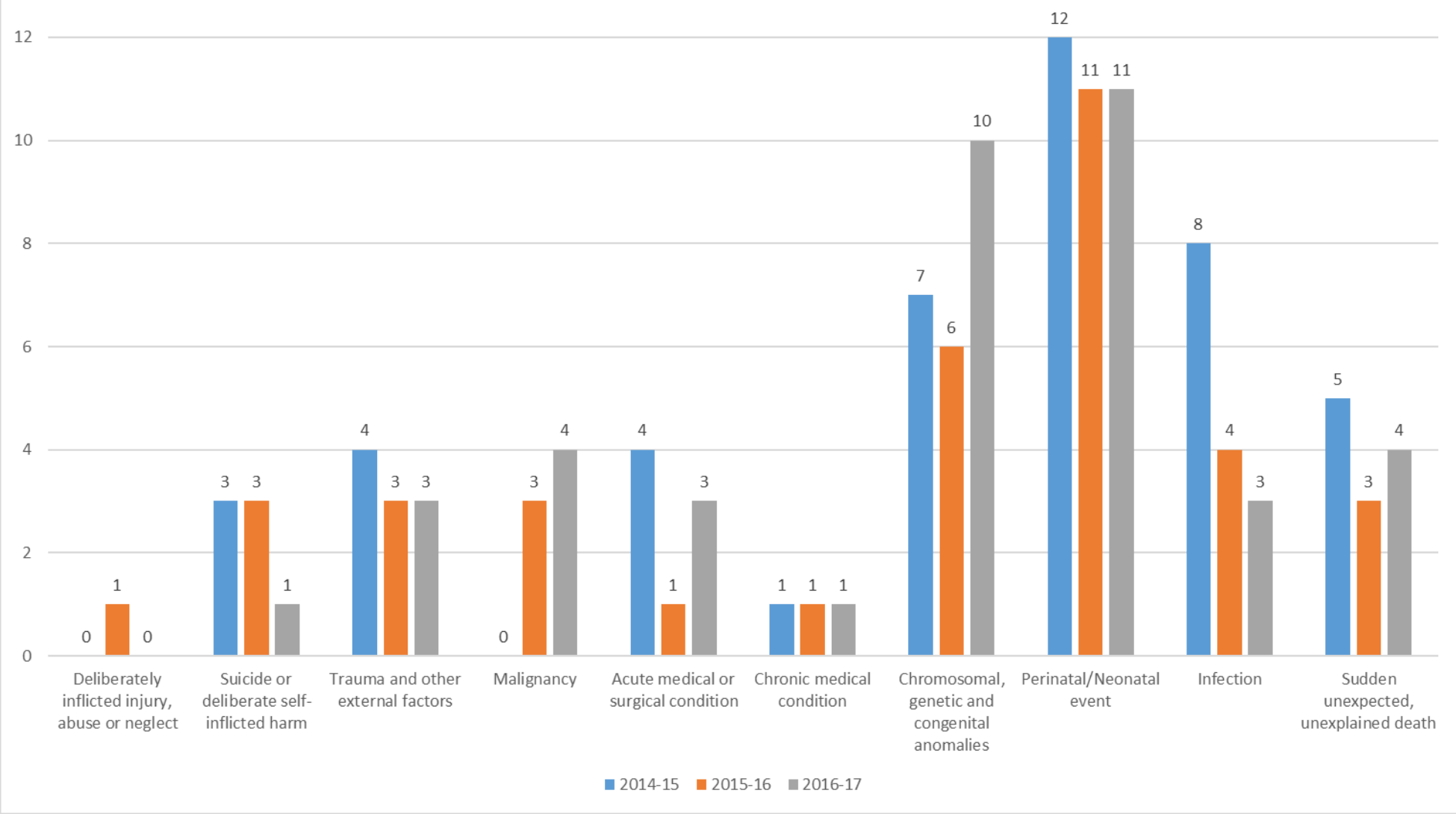


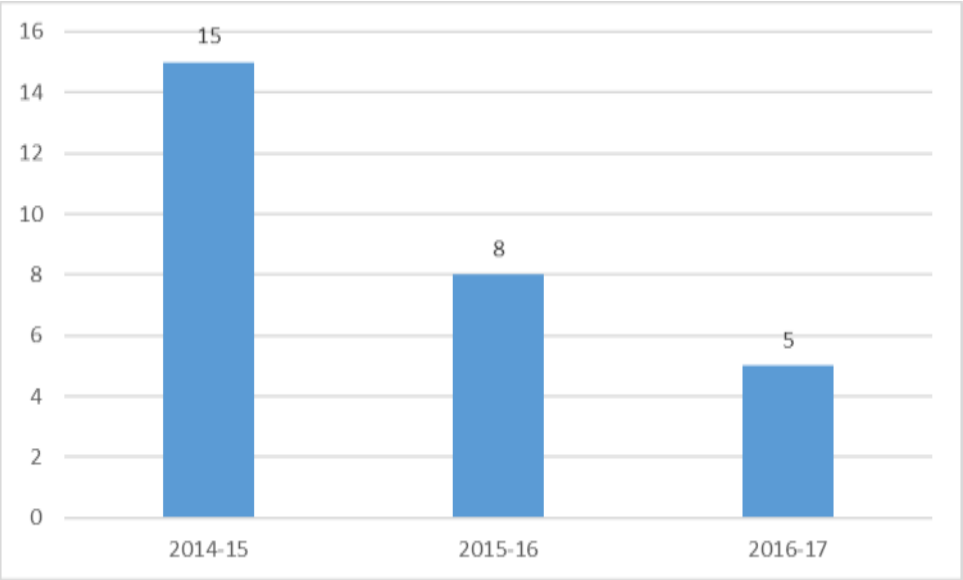
Chart 3: Category of Deaths (comparison with previous years)



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 5 deaths (13%) reviewed in 2016/17 which is a continuing decrease since 2014-15. This is half compared with the national statistics (year ending March 2016) which indicates that 24% of child death reviews are identified as having modifiable factors. All cases with modifiable factors related to children under 1 years of age.

Contributory Factors

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

Child's Needs,

- 32 health factors were identified which was determined to provide a complete and sufficient explanation for the death. One health factor contributed to the vulnerability, ill-health or death of the child.
- One case identified the emotional/behavioural/mental health condition of the child contributed to the vulnerability, ill-health or death of the child.
- There was one case where alcohol/substance misuse by the child was determined to provide a complete and sufficient explanation for the death. There was one case where alcohol/substance misuse by the child contributed to the vulnerability, ill-health or death of the child.

Family and Environment,

- There were three cases where parental mental health was identified as to having contributed to the vulnerability, ill-health or death of the child.
- There were two cases where parental substance misuse was identified as to having contributed to the vulnerability, ill-health or death of the child.
- There were two cases where smoking by the parent/carer was identified as to having contributed to the vulnerability, ill-health or death of the child.
- One case where co-sleeping was identified as to having contributed to the vulnerability, ill-health or death of the child.
- Two cases where parenting capacity was identified as to having contributed to the vulnerability, ill-health or death of the child.

Service Provision,

- One cases was identified where access to health care or prior medical intervention were factors that 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 the home of normal residence which has remained consistently the highest number for the last three years. 36% relate to those with life limiting conditions and 64% died unexpectedly. The Child Death Overview Panel identified modifiable factors in two out of the 14 deaths at home, one of which was subject of a Serious Case Review.

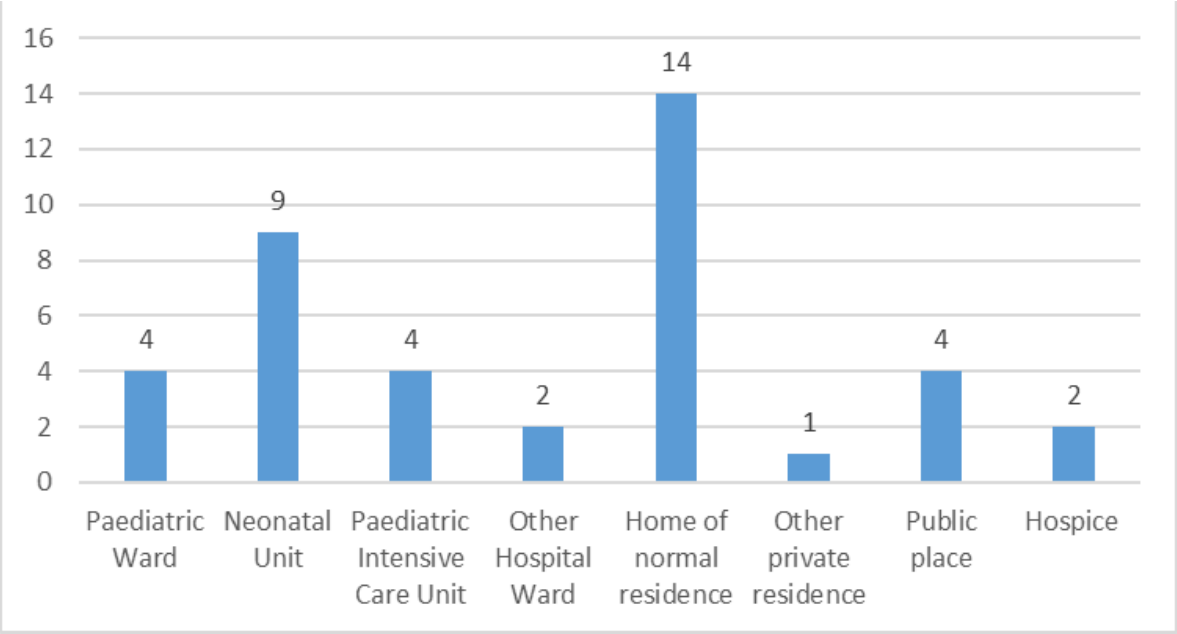


Chart 6: Ages of Children

The DfE annual Official Statistics Release (Child Death Reviews – year ending March 2016) has consistently demonstrated that the deaths of children under one year old (neonatal and post-neonatal) account for around 64% of all child deaths. The reporting period 2016/17 has demonstrated a local position slightly lower than the national average (55%). For Under 10's and Over 10's the local picture shows a slightly higher number compared to the national average (under 10%).

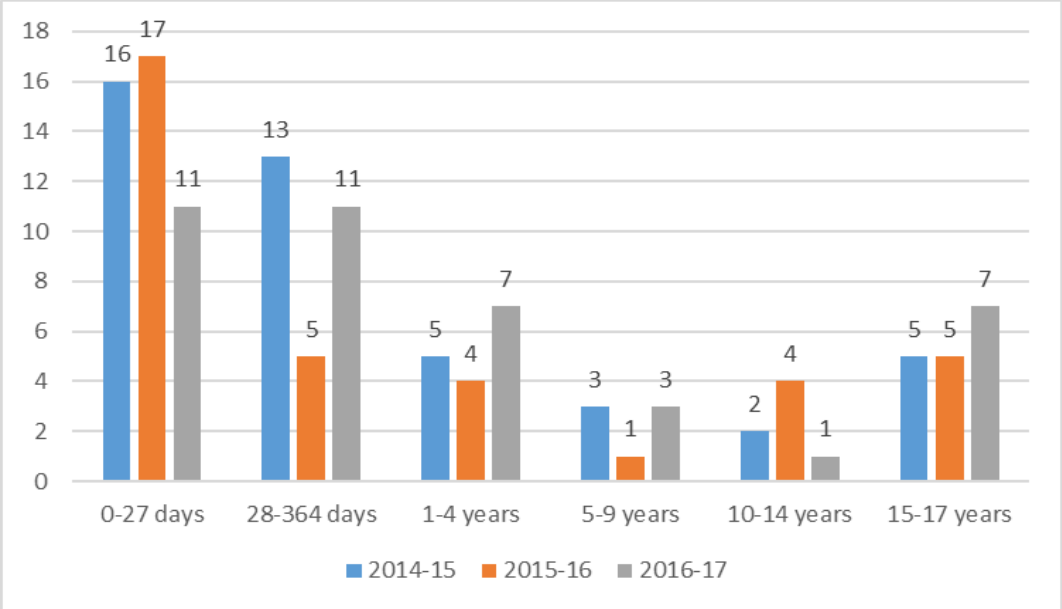
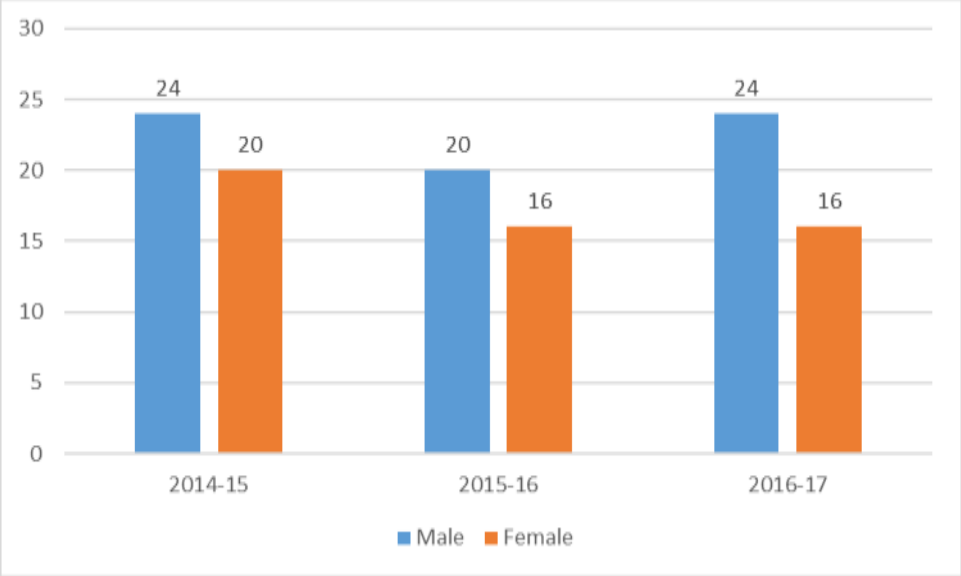


Table 7: Gender

The reporting period demonstrates a local position in keeping with the national picture with 60% of completed cases being in relation to male deaths.



National and Regional Information

The DfE data return was submitted in May 2017 and all CDOPs in England and Wales are required to submit a return. The national aggregated information is usually made available by the DfE in July. Locally we will review the national data and compare our local information to determine if we are an outlier or not.

The Regional Child Death Designated Professionals Group facilitated by NHS England continue to meet on a bi-annual basis to consider key themes and issues from the local Child Death Reviews; share learning; and to identify any national or regional issues that may affect the Child Death Review process.

County Durham & Darlington Child Death Overview Panel have participated in the following national surveys:

- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)
- Learning Disabilities Mortality Review Programme

<u>Child Death Stakeholder Event</u>
Stakeholder events were held in London and Leeds at the beginning of 2017 following a review by NHS England as a result of the Wood Review and the Children and Social Work Bill where the following topics were covered:

- Proposed new framework for Child Death Reviews.
- The establishment of a National Child Mortality Database.
- Structure and function of Child Death Overview Panels.
- Output and linkage with wider processes.
- Guidelines re contacting, engaging and supporting families.

Involvement of Parents

Unexpected deaths

The Rapid Response Nurses 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. This process begins as soon as the Rapid Response Nurse meets the family.

In County Durham and Darlington the Child Death Review process is explained to parents. The Rapid Response Nurse liaises closely with police colleagues and the pathologist, and updates parents as soon as possible after the post mortem to feedback preliminary results. Alongside these visits the Senior Rapid Response Nurse offers to arrange bereavement support to the family and remains in contact by telephone, text and by visits according to the family's wishes.

Expected deaths

All children who die from a life-limiting condition are under the care of a paediatrician, and usually community paediatric nurses and other palliative care staff are participating in the care for the child and family. It is an expectation that the paediatrician involved with the child explains the Child Death Review Process to the family.

Analysis of Key Learning

Thematic Review of Child Deaths
The Child Death Overview Panel conducted a thematic review of all child deaths where there were modifiable factors discussed by the Child Death Overview Panel between April 2014 to May 2016. This is the second thematic review by the Child Death Overview Panel.

Recurrent themes were identified as follows:

Age group	Theme
Perinatal and infant deaths	CTG training
	Escalation policies
	Resuscitation of neonates
	Communication between professionals and units on the transfer of neonatal care
Child deaths	Mandatory training in paediatric resuscitation
	Emergency care plans for children with complex health problems

One case was the subject of a Serious Case Review and a robust action plan was developed which will be monitored by the LSCB Business Unit. Key points include the concealed/denied pregnancy; maternal ambivalence; parental substance misuse; neglect; family engagement and thresholds. Key messages from Serious Case Reviews will be included in the annual Learning Lessons Events for 2017/18 which will be aimed at practitioners working with children across County Durham and Darlington.

One case was referred by the Child Death Overview Panel for consideration of a Serious Case Review which was subsequently not taken forward by the LSCB after it was agreed that the criteria was not met for a Serious Case Review.

Some child death reviews highlighted issues regarding the timescale between post mortems and the receipt of the final post mortem report and also sharing of post mortem reports with parents and as a result has adjusted the information shared with parents accordingly. There were also record keeping and information sharing issues in terms of flagging of records regarding significant events and this work has been addressed with the agencies concerned.

Areas of Good Practice
One case demonstrated good practice in terms of the challenges taken jointly by the Local Authority and Police in ensuring that the actions identified had been robustly addressed.

One case demonstrated good practice by all involved that had managed and provided intervention and support to an extremely complex and rare set of circumstances both prior to and after death. Ofsted had commented on the quality of the care package that had been implemented and were impressed by the care and continuity of care.

Developments during 2016/17

Training
Training has been 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.

Child Death Review Procedures
The Child Death Review Procedures were updated in November 2016 and launched in January 2017.

Notifications
The child death notification process and template has been reviewed to ensure a seamless process from the point of the child death to gathering sufficient information for the Child Death Overview Panel in order to improve the timescales from child death to the case being discussed.

CDOP Identified Developments for 2017/18

1. **Third Thematic Review**
   This involves looking at any trends in child deaths and comparing this with the last thematic review carried out in October 2016.

2. **6-month update report – December 2017**
   The annual report will be updated and presented at CDOP and respective LSCBs once the DfE official national statistics for year ending March 2017 are available.

3. **Child Death Review Administration for Unexpected Deaths**
   A Service Level Agreement to be formulated 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.

Appendix 1

CDOP Membership as at 31 March 2017	
Dr Mike Lavender (Chairperson)	Consultant in Public Health Medicine Durham County Council
Jacqui Doherty	Business Manager, Durham LSCB
Emma Chawner	Business Manager, Darlington SCB
Emma Maynard	Admin Co-ordinator, Durham LSCB
Amanda Hugill	Development Officer, Darlington SCB
Dr Nnenna Cookey	Designated Paediatrician for Child Deaths County Durham & Darlington NHS Foundation Trust
Dr Stephen Cronin	Designated Paediatrician for Safeguarding County Durham & Darlington NHS Foundation Trust
Cath Hodgkiss	Rapid Response Manager County Durham & Darlington NHS Foundation Trust
Jo Crawford	Head of Midwifery & Gynaecological Services County Durham & Darlington NHS Foundation Trust
DCI Dave Ashton	Durham Constabulary
Mark Gurney	Strategic Manager – Child Protection & Disability Durham Children's Services
James Clarke	Darlington Children's Services
Lesley Thirlwell	Designated Safeguarding Officer North East Ambulance Service NHS Foundation Trust
Kim Lawther	Head of Clinical Quality Durham Dales, Easington & Sedgefield CCG
Marie Baister	Designated Nurse Safeguarding & Looked After Children County Durham & Darlington CCGs
Karen Agar	Associate Director of Nursing 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).