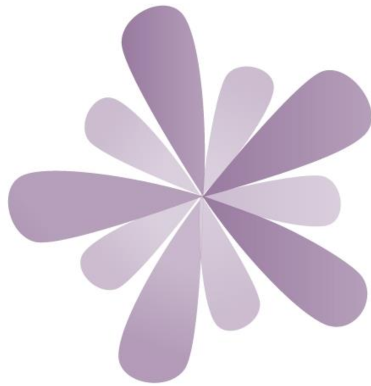

Tees

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

2015 - 2016

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1. INTRODUCTION

Since 2008, each Local Safeguarding Children Board (LSCB) has been responsible for ensuring that a review of all deaths involving a child (up to the age of 18 years, excluding still births and planned terminations) normally resident in the LSCB's area is undertaken by a Child Death Overview Panel (CDOP).

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

Every death of a child is a tragedy for family, friends and peers, and therefore if we can learn from the circumstances and factors present in each death we can:

- Identify whether or not there were any modifiable factors or any lessons which could be learnt that might help to prevent similar deaths in the future
- Share this learning with colleagues regionally and nationally so that the findings will have a wider impact
- Analyse trends and deliver targeted interventions in response to these

The deaths reviewed by the panel are not about allocating blame, it is instead about learning and putting actions in place to prevent future deaths and to ensure that parents and carers receive the highest quality support they require in a timely manner by the most appropriate professional(s).

The value of child death reviews, 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).

2015/2016 is the second year following the independent review of the Tees CDOP functions which saw the appointment of a new Chair and the absorption of the business functions into the RCSCB business unit.

2. TEES CHILD DEATH STATISTICS 1ST APRIL 2015 TO 31ST MARCH 2016

Please note 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 gathered.

Table 1 shows the number of child deaths in each local authority and the overall total across Tees.

Table 1	H	M	R & C	S	Tees
Total Number of Males	5	11	4	10	**30**
Total Number of Females	2	5	4	2	**13**
Total Number of Child Deaths in each local authority	**7**	**16**	**8**	**12**	**43**

2.1 Expected / Unexpected Deaths

The definition of an unexpected death is: "The death of an infant or child (less than 18 years old) which:

- was not anticipated as a significant possibility, for example, 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." Working Together 2015

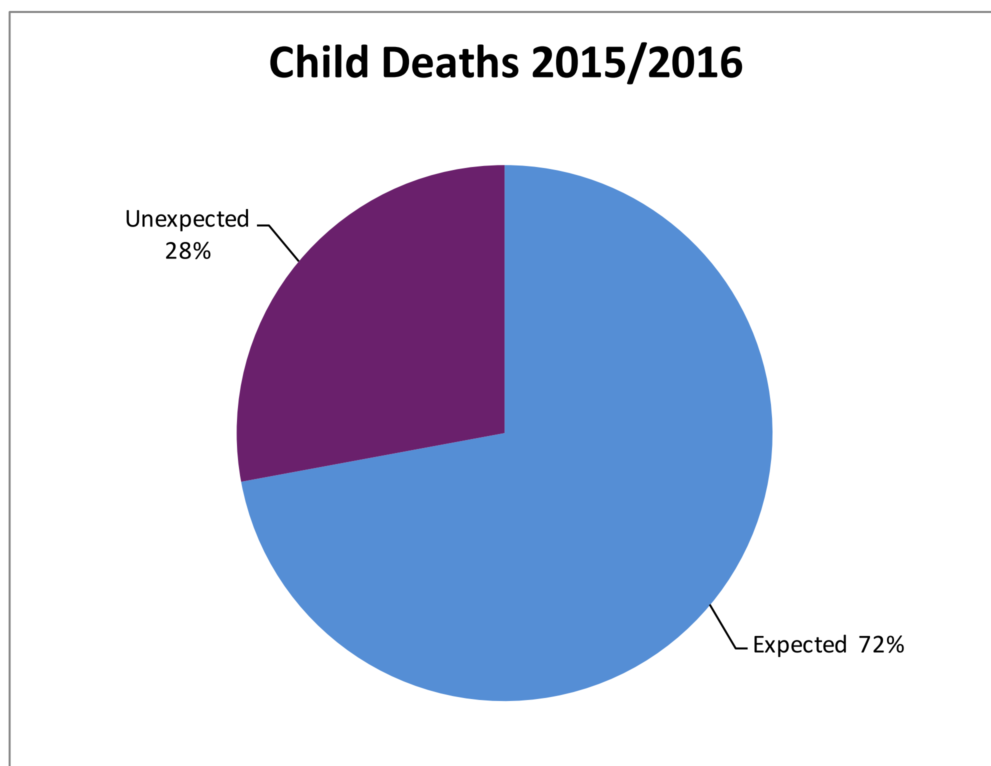

Table 2 shows comparative numbers of **total child deaths** for the current and previous 3 years. (**Numbers in brackets denote unexpected deaths.)**

Table 2	2012-13	2013-14	2014-15	2015-16	Total
Hartlepool	3(0)	5(2)	9(4)	7(4)	**24 (10)**
Middlesbrough	12(4)	9(4)	13(5)	16(8)	**50 (21)**
Redcar & Cleveland	8(4)	5(2)	7(3)	8(4)	**28 (13)**
Stockton	14(5)	17(7)	12(0)	12(6)	**55**
Tees Total	**37**	**36**	**41**	**43**	**157**

3. CASES REVIEWED AND THE OUTCOMES OF THESE CASES

During 2015-16 the Tees CDOP reviewed 41 child deaths making a total of 300 reviewed over the 8 years of operation. The Tees panel met 5 times during this year and reviewed an average of 8 cases per meeting. This is compared to a national average of 6 meetings per CDOP in 2015/16 considering an average of 7 cases per meeting.

During this time no cases took more than a year to review. Delays in reviewing cases beyond six months have been due to late receipt of the Form C's, delays in post mortem examinations and internal reviews being undertaken prior to CDOP being able to review the cases.

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 3 of the deaths reviewed in 2015-16 as having modifiable factors. This equates to 8% of the total deaths reviewed. This is lower than the national average for 2015/16 which remained unchanged at 24% from the previous year.

Table 3 shows the number of Neonatal Deaths and Deaths of Older Children reviewed by Tees CDOP 2015-16 by LSCB Area.

Table 3	Neonatal	Older Children	Total
Hartlepool	5	6	**11**
Middlesbrough	4	5	**9**
Redcar and Cleveland	2	6	**8**
Stockton	6	7	**13**
Tees Total	**17**	**24**	**41**

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

- **Safe Sleep Campaign – Tees Wide**
  All Tees LSCBs Supported the Lullaby Trusts Safe Sleep campaign in March 2016.

- **Challenge to Children and Adolescent Mental Health Service (CAMHS)**
  Assurance provided in respect of communication pathways for children actively involved with CAMHS who failed to attend appointments. This includes other health colleagues being notified when a child is involved with CAMHS.

- **Regional Huntingdon's Service**
  Improved communication between the local and regional Huntington's Service which includes:
  - Commencement of specialist, outreach Nurse led in the Tees area alongside existing clinics to quicken the access for the local services for advice and support.
  - Offer to provide training sessions for local teams to manage Huntington's patients especially Juvenile Huntington's patients.

- **Communication with Coroner**
  The Coroner is now a member and regular attender of the Tees CDOP. This came about following a concern being raised where families received potentially upsetting and confusing information from the Coroner's office.

- **Local Procedures**
  Cases were highlighted at the Tees CDOP by both the panel and the Coroner in respect of the internal processes following child birth. This has led to the two local Hospital Trusts reviewing their existing policies and providing assurance to the Tees CDOP that the policies and procedures have been updated and implemented.

- **Rapid Response**
  Following robust challenge by both the Tees CDOP and all four Tees LSCBs the Tees Rapid Response procedure was successfully implemented during 2015/16. This sets in place procedures for ensuring that unexpected child deaths are responded to appropriately and in a timely manner. This process is essential to ensure the safeguarding of any siblings and support to families is considered as a priority.

4. CHILD DEATHS REVIEWED BY CDOP APRIL 2015 TO MARCH 2016

In total **41** deaths were reviewed by the Tees CDOP during 2015/16 which is an increase of 46% from 28 in 2014/15.

The increase in the number of deaths reviewed in 2015/16 is in part as a result of improved procedures within the CDOP Business Support ensuring more timely completion and return of documentation.

Table 4 shows the respective ages of the children when they died.

Table 4	Neonatal Deaths <4weeks	4-52 weeks	1-4 years	5-9 years	10-14 years	15 up to 18 years	Total
Hartlepool	5	1	2	0	1	2	11
Middlesbrough	3	3	1	1	0	1	9
Redcar & Cleveland	3	2	1	1	0	1	8
Stockton	6	2	1	1	1	2	13
Tees Total	**17**	**8**	**5**	**3**	**2**	**6**	**41**

The chart below sets out the percentages for the data taken from Table 4.

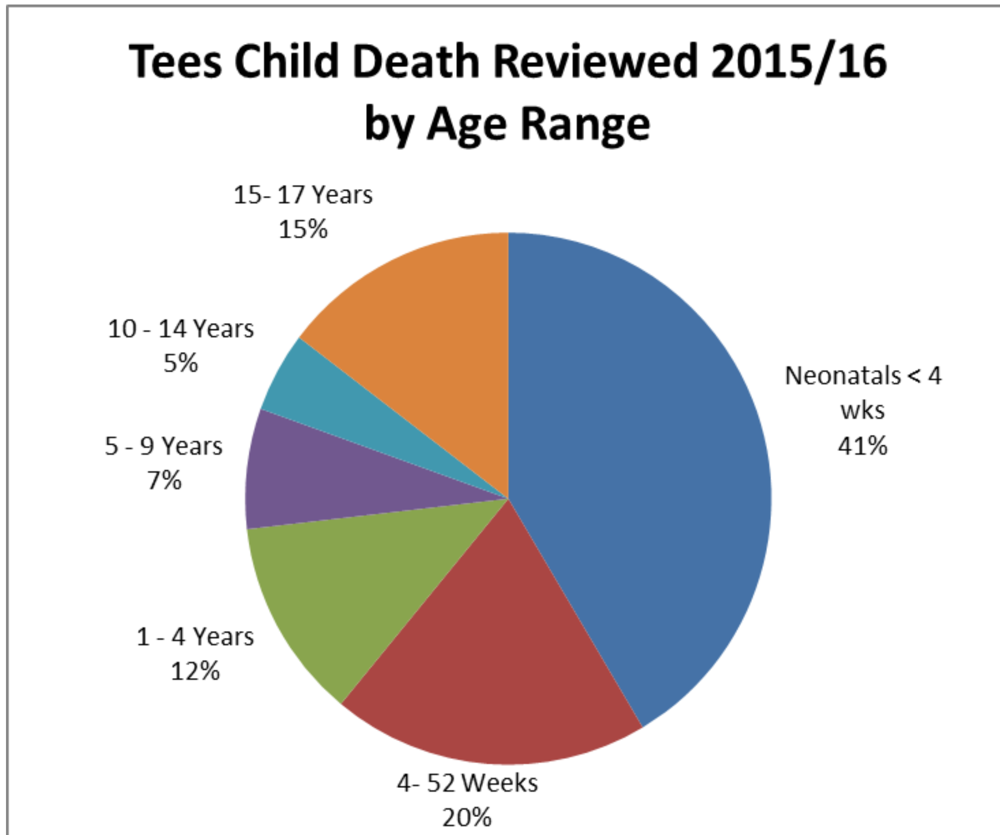

Table 5 shows the children's ethnicity of those cases reviewed in 2015/16 as recorded on returned CDOP forms.

Table 5: Ethnicity	**H**	**M**	**R&C**	**S**	**Tees**
White: British	11	3	5	9	**28**
Mixed/multiple ethnic groups: Any other mixed/multiple ethnic background	0	1	1	3	**5**
Not recorded/unknown	0	5	2	1	**8**
Total	11	9	8	13	**41**

Table 6 details the place of the child's death.

Table 6: Location of death or fatal event	H	M	R&C	S	Tees
Number at home of normal residence or other family home	3	1	0	1	**5**
Number in hospital or medical facility	9	8	8	10	**35**
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	1	**1**
Total	**11**	**9**	**8**	**12**	**41**

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: Numbers of deaths in the categories 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	0	**0**
3	Trauma or other external cause	1	1	1	1	**4**
4	Malignancy	0	1	1	0	**2**
5	Acute medical or surgical condition	0	0	0	1	**1**
6	Chronic medical condition	1	2	2	1	**6**
7	Chromosomal, genetic or congenital anomalies	4	0	3	3	**10**
8	Perinatal/neonatal event	2	2	4	4	**12**
9	Infection	1	2	0	2	**5**
10	Sudden unexplained, unexpected death	0	0	0	1	**1**
11	Unknown category	0	0	0	0	**0**
	TOTALS	**9**	**8**	**11**	**13**	**41**

Table 8 provides additional information in respect of outcomes from the Child Death Overview Panel CDOP.

Table 8 : Additional information	H	M	R&C	S	Tees
Number of deaths that were unexpected	3	4	2	3	**12**
Number of deaths that CDOP deemed to have modifiable factors.	0	1	0	2	**3**
Serious Case Reviews /Learning Review undertaken	0	0	0	0	**0**

5. TEES CDOP BUDGET

Actual 2015-2016	**INCOME £**	**EXPENDITURE £**
Brought Forward from 2015/16	**36,598**	
Salaries: RCSCB Business Manager (1 day per week) RCSCB Administrator (2 days per week)		18,278
Rapid Response Administrator (Jan – March 2016) Hosting of the CDOP website		325 130
TOTAL	**36,598**	**18,733**
CARRY FORWARD TO 2016/17	**17,865**	
2016/17 Budget Forecast	**INCOME**	**EXPENDITURE**
Carry Forward 2015/16 Public Health Contribution	17,865 10,500	
Salaries (inc. on-costs) RCSCB Business Manager (1 day per week) RCSCB Administrator (2 days per week)		20,700
Rapid Response Administrator Hosting of the CDOP website		1,300 130
TOTAL	**28,365**	**22,130**
POTENTIAL CARRY FORWARD INTO 2017/18		**£6,235**

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

6. FUTURE CHALLENGES

The Tees CDOP Terms of Reference have been reviewed to ensure 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 embedded to ensure all unexpected child deaths are responded to appropriately, in a timely way.

- To ensure all partners are represented at Tees CDOP (See Appendix 1 for attendance of organisations 2015-16)

- Accurate completion of all CDOP forms.

- There have been delays in the receipt of Form As being received into the CDOP administration office. Further work is to be undertaken with partners to ensure increased awareness of CDOP requirements.

- Future CDOP funding to be secured beyond 2017.

- Participating in the regional arrangements for the sharing of lessons learned from the review of Child Deaths, with the potential to identify themes.

- Chairing arrangements for CDOP to be reviewed in light of the recent announcement that the Tees Valley Public Health Shared Service will be disbanded.

- The recent National Review of LSCBs undertaken by Alan Wood has recommended that ownership of the arrangements for supporting the CDOPs should move to the Department of Health. Whilst there is no timescale for this change Tees CDOP must respond proactively to this recommendation.

Ros Pluck
CDOP Business Manager
16 August 2016

APPENDIX 1: ATTENDANCE AT TEES CDOP MEETINGS 2015-16

Organisation	May 2015	July 2015	Sept 2015	Nov 2015	Jan 2016	Total attended
Public Health	✓	✓	✓	✓	✓	5
University Hospital North Tees - Neonatologist	✓	✓	✓	-	-	3
Education	✓	✓	-	✓	✓	4
Police	✓	✓	✓	✓	✓	5
Midwifery	-	-	✓	✓	-	2
Designated Paediatrician for Tees CDOP	✓	✓	✓	✓	✓	5
Bereavement Services*	✓	✓	✓	-	-	3
JCUH - Consultant Neonatologist	✓	✓	-	-	-	2
JCUH – Paediatrician	✓	✓	-	✓	✓	4
South Tees Clinical Commissioning Group	-	✓	✓	-	✓	3
Ambulance Service	✓	✓	✓	✓	-	4
Health (Nursing)	✓	✓	✓	✓	-	4
Children's Social Care	✓	✓	✓	✓	✓	5
Lay member	-	✓	✓	✓	✓	4

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.

* Bereavement Services ceased attending every meeting mid 15/16 due to staffing situation. They remain committed to supporting the Tees CDOP and will attend as required.