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

2014 - 2015

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1. Introduction

The Tees Child Death Overview Panel (CDOP) reviews the deaths of children from the Hartlepool, Middlesbrough, Stockton-on-Tees and Redcar & Cleveland Local Safeguarding Children Board (LSCB) areas. The CDOP is a sub group of the 4 Tees LSCBs.

The role of the CDOP is to ensure that wherever child deaths occur, and under whatever circumstances, scrutiny of the cases result in recognised improvements that can be made to practice to improve the quality of care, as well as the safety of children. CDOP also identifies any relevant strategic issues and ensure that these translate into action within or between agencies. CDOP ensures that the team looking after children have the opportunity to discuss and reflect on the death, learn any lessons, and implement any helpful changes to practice or to systems of care.

The value of child death review, and the necessity for its coordination and scrutiny by a Child Death Overview Panel, has been understood nationally and remains a core component of the latest version of Working Together (2015).

2014-15 has been the first year following the independent review of Tees CDOP functions. A new chair has been appointed and the revised staffing arrangements have been combined with the RCSCB Business functions. This review has led to a full review of operational procedures to ensure the process operates in a SMART manner. The RMSO annual report which contains details and numbers of child deaths reviewed regionally can be accessed on the CDOP Website.

2. Cases reviewed and the outcomes of these cases

During 2014-15 Tees CDOP reviewed 28 child deaths making a total of 259 reviewed over the 7 years of operation. The Tees Panel met 6 times during the year and reviewed an average of 5 cases per meeting. This is very similar to the national picture where CDOPs met 6 times a year and reviewed an average of 7 cases per meeting.

During this time 4 cases took more than a year to review and one of these had modifiable factors identified as internal communications within the hospital. This has been a reoccurring theme in reviewing child deaths across Tees and assurance that actions have been taken to address this have been sought.

The other delays in reviewing cases have been due to late receipt of the Form C's and internal reviews being undertaken, prior to CDOP being able to review the cases. The issue in relation to receiving the Forms C's in a timely manner has been addressed and the recently appointed CDOP Administrator has implemented robust systems to ensure these are received within timescales.

All cases are classified via the national classification system to reflect one of the following:

- Modifiable factors identified – factors identified in the case which by means of local or nationally achievable interventions could be modified to reduce the risk of future child deaths.
- No modifiable factors identified – the panel have not identified any potentially modifiable factors in relation to the death
- Inadequate information to make a judgement

Tees CDOP classified 9 of the deaths reviewed in 2014-15 as having modifiable factors. This equates to 32% of the total deaths reviewed.

The Safe Sleeping e-learning course is still available for staff across Tees too access. This course encourages all staff going into family homes to give the same messages on how to keep babies safe. Tees CDOP have also identified the need for a publicity campaign targeting these issues, which will be launched across Tees, highlighting the risk of co-sleeping, with additional risk factors such as substance and alcohol misuse.

2014-15 was the first year that Tees CDOP operated in accordance with the revised Terms of Reference. Each hospital already has a neonatal unit whereby neonatal death review meetings are held and the outcomes of these meetings are captured on Form C's and shared with CDOP. These forms C's are now considered at the Tees CDOP Pre-Agenda meeting with Public Health, the Designated Doctor for Child Deaths and the CDOP Business Manager. The outcomes from the pre-agenda are fed into the Tees CDOP. The neonatal death review meetings are cross chaired from each hospital to provide additional external peer review and scrutiny as well as attendance by the Designated Paediatrian for Child Deaths. Tees CDOP therefore no longer scrutinise the neo-natal deaths in such detail allowing them to be more focussed on improved outcomes.

Deaths reviewed by Tees CDOP 2014-15

LSCB	No of Deaths Neonates	No of Deaths Older Children	Total
Hartlepool	2	1	**3**
Middlesbrough	8	6	**14**
Redcar and Cleveland	0	4	**4**
Stockton	3	4	**7**
Total	**13**	**15**	**28**

Outcomes in relation to the reviews of these deaths include:

- An awareness raising campaign supported by Public Health and Education in relation to the risks of solvent inhalation.

- The challenge to hospitals in respect of dealing with a death of a child on an adult ward.

- Increased awareness in the hospitals and encouragement to include a multi-disciplinary team and junior doctors and nurses at the local case discussions, to increase learning opportunities.

- Revised Sudden Unexplained Deaths in Infants (SUDI) protocol launched across Tees; training in respect of this has been delivered to all Accident and Emergency and paediatric staff.

- Information sharing between primary care and social care has been challenged and Tees CDOP identified the need for improvements to be made in notifications to GP's when a child is subject to a strategy meeting. A proforma has been devised, agreed and implemented across Tees.

- Tees CDOP identified the absence of a Tees Rapid Response Process. Various challenges were made in respect of this and the process will soon be in place.

- Additional lighting has been recommended at a particular bus stop.

- A challenge was posed to the Regional Foundation Trust regarding the vacant post of Perinatal Pathologist. The Trust has now taken action with additional recruitment.

- Assurance was sought in respect of health professionals who hold responsibility for undertaking appropriate SWABS and ensuring results are undertaken in a timely manner.

- Assurance sought in respect of improvements needed in the communication streams between antenatal and post-natal departments.

- The importance of an appropriate response if a fatal accident happens to a child or a child dies when attending an outdoor course has been raised with all appropriate outdoor provision centres across Tees.

3. Tees Child Death Statistics 1st April 2014 to 31st March 2015

The numbers of deaths reviewed will differ to the number of children who died in this year due to the time delay in reviewing cases whilst relevant information is being gathered.

3.1 Table 1 shows the number of child deaths in each local authority and the overall total across Tees. (It should be noted that the number of child deaths in any one year is likely to vary and sometimes notifications to the CDOP are made after the year end.)

Table 1	H	S	M	R & C	**Tees**
Total Number of Males	6	7	7	4	**24**
Total Number of Females	3	5	6	3	**17**
Total Number of Child Deaths in each local authority	**9**	**12**	**13**	**7**	**41**

3.2 Table 2 shows comparative numbers of **total child deaths** for the current and previous 3 years.

Table 2	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**Total**
Hartlepool	3 (1)*	3 (0)*	5 (2)*	9(4)	**20**
Stockton	25 (8)*	14 (5)*	17 (7)*	12(0)	**68**
Middlesbrough	11 (3)*	12 (4)*	9 (4)*	13(5)	**45**
Redcar & Cleveland	6 (2)*	8 (4)*	5 (2)*	7(3)	**26**
Total	**45**	**37**	**36**	**41**	**159**

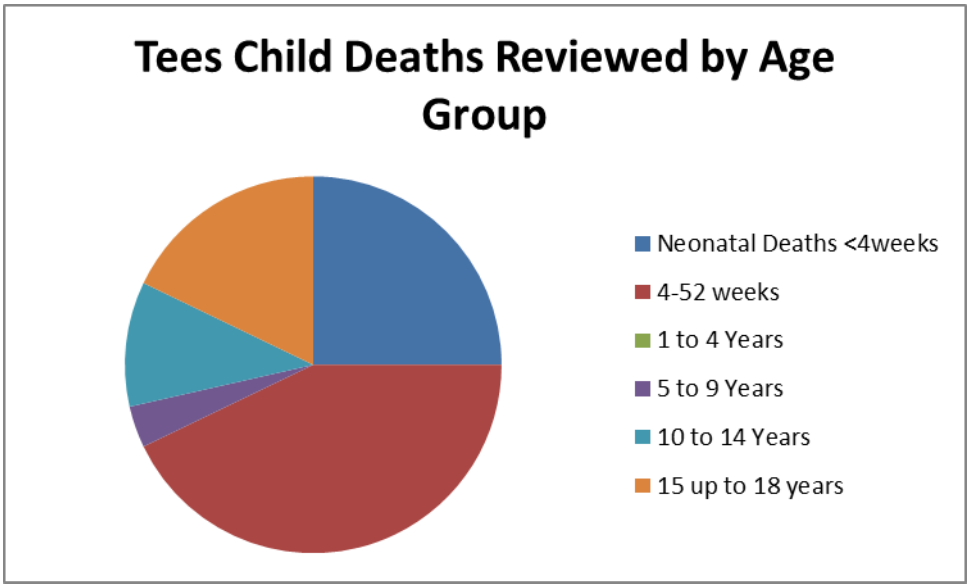
***Numbers in brackets denote unexpected deaths**

4. Child Deaths considered by CDOP April 2014 to March 2015

4.1 Table 3 shows the respective ages of the children when they died. In total 28 deaths were reviewed during this year.

Table 3: Numbers in age range

	Neonatal Deaths <4weeks	4-52 weeks	1-4 years	5-9 years	10-14 years	15 up to 18 years	Total
Hartlepool LSCB	0	2	0	0	1	0	**3**
Stockton LSCB	0	5	0	0	2	0	**7**
Middlesbrough LSCB	**7**	5	0	0	0	2	**14**
Redcar & Cleveland LSCB	0	0	0	1	0	3	**4**
Total Tees	**7**	**12**	**0**	**1**	**3**	**5**	**28**



4.2 Table 4 shows the children's ethnicity which is overwhelmingly White British

Table 4: Ethnicity
as recorded on returned CDOP forms

	H	S	M	R&C	Tees
White: British	3	5	6	4	**18**
Mixed/multiple ethnic groups: Any other mixed/multiple ethnic background	0	1	3	0	**4**
Not recorded/unknown	0	1	5	0	**6**
Total	3	7	14	4	**28**

4.3 Table 5 details the place of the child's death.

Table 5: Location of death or fatal event					
	H	**S**	**M**	**R&C**	**Tees**
Number at home of normal residence or other family home	0	0	2	3	**5**
Number in hospital or medical facility	3	7	12	1	**23**
Number in educational establishment	0	0	0	0	**0**
Number in public place (including roads, railways, parks, restaurant, beaches etc)waterway (i.e. river, canal, sea,)	0	0	0	0	**0**
Total	**3**	**7**	**14**	**4**	**28**

4.4 Table 6 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 6: Numbers of deaths in the categories * *****as taken from the DfE website					
	H	**S**	**M**	**R&C**	**Tees**
Deliberately inflicted injury, abuse or neglect	0	0	0	0	**0**
Suicide or deliberate self-inflicted harm	0	2	1	1	**4**
Trauma or other external cause	1	0	0	1	**2**
Malignancy	0	0	0	2	**2**
Acute medical or surgical condition	0	0	0	0	**0**
Chronic medical condition	0	0	0	0	**0**
Chromosomal, genetic or congenital anomalies	1	1	2	0	**4**
Perinatal/neonatal event	0	2	6	0	**8**
Infection	1	1	2	0	**4**
Sudden unexplained, unexpected death	0	1	3	0	**4**
Totals	**3**	**7**	**14**	**4**	**28**

4.5 Table 7 provides additional information in respect of outcomes from the Child Death Overview Panel CDOP.

Table 7 : Additional information	H	S	M	R&C	**Tees**
Number of deaths that were unexpected	1	3	4	2	**10**
Number of deaths that CDOP deemed to have modifiable factors.	1	4	3	1	**9**
Serious Case Reviews /Learning Review undertaken	0	1	0	0	**1**

5. Tees CDOP Budget

Actual Spend 2014-2015	**£ 2014-2015**	
CDOP Budget	**61,484**	
Salary costing: April 2014 - July 2014 (includes part-time CDOP Business Manager and part-time CDOP Administrator) July 2014- March 2015 includes RCSCB Administrator (2 days per week) and RCSCB Business Manager (1 day per week)		**21,596**
Other expenditure: Hospice staff attendance at CDOP meetings (2 x200) Hosting of the CDOP website RMSO contract for notifications		**400** **50** **2,840**
TOTAL		**24,886**
Potential spend 2015/16 (carry forward from 2014-15)	**£36,598**	
Proposed staffing costs - This includes the RCSCB Administrator 2 days per week and RCSCB Business Manager 1 day per week		**18,278**
Other potential expenditure – This may include costs for GP attendance at CDOP meetings (6 x £250) Rapid Response Administrator Hospice staff attendance at CDOP meetings (6 x200) Hosting of the CDOP website		**1,500** **1,300** **1,200** **50**
TOTAL		**22,328**
Carry forward - 2016/17	**£14,270**	

6. Future Challenges

Tees CDOP Terms of Reference have been reviewed to ensure a robust reporting arrangement occurs with all Tees LSCB's. Although this ensures partners accountability has increased there have been further challenges identified for the forth-coming year:

- The Tees Rapid Response Procedure to be implemented to ensure all unexpected child deaths are responded to appropriately, in a timely way.

- The contract between Tees CDOP and RMSO needs reviewing. This is costly and some notifications of child deaths are being received directly from hospitals. This contract requires a full review.

- The CDOP budget highlights the lack of funding to for Tees CDOP to continue post 2015-2016. Tees LSCBs to consider how this is to be addressed.

- To ensure all partners are represented at Tees CDOP (See Appendix 1 for attendance of organisations 2014-15)

APPENDIX 1: Attendance at Tees CDOP meetings 2014-15

Organisation	May 2014	July 2014	Oct 2014	Nov 2014	Jan 2015	Mar 2015	Total Attended
Public Health (Chair) Tees Shared Services	✓	✓	✓	✓	✓	✓	6
Neonatal Service North Tees & Hartlepool Foundation Trust	-	-	-	-	-	✓	1
Education - representation rotates from 4 Local Authorities across Tees on a 2 yearly cycle, currently represented by Redcar and Cleveland Council	-	-	-	✓	✓	✓	3
Police	-	-	-	-	-	-	0
Midwifery Representation currently from North Tees & Hartlepool Foundation Trust	✓	✓	-	-	-	-	2
Designated Paediatrician for Tees CDOP – South Tees CCG & Hartlepool & North Tees CCG	✓	✓	✓	✓	✓	✓	6
Bereavement Services	✓	✓	✓	-	-	✓	4
GP	-	-	✓	✓	✓	✓	4
Neonatal Service South Tees Hospital Foundation Trust	-	✓	-	-	-	✓	2
Children Palliative Care Palliative Care Paediatrician from South Tees Hospital Foundation Trust	-	-	-	-	-	✓	
Designated Nurse Safeguarding Children and LAC - South Tees CCG and North Tees & Hartlepool CCG	✓	✓	✓	✓	-	-	4
North East Ambulance Service	✓	-	-	✓	-	-	2
Children's Nursing Service currently representative from South Tees Hospital Foundation Trust	✓	-	✓	-	✓	✓	4
Children's Social Care – representative rotates from Social Care in Teesside on a 2 yearly cycle currently Assistant Director Hartlepool Children Services	✓	✓	-	-	✓	✓	4
Lay member	✓	-	-	-	✓	✓	3

- Appropriate actions were taken through the year when it was identified that organisations were not attending Tees CDOP.
- All CDOP Members represent various services across Tees and not their own organisations. They also liaise with their counter parts in other organisations/agencies to facilitate CDOP recommendations/actions relevant to theirs.