Tees

child death overview panel

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

TEES

CHILD DEATH OVERVIEW PANEL

ANNUAL REPORT

2012 - 2013

CONTENTS

Foreword to CDOP annual report 2012-13

I am delighted to introduce the fifth annual report of the Tees Child Death Overview panel.

The year 2012-13 was overshadowed by the imminent changes to the structure of the NHS, the responsibilities of Local Authorities in relation to public health, and the benefits system, all due to be implemented from April 2013. Robert Francis QC published his report into the standards of care, and excess deaths, at the Mid Staffordshire Hospital in February 2013. Lastly, the new version of Working Together to Safeguard Children was published in March 2013, following the Munro review of child protection in May 2011.

Paradoxically, of all these influences, the one with the least impact for the Child Death Overview Panel (CDOP) was Working Together, precisely because the only chapter largely unchanged relative to the previous versions was that on child death review. The very fact that no significant changes were proposed is evidence that the child death review processes are regarded as being of national importance, and that the structure, function and role of overview panels within the child death review process is broadly correct and successful.

In relation to the Francis Report, the value of child death review in relation to hospital mortality cannot be overstated. We already know from the CEMACH report just 5 years ago (May 2008), that around a quarter of child deaths over the age of a month, many of which occur in hospital, could potentially have been avoided; and almost as many again had contributory factors that could have been modified.[1] By mandating discussion of these deaths by the team that looked after the child, and scrutinising the process at CDOP meetings, the child death review process directly creates the necessary conditions and incentives for improvements in medical and nursing practice, in terms of both quality and safety. The Francis report focused on hospital deaths in adults, but child deaths, though less frequent, tend to generate a higher media profile. Tees CDOP is committed to driving up quality of care, and patient safety, for infants and children of all ages.

Outside hospitals, the changes to the benefits system, together with a challenging background of unemployment and economic weakness, will undoubtedly impact on the lives of children. We don't yet know if it will increase rates of death in children, but if it does, it will be the CDOPs that notice this first. The coordination of multi-disciplinary and multi-agency approaches to unexpected child deaths, palliative care and after bereavement support remains a major focus of CDOP activity.

The Panel was sorry to have to say goodbye to Alex Giles, Designated Nurse for Tees , who retired just after the end of the 2012-3 year. She was involved with the child death review project from the beginning and gave me tremendous personal support and help, as well as being a fertile source of ideas and challenges for the group as a whole. On behalf of the CDOP I wish her a long and happy retirement. I look forward to working with Alex's successor in due course, and I was also pleased to welcome Joanne Atkinson as our new lay member in 2012.

The CDOP continues to work closely with colleagues on the four Local Safeguarding Children Boards to whom we are accountable, and to this end we staged another

1 Pearson, G A (Ed) Why Children Die: A Pilot Study 2006; England (South West, North East and West Midlands), Wales and Northern Ireland. London: CEMACH. 2008

training session event on 16th April which had good feedback. During this session I highlighted the three themes that will be our focus for the next year or more: the legacy of the Mid Staffordshire Hospital scandal, the benefits reforms, and the impact of NHS reconfiguration. Never has our work been more timely or important.

Dr Martin Ward Platt
Independent Chair, Tees Child Death Overview Panel

1. Introduction

The Tees Child Death Review Project (CDRP) was set up to support the work of the Tees Child Death Overview Panel (CDOP) in reviewing the deaths of children from the Hartlepool, Middlesbrough, Stockton-on-Tees and Redcar & Cleveland Local Safeguarding Children Board (LSCB) areas.

Tees CDOP met 6 times in 2012/13 and discussed 37 cases which is in line with the national average during the previous year. The business of these meetings form the basis of this Annual Report. In addition the CDOP members took part in a Development Session to improve the functioning of the child death review process.

A comprehensive Independent Review is currently being planned to identify how best to continue with the statutory process of reviewing Tees child deaths when the current funding regime ends on 31st March 2014.

The membership of CDOP and panel meeting dates can be found at Appendix 1. The Tees CDOP continues to be chaired by an Independent Chair, Dr Martin Ward Platt, and community involvement is demonstrated through the appointment of two Lay Members.

Financial information can be found at Appendix 2.

2. Reviewing cases

During 2012-13 Tees CDOP reviewed 37 child deaths including one out of area death, which made a total of 178 reviewed over the 5 years of operation. Reference is made in this report to national statistics on child death review, the latest of which are from 2011/12.

There has again been an improvement in the time delay between the child's death and the CDOP review with only 5 cases taking a year or more to review. The variation in timescales for reviews is sometimes because of difficulties in arranging Local Case Discussions when several agencies have been involved with the child. Once again thanks go to the administrator within Tees Health who has the difficult task of arranging and minuting these meetings. There have also been issues around ensuring that children who die at home, such as those with terminal cancer, have a review by staff involved with their care before CDOP looks at the case. Due to interventions by the Independent Chair it is anticipated that this process will work much better during the coming year.

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

The CDOP classified 6 of the deaths reviewed as having modifiable factors and 1 other as having insufficient information to make a decision.. This equates to 19% of the total deaths reviewed which is slightly less than the national figure of 20% for the previous 2 years. Once inquests have been held this classification can be revisited and revised locally.

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Two of the cases with modifiable factors involved co sleeping either in parent's bed or on a sofa. In both of these cases there was passive smoking in the home as well as ante and post natal smoking by the mothers. These two factors are recognised nationally as increasing the vulnerability of babies and are risk factors in infant deaths. Tees CDOP has launched an E learning course on Safe Sleeping for babies and are encouraging all staff who go into family homes to give the same messages on how to keep babies safe. CDOP are also considering a publicity campaign targeting these issues.

A child died of acute asthma. There were many issues which may have contributed to the vulnerability of the child, and there also appeared to be difficulties for all agencies in maintaining continuity in their contact with the family, especially when the family moved house to a different locality. Issues were identified in the acute healthcare sector, CAMHS procedures when children are not brought for appointments, and the process for using the Common Assessment Framework (which needed to include stronger health input) so that all relevant agencies are aware of each others' issues in future. As there were so many issues around the vulnerability of this child the Local Safeguarding Children Board have been asked to consider whether a management or serious case review should be undertaken.

Another modifiable factor was identified when a child died after a choking episode at school. The recommendation was made to all schools that a first aider should be on duty at all times in the dining hall over lunchtime to try to prevent future incidents.

Three other cases with modifiable factors concerned processes within hospitals. One of these was a recommendation that in certain cases prophylactic fluconazole should be given from the first day of life and CDOP has been assured that this is happening.

In another case the local review identified issues with the recognition and management of post term rupture of membranes with meconium stained liquor. These issues have been addressed in the maternity service.

In the last case with modifiable factors it was recognised that there needed to be improved communication between different hospital respiratory teams around transfer of patients. A local and internal review was carried out and an agreement on improvements was made. Due to issues in the home there had also been a delay from the pre discharge meeting until the child was actually discharged. Protocol in the hospital concerned has now been changed to ensure that when discharge is delayed then another discharge meeting must be held.

3. Impact of Tees CDOP:

The Tees CDOP Procedures for Unexpected Death give agencies a comprehensive understanding of their role in the child death review process and how this fits in with the review as a whole. Following the procedures means that investigations into any child death should be comprehensive and identify any lessons which can prevent future deaths.

Any lessons learned in Tees which may be of benefit to other areas are circulated through the CDOP national network and other areas also share important messages this way. An example of this is the recommendation that a First Aider should always be present in school dining halls after a local schoolchild died after a choking episode.

It is important that families should be offered appropriate support around the death of their child and CDOP regularly updates the list of resources available locally and publishes this on its' website: http://www.tees-cdrp.org.uk**.** Deaths in schoolchildren

are relatively rare but CDOP has also identified organisations which can help staff support other children in their school through the bereavement process.

Work has been carried out regionally around the importance of developing an end of life plan for those children who are receiving palliative care or who have life limiting conditions. Tees CDOP has supported the development of the pathway which has been adopted by James Cook University Hospital and is being adapted for use in University Hospital of North Tees and Hartlepool.

Issues which have been highlighted in the national data collection from CDOPs which are relevant to Tees CDOP cases are around safe sleeping, smoking and road safety. Health promotion issues that have been highlighted during Tees CDOP reviews include road safety and substance misuse. Specific issues have been raised with police and local authorities as a result of this, for example changing road markings to reduce speed of traffic where a child has been killed.

Tees CDOPs working relationship with the local Coronial service has improved so that relevant information can be shared to the benefit of both processes.

CDOP has also been consulted and supported development of a protocol around Organ donation.

An e learning course has been provided free of charge to the public sector and not for profit agencies to highlight dangers around co sleeping with babies and to promote safe sleeping practices. Although this hasn't been a huge issue so far in this area we have seen a few deaths so a promotion campaign will be undertaken during the next year to further highlight the risks.

4. Tees Child Death Statistics 1st April 2012 to 31st March 2013

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

4.1 Table 1 shows the number of child deaths in each local authority and the cumulative 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 project are made after the year end.)

Table 1	H	S	M	R & C	**Tees**
Total Number of Child Deaths in each local authority	3 (0)*	14 (5)*	12 (4)*	8 (4)*	**37**
Total Number of Males	2 (67%)	11 (79%)	7 (58%)	6 (75%)	**70%**
Total Number of Females	1 (33%)	3 (21%)	5 (42%)	2 (25%)	**30%**

* Numbers in brackets show unexpected deaths

4.2 Table 2 shows comparative numbers of total child deaths per area for the 5 complete years of the Tees CDOP.

Table 2	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**Total**
Hartlepool	5 (1)*	9 (1)*	9 (3)*	3 (1)*	3 (0)*	**29**
Stockton	15 (3)*	10 (4)*	18 (8)*	25 (8)*	14 (5)*	**82**
Middlesbrough	20 (9)*	18 (8)*	12 (6)*	11 (3)*	12 (4)*	**73**
Redcar & Cleveland	12 (8)*	8 (5)*	13 (1)*	6 (2)*	8 (4)*	**47**
TOTAL	**52**	**45**	**52**	**45**	**37**	**231**

*Numbers in brackets denote unexpected deaths

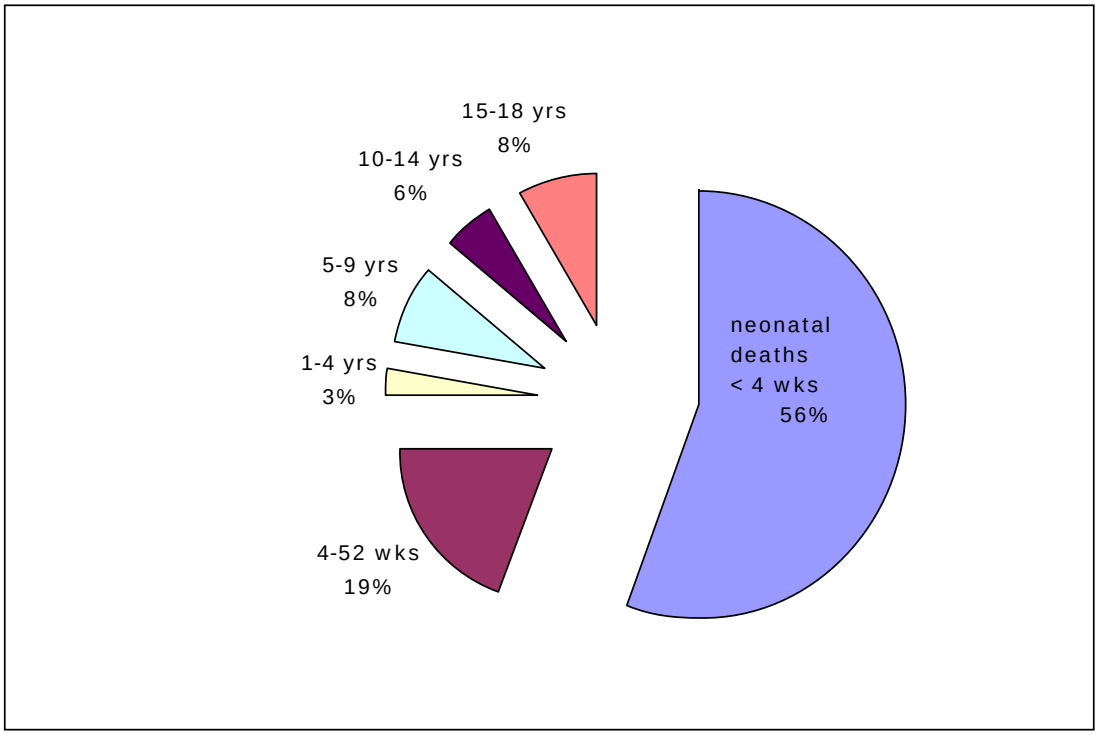
5. Child Deaths considered by CDOP April 2012 to March 2013

5.1 Table 3 shows the respective ages of the children when they died. 36 deaths were reviewed plus one out of area case where the child died at James Cook University Hospital. This case was reviewed by both North of Tyne and Tees CDOP as there had been substantial involvement by both JCUH and the RVI.

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	2		1				**3**
Stockton LSCB	10	4		2	1	2	**19**
Middlesbrough LSCB	4	3		1			**8**
Redcar & Cleveland LSCB	4				1	1	**6**
Tees	**20**	**7**	**1**	**3**	**2**	**3**	**36**

5.2 **Percentage of deaths reviewed by age group**



The latest national figures available are for 2011/12 which showed that 66% of child death reviews were on those aged under 1 year old.

5.3 In considering the gender of the children who died there were more boys than girls.

Table 4: Gender		
	Male	**Female**
Hartlepool LA	3	0
Stockton LA	11	8
Middlesbrough LA	3	5
Redcar & Cleveland LA	4	2
Tees	**21**	**15**

5.4 Table 5 shows the children's ethnicity which unsurprisingly given the ethnic mix across Tees is overwhelmingly White British

Table 5: Ethnicity as recorded on returned CDOP forms						
		H	**S**	**M**	**R & C**	**Tees**
White	British	3	14	8	6	**31**
Asian or Asian British						
	Pakistani		5			**5**

5.5 Table 6 shows the number of children who died and who could be considered to have a higher level of vulnerability than most children in the locality.

Table 6: vulnerable children	H	S	M	R&C	**Tees**
Number of children that were Looked After by the LA	0	0	0	0	**0**
Number of children with a disability or with life limiting conditions	2	7	2	2	**13**
Number of children with a current Protection Plan	0	0	1	0	**1**

5.6 Table 7 looks at the place of death. It should be noted that when a child dies in hospital after an incident that occurred elsewhere, such as a river or a highway, the place of the incident that led to the child's death is recorded.

Table 7: Location of death or fatal event					
	H	S	M	R&C	**Tees**
Number at home of normal residence		3	4	2	**9**
Number in hospital	3	14	4	4	**25**
Number in educational establishment		1			**1**
Number in public place (including roads, railways, parks, restaurant, beaches etc)waterway (i.e. river, canal, sea,)		1			**1**

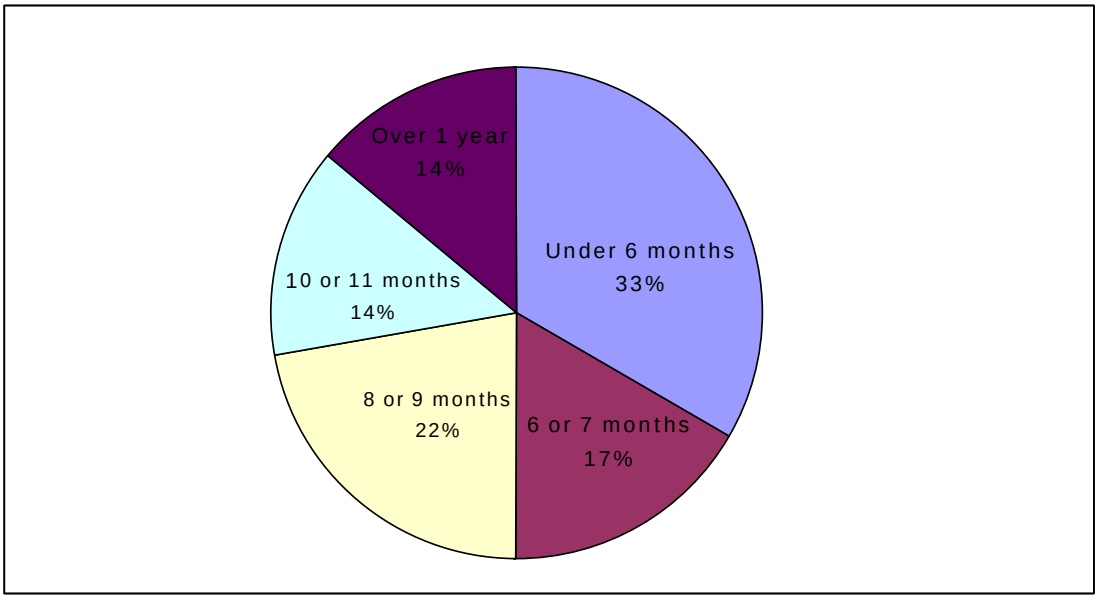
5.7 Table 8 sets out the recorded reason for the child's death. This data reflects the original categorisation from the Local Case Discussion (LCD) and Form C information.

Numbers of deaths in the categories * ***as taken from the DfE website**						
Table 8		H	S	M	R&C	**Tees**
1. Deliberately inflicted injury, abuse or neglect						
2. Suicide or deliberate self inflicted harm			1			**1**
3. Trauma or other external cause			2			**2**
4. Malignancy		1			1	**2**
5. Acute medical or surgical condition			1	1		**2**
6. Chronic medical condition						
7. Chromosomal, genetic or congenital anomalies		1	7	1		**9**
8. Perinatal/neonatal event		1	8	4	3	**16**
9. Infection					1	**1**
10. Sudden unexplained, unexpected death (Of these any classed as SUDI)				2	1	**3**

5.8 Table 9 provides additional information in respect of the Child Death Review (CDR) process and outcomes from the Child Death Overview Panel CDOP.

Table 9 : additional information	H	S	M	R&C	**Tees**
Number of Coroner's cases	0	3	2	2	**7**
Number of deaths that were unexpected	1	5	3	2	**11**
Number of deaths that CDOP deemed to have modifiable factors.	0	2	3	1	**6**
Number of cases were CDOP had insufficient information to make a decision on modifiable factors	0	0	1	0	**1**
Serious Case Reviews /Learning Review considered or CDOP flagged this up as a possibility	0	0	2	0	**2**

5.9 Length of time taken from date of death to case being reviewed by CDOP



Half of the cases were reviewed within 7 months of the child's death but a small number of them take over a year. Primarily this is down to issues around gaining relevant information from staff when children have died expected deaths at home from conditions such as cancer. Tees CDOP has been working to resolve this problem. However this figure remains under the national average of 23% of child deaths taking over a year to review during 2011/12

6.Tees CDOP and the Child Death Review Process

CDOP recognises, and greatly appreciates, the work done by partners across all services to ensure the smooth implementation of the Child Death Review processes and hopes to enjoy their ongoing support and commitment to ensure that all those who are required to, play their full and proper part in the process.

Local Case Discussion:

Working Together to Safeguard Children(2010) stipulates that deaths of all children and young people from birth up to the age of 18 years should be reviewed at a Local Case Discussion (LCD) this would in turn inform a Child Death Overview Panel (CDOP) which has the statutory requirements to review all childhood deaths.

The deaths in children and young people fall into three broad categories

1 Neonatal Deaths
2 Unexpected Deaths
3 Expected Deaths

Neonatal Deaths:
These are discussed and reviewed by the medical and nursing staff of the two neonatal units on Teesside as well as receiving input from the neonatal unit in Newcastle if a child was transferred for care to the Royal Victoria Infirmary (RVI) in Newcastle. Two neonatologists (one from each unit on Teesside) have been co-opted to CDOP so that they could present local deaths to the Panel for discussion,

whilst the Panel Chair, Dr Ward Platt is often able to give additional information on deaths which occur in Newcastle hospitals.

Unexpected Deaths:
The Tees Designated Paediatrician for Child Death Review convenes and chairs LCDs for all Unexpected Child Deaths in the area covered by the four Tees LSCBs. The meeting includes all those professionals who knew/cared for the child and family and those involved in the investigation of the child's death.

The main purpose of the case discussion is to share information and to identify the cause of death as well as the factors that may have contributed to the death and plan for the future care of the family. Potential lessons to be learnt from the death will also be identified by this process.

The case review analysis proforma, form C, is used to facilitate the discussion and it also provides a template for local and national data collection. The emphasis is on openness by all the professionals in order to learn lessons to prevent future deaths and to improve the services for children and their families. In this respect our experience on Teesside has been very positive.

The person who has been most closely involved with the child and the family is usually nominated at the meeting to share with the family the detailed information about the cause of death and any relevant actions/recommendations identified from the case discussion.

Form C is then discussed at a subsequent CDOP meeting where additional recommendations may be made as well as monitoring of actions taken forward for implementation.

In cases where complex medical issues are identified the Designated Paediatrician for Child Death Review can visit the family to explain the relevant medical information and to answer any questions they may have. Such visits have been extremely valuable from both the family and professional's point of view. In many cases the family then feels that they have been given appropriate information and adequate explanation surrounding the medical issues and the care of the child. This has been helpful for parents to be able to find some closure and to be able to grieve for their child.

Expected Deaths: When a child's death is expected, such as where an End of Life Care Pathway is in place, then the team looking after the child organises a LCD since it is likely that important lessons can be leant that might improve the care of other children.

The output of the LCD can also be captured on the analysis proforma Form C, which provides the CDOP with evidence of good practice and allows wider professional engagement with the Child Death Review Process

7. <u>The future:</u>

The Child Death Review process has become embedded across Tees with a dedicated panel reviewing all child deaths, and professionals now beginning to understand their role in the process, including involvement in Local Case Discussions. A workplan up till March 2014 was developed and this is attached as Appendix 3.

The CDOP will continue to monitor any effects upon child deaths as a result of change to the benefits system and health services and report this back to LSCBs across Tees.

The project was funded until 31st March 2014 although subject to an annual review of finance by the host, Redcar & Cleveland LSCB. Plans are being made for a review to be carried out by an Independent Consultant during Summer 2013 to identify how best to take forward the statutory responsibility of reviewing child deaths.

APPENDIX 1

CHILD DEATH OVERVIEW PANEL

MEMBERSHIP 2012 – 2013

Core Members

Dr Martin Ward Platt	Consultant Paediatrician (Independent Chair)
Gordon Lang	Acting Head of Crime, Cleveland Police (until September 2012)
Darren Best	Head of Crime Operations, Cleveland Police(from September 2012)
Dr Kailash Agrawal	Designated Doctor
Dr Raj Pandey,	GP representative
Mark Adams	Assistant Director for Health Improvement, NHS Tees
Alex Giles	Designated Nurse, Safeguarding Children, Tees
Lesley Thirlwell	Named Professional for Safeguarding, NEAS NHS Trust
Janet Alderton	Supervisor of Midwives, UHNTH NHS FT
Jacqui Tucker	Lay Member
Jane Wiles	Children's Service Manager, JCUH
Hilary Minter	Head of Counselling, Teesside Hospice
John Catron	Deputy Director, Achievement ,Middlesbrough CFL
Shaun McLurg	Head of Children and Young People's Services, SBC
Dr Steve Byrne	Consultant Neonatologist
Dr Bernd Reichert	Consultant Neonatologist
Dr Yifan Liang	Consultant Paediatrician

Deputies and Ad Hoc Members

Barry Waller	Head of Fire Engineering
Dean Jackson	Assistant Director (Education), Hartlepool Borough Council

Officers in Attendance

Marcia Ingram	Tees Child Death Review Manager
Sue Thubron	Tees Child Death Review Administrator

CDOP Meeting Dates and Development Sessions for 2012/2013

There were CDOP meetings in May, July, September, November 2012 and January and March 2013.

A development session was held for CDOP in March 2013. There was an annual internal review of CDOP in November 2011 to inform LSCBs of the funding position and updates on the workplan.

APPENDIX 2

Child Death Review Income & Expenditure 2012/13

INCOME	£	Total 12/13
Redcar & Cleveland Borough Council		1200
Middlesbrough Borough Council		1200
Hartlepool Borough Council		1200
Carry forward from 2011/12		145,501 *
Total Income		**149,101**

EXPENDITURE	£	Total 12/13
Staffing: Manager/ administrator and on costs		33,576
Professional Fees**		15,044
Training costs		1,000
Supplies and services		150
Total Expenditure		**£49,770**
Carry forward 13/14		99,331
Total		**149,101**

Notes:

* Carry forward income includes payments made in advance from SLSCB and R&C PCT for 2012/13

**Professional fees include costs for the Independent Chair including attendance at pre agenda meetings, training and other professional meetings. Other costs within this heading include Lay Members expenses, Hospice staff attendance at meetings, hosting of the website and the RMSO contract for notifications.

During reviews it was agreed to carry underspent funding forward to cover the running of the Child Death review process till at least April 2014. An Independent Review will be carried out to determine how to continue with the Child Death Review process post March 2014.

APPENDIX 3

TEES CDOP
WORK PLAN 2011-2014

PRIORITY	ACTIVITY	LEAD	TIMESCALES/ PROGRESS
1: Review of all child deaths by Panel.	• Panel meetings to be arranged a year in advance • Membership of Panel to be representative of all major agencies • Panel meetings to be organised and minuted by CDOP support team. • Panel members to attend annual Development Session to improve aspects of review. • LCDs to be held on all unexpected child deaths.	Marcia Ingram Martin Ward Platt Marcia Ingram Martin Ward Platt Kailash Agrawal	Completed Completed Ongoing Completed Ongoing
2. Monitoring of actions from each Case Discussion.	• All actions from each case discussion to be recorded and updated as information becomes available. • Monitoring data to be standing item on CDOP agenda • Any outstanding actions to be followed up by the appropriate member of CDOP or CDRP Manager. • Facilitation of appropriate actions that may be required following review eg ensuring families are aware of the need for genetic counselling.	Sue Thubron Marcia Ingram Marcia Ingram Kailash Agrawal	Ongoing Ongoing Ongoing Ongoing
3. Learning lessons to prevent Child Deaths	• Ensuring lessons are learned where appropriate from each review. • Facilitating discussion on preventative work eg para suicide • Dissemination of lessons learned to prevent future deaths occurring.	Martin Ward Platt Martin Ward Platt Martin Ward Platt	Ongoing Ongoing Ongoing
4. Produce and disseminate Annual Report	• Annual report to be available by September/October each year • Annual report to be circulated to Independent Chairs and Business Managers of Tees LSCBs for comment prior to publication. • Annual reports to be made accessible on Tees CDOP website.	Martin Ward Platt Marcia Ingram Marcia Ingram	Ongoing Ongoing Completed
5. Support for	• Monitoring of support services available for families	Martin Ward Platt	Completed

families	• Informing LSCBs when gaps in services are identified.	Martin Ward Platt	Ongoing
6. Collation of annual stats to inform national reporting	• Data to be compiled onto appropriate spreadsheets as per national guidance • National annual statistical pro formas to be completed and returned to DfE as required.	Sue Thubron Marcia Ingram	Ongoing Completed
7. Develop closer links with Tees LSCBs	• Panel minutes and overview of case discussions to be sent to each of the 4 Tees LSCBs after ratification. • Circulating Annual Reports and other updates as requested to Tees LSCBs.	Marcia Ingram Marcia Ingram	Ongoing Ongoing
8. Develop collaborative relationships with other North Eastern CDOPs	• Maintain and develop links with other CDOPs in North East and North Yorkshire through attendance at regional meetings and contribution to conferences. • Taking part in themed projects around specific areas of child deaths	Martin Ward Platt Marcia Ingram	Completed Ongoing
9. Ensure an annual review is carried out	• Ensure annual review of finances and staffing is carried out and a report submitted for information to each LSCB	Manager RCSCB	Ongoing