Tees

child death overview panel

Hosted by Redcar & Cleveland Safeguarding Children Board in statutory partnership with Hartlepool, Middlesbrough and Stockton-on-Tees Local Safeguarding Children Boards

TEES CHILD DEATH OVERVIEW PANEL

ANNUAL REPORT

2016/2017

Hartlepool safeguarding children board

REDCAR & CLEVELAND SAFEGUARDING CHILDREN BOARD

MIDDLESBROUGH Safeguarding Children Board

Local Safeguarding Children Board LSCB Stockton-on-Tees

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1. INTRODUCTION

This report covers the period from 1st April 2016 to 31st March 2017 and provides information on the total number of child deaths reviewed in the Tees. It also reflects the activity of the Child Death Overview Panel (CDOP) highlighting its positive outcomes, current developments, learning and challenges.

The death of a child is a devastating loss that profoundly affects all those involved. The process of systematically reviewing all children's deaths is grounded in respecting the rights of children and their families, with the intention of learning what happened and why, and preventing future child deaths.

Child Death Overview Panels (CDOP) where established in April 2008 to review all child deaths (up to the age of 18 years), excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law. The primary function of CDOP, as set in Working Together 2015, is:

- Collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members.
- Discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family.
- Determine whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths.
- Making recommendations to the Local Safeguarding Children Board (LSCB) or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible.
- Identifying patterns or trends in local data and reporting these to the LSCB.
- Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether a Serious Case Review (SCR) is required.

The purpose of the review is to determine whether the death was deemed preventable, that is one in which there are identified modifiable factors which may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced. If this is this case the Panel must decide what, if any, actions could be taken to prevent such deaths in the future.

2. TEES CDOP

The Tees CDOP is responsible for reviewing the deaths of children normally resident in the four local authority areas across the Tees, namely Hartlepool, Middlesbrough, Redcar & Cleveland and Stockton-on-Tees and is accountable to the four Tees LSCBs.

2016/2017 saw the appointment of a new Chair, Director of Public Health (Middlesbrough & Redcar and Cleveland). The Panel comprises of a fixed core membership of senior professionals drawn from organisations represented on the Tees LSCBs with flexibility to co-opt other relevant professionals to discuss certain issues as and when appropriate.

The core membership is detailed below:

Organisation	Title
Public Health	Director of Public Health (Chair)
Hartlepool & Stockton on Tees Clinical Commissioning Group & South Tees Clinical Commissioning Group	Designated Paediatrician for Child Death
	Designated Nurse for Safeguarding & Looked After Children
North Tees & Hartlepool Hospital NHS Foundation Trust	Consultant Neonatologist, North Tees University Hospital
South Tees Hospitals NHS Foundation Trust	Consultant Neonatologist, James Cook University Hospital
Police	Detective Superintendent, Head of Specialist Crime
Midwifery	Patient & Safety Lead, Women's & Children's Services, University Hospital North Tees
Nursing Representative	Associate Director of Nursing, Community Care Centre, South Tees NHS Foundation
North East Ambulance Service (NEAS)	Safeguarding Lead
Children's Social Care	Assistant Director, Hartlepool Council
Tees Esk & Wear Valley NHS Trust (TEWV)	Service Manager, Tees CYPS
Education	Principal Manager, Redcar and Cleveland Council
LSCB / CDOP	Business Manager
CDOP	Administrator
Lay Member	Independent Lay Member
Coroner Service	Senior Coroner

The administration of the CDOP process is hosted by Redcar and Cleveland Safeguarding Children Board and is funded jointly by all Tees area Public Health. A breakdown of the CDOP budget is included at Appendix 1.

3. CHILD DEATH REVIEW PROCESS

The review of child deaths consists of the following processes:

1. ***Rapid Response Meeting*** – usually held within 48 hours of a sudden and unexpected child death, with the exception of neonatal deaths.

   The purpose of the Rapid Response Meeting is to:

   - To help identify the provisional cause of death and identify any risk factors pertaining to that death.
   - To explicitly consider whether there are any safeguarding issues for surviving siblings, potential future siblings and other associated children.
   - Identify any urgent action to be taken by any agency.
   - To signpost appropriate help and support for family/friends and staff where necessary.
   - To help gather information for the Tees CDOP in a standard format.

   Key professionals from all agencies involved with the child are expected to attend the meeting.

2. ***Local Case Discussion*** – this review meeting takes place in respect of all child deaths once the post-mortem examination results are available (where appropriate) and once the cause of death has been established. This meeting includes all those professionals who knew the family and were involved in investigating the child's death. The professionals should review any further available information, including any that may raise concerns about safeguarding issues. This is in order to share information about the cause of death or factors that may have contributed to the death and to plan future care of the family. A record of the discussion (Form C) is shared with the coroner, where appropriate, and the relevant CDOP, to inform the child death review.

3. **CDOP Meeting** – An overview of all child deaths up to the age of 18 years occurring in the Tees area is undertaken by the panel. This takes place at the bi-monthly CDOP meetings. This is a paper exercise based on information available from those who were involved in the care of the child, both before and immediately after the death, and other sources, including, perhaps, the Coroner. This provides a further opportunity for challenge. Following satisfactory discussion, cases are closed at this stage.

Within the Child Death Review Process the following definitions are used:

A **Child** is defined as anyone who has not yet reached their 18th birthday.

Unexpected death is defined as the death of a child that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death.

Preventable Child deaths are those in which modifiable factors may have contributed to the death. These factors are defined as those which, by nationally or locally achievable interventions, could reduce the risk of future child deaths. The factors include those in the family or environment, parenting capacity or service provision (this includes the input of all partner agencies who are ordinarily involved in the welfare of our children and families) as well as actions that could be taken at a regional or national level.

4. TEES CHILD DEATHS REPORTED - 1 APRIL 2016 TO 31 MARCH 2017

4.1 Total Number of Child Deaths 2016/17

Table 1 shows the number of child deaths reported in each Local Authority area across the Tees in 2016/17:

Table 1 - Child Deaths 2016/17					
	H	**M**	**R & C**	**S**	**TOTAL**
Total Number of Males	7	8	4	9	**28**
Total Number of Females	4	5	5	7	**21**
Total Number of Child Deaths in each local authority	**11**	**13**	**9**	**16**	**49**

4.2 Expected / Unexpected Child Deaths 2013/14 to 2016/17

Table 2 shows the **total child deaths** across the Tees for the current and previous 3 years. (**Numbers in brackets denote unexpected deaths.)**

Table 2 - Child Deaths 2013/14 to 2016/17					
	2013/14	**2014/15**	**2015/16**	**2016/17**	**Total**
Hartlepool	5(2)	9(4)	7(4)	11(8)	**32**
Middlesbrough	9(4)	13(5)	16(8)	13(2)	**51**
Redcar & Cleveland	5(2)	7(3)	8(4)	9(4)	**29**
Stockton	17(7)	12(0)	12(6)	16(8)	**57**
Tees Total	**36(15)**	**41(12)**	**43(22)**	**49(22)**	**169**

A total of 17 Rapid Response meetings were held in respect of unexpected deaths occurring in 2016/17.

The tables above demonstrate that:

- Child deaths have continued to increase rising from 36 in 2013/14 to 49 in 2016/17.
- Whilst there has been an increase in the number of unexpected deaths, the overall percentage of unexpected deaths in 2016/17 is 44%, similar to that in 2013/14 of 42%.
- As in previous years there continues to be more male than females deaths.

PLEASE NOTE: The total number of child deaths reported in 2016/17 is different to the total number of deaths reviewed by CDOP in 2016/17 because cases can take in excess of 6 months to be reviewed by CDOP therefore:

- **some deaths reviewed in 2016/17 will have occurred in 2015/16 or earlier, and**
- **some child deaths which occurred in 2016/17 may not be reviewed until 2017/18.**

The remainder of this report is in respect of Child Death's reviewed in 2016/17

5. TEES CHILD DEATHS REVIEWED BY CDOP IN 2016/17

During 2016-17 the Tees CDOP reviewed 44 child deaths making a total of 344 reviewed over the 9 years of operation. This is a slight increase from the 41 cases reviewed in 2015/16. The Tees panel met 7 times during this year and reviewed an average of 6 cases per meeting.

36% of child deaths reviewed during 2016/17 year were finalised within less than 6 months of the child's death. 64% of child deaths reviewed during 2016/17 were finalised within 12 months of the child's death. During this time no cases took more than a year to review.

Delays in reviewing cases beyond the six months have been due to the following factors:

- Late receipt of the Local Case Discussions (Form C's).
- Delays in pathologist reports.
- Ongoing Police Investigations.

Table 3 shows the number of Neonatal Deaths and Deaths of Older Children reviewed by Tees CDOP 2016-17 by LSCB Area:

Table 3 - Child Deaths Reviewed in 2016/17			
	Neonatal	**Older Children**	**Total**
Hartlepool	2	1	**3**
Middlesbrough	3	13	**16**
Redcar and Cleveland	5	5	**10**
Stockton	5	10	**15**
Total	**15**	**29**	**44**

Table 4 details the respective ages of the children when they died:

Table 4 - Age Range of Deaths Reviewed in 2016/17							
	Neonatal Deaths <4weeks	**4-52 weeks**	**1-4 years**	**5-9 Years**	**10-14 years**	**15 up to 18 years**	**Total**
Hartlepool	2	0	0	0	0	1	**3**
Middlesbrough	3	9	1	0	2	1	**16**
Redcar & Cleveland	5	3	1	1	0	0	**10**
Stockton	6	3	2	0	2	2	**15**
Tees Total	**16**	**15**	**4**	**1**	**4**	**4**	**44**

The chart below illustrates the data taken in respect of ages as detailed in Table 4.

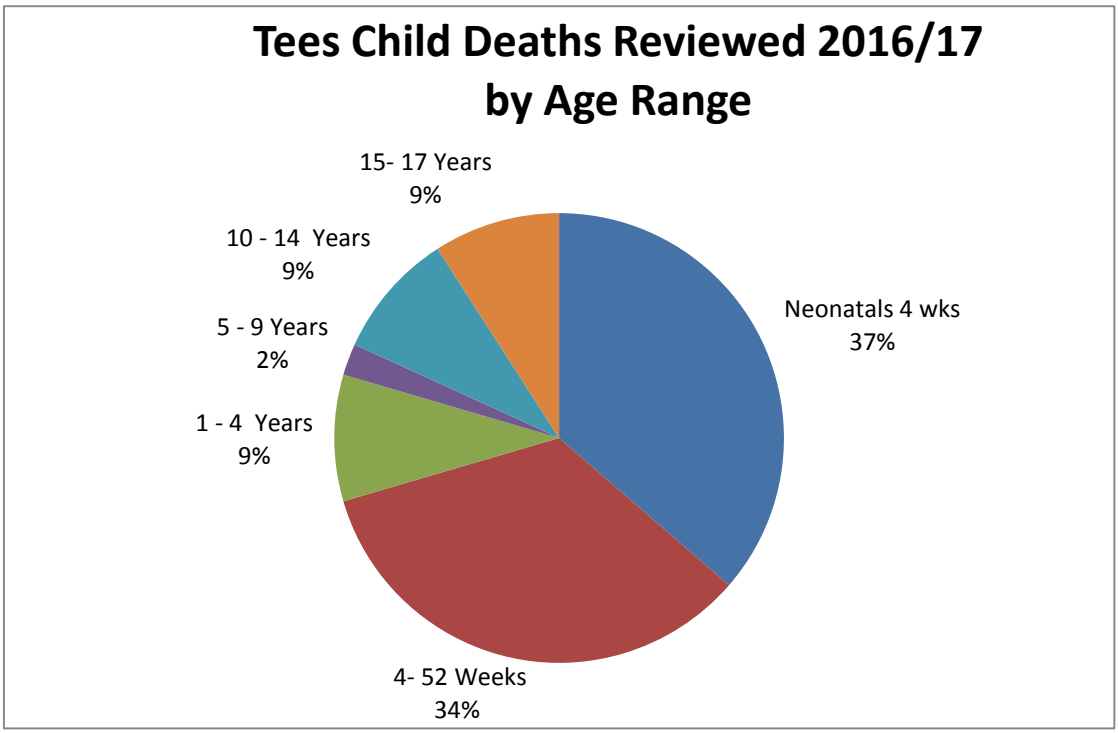

Table 5 below details the ethnicity of children whose deaths were reviewed in 2016/17 as recorded on returned CDOP forms.

Table 5 - Ethnicity of Children Whose Death was Reviewed in 2016/17					
	H	**M**	**R&C**	**S**	**Tees**
White: British	2	8	6	12	**28**
Mixed/multiple ethnic groups: Any other mixed/multiple ethnic background	1	5	0	3	**9**
Not recorded/unknown	0	3	4	0	**7**
Total	**3**	**16**	**10**	**15**	**44**

Table 6 details the location of the child's death of those cases reviewed in 2016/17

Table 6 - Location of Death or Fatal Event					
	H	**M**	**R&C**	**S**	**Tees**
Number at home of normal residence or other family home	0	0	1	7	**8**
Number in hospital or medical facility	2	16	9	8	**35**
Number in educational establishment	0	0	0	0	**0**
Number in public place (including roads, railways, parks, restaurant, beaches, waterway etc.)	1	0	0	0	**1**
Total	**3**	**15**	**16**	**10**	**44**

Table 7 sets out the recorded reason for the child's death. This data reflects the original categorisation from the Local Case Discussion (LCD) and Form C information:

Table 7 - Categories of Death as Defined by DfE						
		H	**M**	**R&C**	**S**	**Tees**
1	Deliberately inflicted injury, abuse or neglect	0	0	0	0	**0**
2	Suicide or deliberate self-inflicted harm	0	0	0	1	**1**
3	Trauma or other external cause	1	2	0	2	**5**
4	Malignancy	0	2	1	1	**4**
5	Acute medical or surgical condition	0	2	1	0	**3**
6	Chronic medical condition	0	3	0	1	**4**
7	Chromosomal, genetic or congenital anomalies	0	4	1	3	**8**
8	Perinatal/neonatal event	2	2	5	6	**15**
9	Infection	0	0	0	0	**0**
10	Sudden unexplained, unexpected death	0	1	2	1	**4**
11	Unknown category	0	0	0	0	**0**
	TOTAL	**3**	**16**	**10**	**15**	**44**

Table 8 provides additional information in respect of child deaths reviewed by CDOP in 2016/17

Table 8 - Additional information					
	H	**M**	**R&C**	**S**	**Tees**
Number of deaths that were unexpected	1	5	3	5	**14**
Number of deaths that CDOP deemed to have Modifiable Factors.	0	3	2	4	**9**
Serious Case Reviews /Learning Review	0	0	0	0	**0**

Modifiable Factors are defined as 'those where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced'. When Tees CDOP reviews the death of a child they will identify and agree any modifiable factors that may have prevented the death. As identified in Table 8 above out of the 44 child deaths that were reviewed in 2016/17, there were 9 cases where modifiable factors were identified. Some of these included risk factors such as smoking, alcohol/substance misuse and co-sleeping. Where modifiable factors are identified the Panel has taken appropriate action to address these where appropriate

Findings from the child deaths reviewed in 2016/17:

- The majority of children whose death was reviewed in 2016/17 were less than a year old (71%)
- As in previous years, the main cause of death was as a result of perinatal or neonatal difficulties (34%), which is a slight increase from 2015/16 (29%).
- Sudden Infant Deaths have increased from one case (2.4%) in 2015/16 to four cases (9%) in 2016/17.
- As in 2015/16 the majority of children died in a hospital or medical setting (79%).
- As in previous years the majority of children whose deaths were reviewed were White British.

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6. OUTCOMES AND RECOMMENDATIONS

Positive outcomes in relation to the reviews undertaken by Tees CDOP include:

- **Safe Sleep Campaign – Tees Wide**
  Once again all Tees LSCBs supported the Lullaby Trust's Safe Sleep Campaign during the week of 13 March to 17 March 2017.
- **Revision of SUDI Protocol**
  The Sudden Unexpected Death in Infancy Protocol (SUDI) was revised nationally in 2016/17 and as a result the Tees process has been reviewed with the support and agreement of all relevant partner agencies.
- **Funding**
  The four Tees Directors of Public Health have agreed to fund the costs of Tees CDOP until 31 March 2019.
- **Organ Donation**
  At the recommendation of CDOP annual training will be offered to Consultant Pediatric Intensivists to support them in the sensitive and sometimes difficult discussion with families in respect of potential organ donation.
- **Cross Reviewing of Cases**
  As part of the review of neonatal deaths a process is in place to ensure that an external reviewer will attend Local Case Discussions to ensure external scrutiny.
- **Information Included on Form C**
  Work has been undertaken across the Tees to improve the quality and timeliness of the Form C's following a number of poor submissions. This has resulted in an improvement in both the quality and timeliness of returned forms.

7. FUTURE CHALLENGES AND PRIORITIES

Tees CDOP is committed to continuous improvement and in 2017/18 there will be particular focus on:

- **Supporting Families**
  We will work closely with Child Bereavement UK to ensure that arrangements are in place to support families who have experienced the tragedy of child death.
- **Improving Communication**
  We will develop information and communication mechanisms to ensure that families are aware of the CDOP processes and the support that is available to them.
- **Learning Lessons**
  We will consider how best to ensure Lessons Learned from the review of child deaths is cascaded both locally and where appropriate nationally to help prevent further deaths.
- **Improve Quality and Content of CDOP Forms**
  We will work with partners to ensure a continued improvement in the quality and content of all CDOP forms. In particular we will focus on ensuring that the ethnicity of children is recorded.
- **Children and Social Care Act 2017**
  The enactment of the Children and Social Care Act, which abolishes LSCBs, will fundamentally change the way that safeguarding in partnership is delivered. This will include changes to the Child Death Review processes. Tees CDOP will ensure that the present processes are maintained whilst preparing for any anticipated structural changes.
- **Longitudinal Analysis of Child Death Data**
  Work has commenced in the analysis of Child Death data which will consider all child deaths between January 2013 and December 2016. The report will aim to identify patterns or trends in local data. The report will consider both regional and national comparators and make recommendations in respect of future actions.

APPENDIX 1 - TEES CDOP BUDGET

Income/Expenditure 2016-2017	**Income £**	**Expenditure £**
CDOP Budget c/f 15/16 Contributions from Public Health **TOTAL INCOME**	14,270 10,500 **24,770**	
Salaries **(inc. on-costs):** RCSCB Business Manager (1 day per week) RCSCB Administrator (2 days per week)		20,700
Other expenditure: Rapid Response Administrator Hosting of the CDOP website		1,690 110
TOTAL EXPENDITURE		**22,500**
BALANCE	**£2,270**	
Forecast Income Expenditure 2017/18	**Income £**	**Expenditure £**
CDOP Budget c/f 16/17 Contributions from Public Health **TOTAL INCOME**	2,270 22,100 **24,370**	
Salaries **(inc. on-costs):** RCSCB Business Manager (1 day per week) RCSCB Administrator (2 days per week)		20,700
Expenditure – Rapid Response Administrator Hosting of the CDOP website		1,690 110
TOTAL EXPENDITURE		**22,500**
POTENTIAL C/F 2018/19	**£1,870**	

In kind contributions from partner agencies are not calculated however they are acknowledged.

APPENDIX 2 - ATTENDANCE AT TEES CDOP MEETINGS 2016-17

Organisation	1 Apr 2016	27 May 2016	29 July 2016	30 Sept 2016	25 Nov 2016	27 Jan 2017	24 Mar 2017	Meetings Held	Total Attended
Director - Public Health - (CHAIR)	Y	Y	Y	Y	Y	Y	Y	7	7
UNTH – Neonatologist	X	X	X	Y	Y	X	Y	7	3
UNTH – Paediatrician	Y	X	X	X	A	Y	X	7	2
RCBC Education	Y	Y	Y	A	Y	Y	Y	7	6
Cleveland Police	Y	Y	Y	Y	Y	Y	Y	7	7
Midwifery Representative	X	Y	Y	Y	Y	Y	Y	7	6
Designated Paediatrician for Tees CDOP	Y	Y	A	X	N/A*	N/A*	N/A*	7	N/A*
Coroner	Y	A	Y	Y	Y	A	Y	7	5
JCUH - Consultant Neonatologist	A	Y	A	Y	Y	A	Y	7	4
JCUH – Consultant Paediatrician	Y	A	Y	Y	Y	Y	Y	7	6
South Tees CCG (Vice Chair)	Y	Y	Y	Y	Y	Y	Y	7	7
NEAS Ambulance Service	Y	A	X	Y	A	A	A	7	2
Nursing – JCUH	A	A	Y	Y	Y	Y	Y	7	5
Hartlepool Children's Services	A	A	Y	A	Y	A	Y	7	3
Lay member	Y	Y	A	A	A	Y	A	7	3
CDOP Business Manager	Y	Y	Y	A	Y	Y	Y	7	6
CDOP Administrator	Y	Y	Y	Y	Y	Y	Y	7	7

KEY: Y – Present A – Apologies received X – Not in attendance and no apologies received

***Following to the retirement of the designated Paediatrician for CDOP in November 2016, the Consultant Paediatrician, JCUH undertook this role as a temporary measure.