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

2017/2018

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 2017 to 31st March 2018 and provides information on the total number of child deaths reviewed across the Tees area 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.

In 2017/2018 Director of Public Health (Middlesbrough & Redcar and Cleveland) continued in his role as Chair. 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. In 2017/18 a representative from Child Bereavement UK (CBUK), who are delivering a project in the area, joined Tees CDOP.

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
	Named GP for Safeguarding
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, Middlesbrough Council
Tees Esk & Wear Valley NHS Trust (TEWV)	Named Nurse, Safeguarding
Education	Principal Manager, Redcar and Cleveland Council
Child Bereavement UK	Bereavement Support Practitioner
School Nursing and Health Visiting Service	Harrogate and District NHS Foundation Trust
Lay Member x 2	Independent Lay Member

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. The CDOP panel considers 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 scrutiny and 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 2017 TO 31 MARCH 2018

4.1 Total Number of Child Deaths 2017/18

Table 1 shows the number of child deaths reported in each Local Authority area across the Tees in 2017/18:

Table 1 - Child Deaths 2017/18					
	H	**M**	**R & C**	**S**	**TOTAL**
Total Number of Males	3	10	4	7	**24**
Total Number of Females	2	4	3	5	**14**
Total Number of Child Deaths in each local authority	**5**	**14**	**7**	**12**	**38**

4.2 Expected / Unexpected Child Deaths 2014/15 to 2017/18

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 2014/15 to 2017/18					
	2014/15	**2015/16**	**2016/17**	**2017/18**	**Total**
Hartlepool	9(4)	7(4)	11(8)	5 (2)	**32 (18)**
Middlesbrough	13(5)	16(8)	13(2)	14 (8)	**56 (23)**
Redcar & Cleveland	7(3)	8(4)	9(4)	7 (3)	**31 (14)**
Stockton	12(0)	12(6)	16(8)	12 (6)	**52 (20)**
Tees Total	**41(12)**	**43(22)**	**49(22)**	**38 (19)**	**171 (75)**

A total of 16 Rapid Response meetings were held in respect of unexpected deaths occurring in 2017/18. Rapid Response meetings did not take place in respect of three unexpected deaths as they were neonatal cases which do not routinely require a Rapid Response meeting to be held.

The tables above demonstrate that:

- Total Tees Child deaths have decreased by 22% from 49 in 2016/17 to 38 in 2017/18.
- Despite there being a decrease in the total number of unexpected deaths, there was however an increase in the percentage of unexpected deaths in 2017/18 from 44% in 2016/17 to 50% in 2017/18. It is of note however that this figure has fluctuated in recent years and there is nothing to suggest that there is statistical relevance to this small increase.
- **PLEASE NOTE: The total number of child deaths reported in 2017/18 is different to the total number of deaths reviewed by CDOP in 2017/18 because cases can take in excess of 6 months to be reviewed by CDOP therefore:**
  - **some child deaths reviewed in 2017/18 will have occurred in 2016/17 or earlier, and**
  - **some child deaths which occurred in 2017/18 may not be reviewed until 2018/19.**

The remainder of this report is in respect of Child Death's reviewed in 2017/18

5. TEES CHILD DEATHS REVIEWED BY CDOP IN 2017/18

During 2017/18 the Tees CDOP reviewed 45 child deaths making a total of 389 reviewed over the 10 years of operation. This is a very slight increase from the 44 cases reviewed in 2016/17. The Tees panel met 6 times during this year and reviewed an average of 7 cases per meeting.

19% of child deaths reviewed during 2017/18 year were finalised within less than 6 months of the child's death. 64% of child deaths reviewed during 2017/18 were finalised within 12 months of the child's death. During this time 17% of cases took more than a year to review.

Delays in reviewing cases beyond 1 year 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 in 2017/18 by LSCB Area:

Table 3 - Child Deaths Reviewed in 2017/18			
	Neonatal	**Older Children**	**Total**
Hartlepool	4	8	**12**
Middlesbrough	3	9	**12**
Redcar and Cleveland	3	4	**7**
Stockton	3	11	**14**
Total	**13**	**32**	**45**

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

Table 4 - Age Range of Deaths Reviewed in 2017/18							
	Neonatal Deaths <4weeks	**4-52 weeks**	**1-4 years**	**5-9 Years**	**10-14 years**	**15 up to 18 years**	**Total**
Hartlepool	4	1	1	3	0	3	**12**
Middlesbrough	3	3	1	1	0	4	**12**
Redcar & Cleveland	3	1	1	0	0	2	**7**
Stockton	3	3	4	2	2	0	**14**
Tees Total	**13**	**8**	**7**	**6**	**2**	**9**	**45**

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

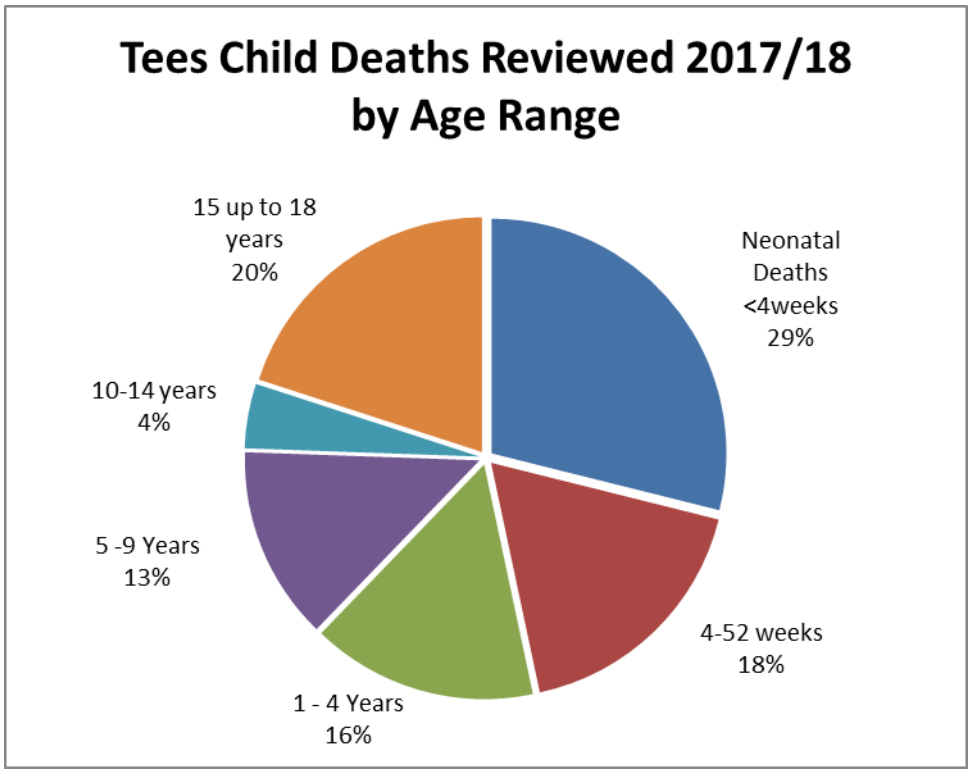

Table 5 below details the ethnicity of children whose deaths were reviewed in 2017/18 as recorded on returned CDOP forms.

Table 5 - Ethnicity of Children Whose Death was Reviewed in 2017/18					
	H	**M**	**R&C**	**S**	**Tees**
White: British	11	8	5	11	**35**
Mixed/multiple ethnic groups: Any other mixed/multiple ethnic background	1	2	0	2	**5**
Not recorded/unknown	0	2	2	1	**5**
Total	**12**	**12**	**7**	**14**	**45**

Table 6 details the location of the child's death of those cases reviewed in 2017/18

Table 6 - Location of Death or Fatal Event 2017/18					
	H	**M**	**R&C**	**S**	**Tees**
Number at home of normal residence or other family home	3	0	1	2	**6**
Number in hospital or medical facility	6	11	4	10	**31**
Number in educational establishment	0	0	0	0	**0**
Number in public place (including roads, railways, parks, restaurant, beaches, waterway etc.)	3	1	2	2	**8**
Total	**12**	**12**	**7**	**14**	**45**

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 2017/18						
		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	2	**2**
3	Trauma or other external cause	6	2	2	1	**11**
4	Malignancy	0	2	0	0	**2**
5	Acute medical or surgical condition	0	0	0	3	**3**
6	Chronic medical condition	0	1	2	1	**4**
7	Chromosomal, genetic or congenital anomalies	4	4	1	4	**13**
8	Perinatal/neonatal event	1	2	1	2	**6**
9	Infection	1	1	0	0	**2**
10	Sudden unexplained, unexpected death	0	0	1	1	**2**
11	Unknown category	0	0	0	0	**0**
	TOTAL	**12**	**12**	**7**	**14**	**45**

Table 8 provides additional information in respect of child deaths reviewed by CDOP in 2017/18

Table 8 - Additional information 2017/18					
	H	**M**	**R&C**	**S**	**Tees**
Number of deaths that were unexpected	8	4	3	8	**23**
Number of deaths that CDOP deemed to have Modifiable Factors.	3	4	2	5	**14**
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 45 child deaths that were reviewed in 2017/18, there were 14 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 action to address these where appropriate

Findings from the child deaths reviewed in 2017/18:

- Of note is the increase of child deaths in the age group of 15 up to 18 years from 9% in 2016/17 to 20% in 2017/18.
- In previous years, the main cause of death was as a result of perinatal or neonatal difficulties however in 2017/18 the main cause of death was as a result of Chromosomal, genetic or congenital anomalies (28%) which is an increase from 18% in 2016/17.
- Sudden Infant Deaths have decreased from 4 cases (9%) reviewed in 2016/17 to 2 cases (4%) in 2017/18.
- As in 2016/17 (79%) the majority of children died in a hospital or medical setting (68%) 2017/18. However in respect of child deaths in a public place there is an increase from 2016/17 (2%) to 2017/18 (17%).
- As in previous years the majority of children whose deaths were reviewed were White British.
- Out of the 45 child deaths reviewed in 2017/18 none resulted in a Serious Case Review.

6. OUTCOMES AND RECOMMENDATIONS

Positive outcomes in relation to the work of 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 12 March to 16 March 2018.
- **Funding**
  The four Tees Directors of Public Health will continue to fund the Business Unit costs associated with Tees CDOP until 31 March 2019.
- **Cross Reviewing of Cases**
  An external reviewer continues to attend Neonatal Local Case Discussions to ensure independent scrutiny.
- **Obstetric Representation**
  Obstetric representatives are now routinely invited to Neonatal LCDs to ensure appropriate and relevant information is shared and included within discussions.
- **Improved Links with GPs**
  In 2017/18 the Named GP for Safeguarding became a standing member of Tees CDOP ensuring that the GPs are represented and where appropriate lessons learned are shared across the Tees.
- **Links with Education**
  The Education representative and other partners ensure that, where appropriate, identified risks and lessons learned are shared with Education establishments.
- **Improved Links with Health Visiting and School Nursing**
  In 2017/18 a representative from Health Visiting/School Nursing became a standing member of Tees CDOP.
- **Form Cs**
  The timeliness and quality of Form Cs has improved during 2017/18 ensuring appropriate information is captured and recommendations highlighted. Work has been completed with Neonatal staff in respect of information provided in form Cs

7. FUTURE CHALLENGES AND PRIORITIES

Tees CDOP is committed to continuous improvement and in 2018/19 there will be particular focus on:

- **Information for Families**
  To ensure information is available to all families aimed at keeping children safe and highlighting childhood risks.

- **External Review of Neonatal Deaths**
  The neonatal teams from both South Tees NHS Hospitals Foundation Trust and North Tees Foundation Trust are due to merge in 2018/19. It will therefore be necessary to consider the way in which cases receive independent scrutiny.

- **Supporting Families**
  We will continue to work closely with Child Bereavement UK to develop appropriate pathways to ensure support is available for families who have experienced the tragedy of child death.

- **Supporting Practitioners**
  Work will continue with Child Bereavement UK to provide training for practitioners.

- **Improving Communication**
  We will consider how to raise awareness with families in respect of the CDOP processes.

- **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.

- **Children and Social Care Act 2017 and Working Together 2018**
  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.

- **Communication with the Coroner**
  We will endeavour to ensure there is an effective communication process in place with the Coroner.

- **Designated Paediatrician for Child Death**
  The role of Designated Paediatrician for Child death is presently vacant. Recruitment and retention of a suitably qualified Paediatrician is a priority for 2018/19 to ensure Local Case Discussions are held in a timely manner.

APPENDIX 1 - TEES CDOP BUDGET

Income/Expenditure 2017-2018	Income £	Expenditure £
CDOP Budget c/f 16/17 Contributions from Public Health TOTAL INCOME	1,870 22,100 23,970	
Salaries (inc. on-costs): RCSCB Business Manager (1 day per week) RCSCB Administrator (2 days per week)		20,000
Other expenditure: Hosting of the CDOP website Admin Costs – Rapid Response – CCG Website Domain Registration		110 700 40
TOTAL EXPENDITURE		20,850
BALANCE	£3,120	
Forecast Income Expenditure 2018/19	Income £	Expenditure £
CDOP Budget c/f 17/18 Contributions from Public Health TOTAL INCOME	3,120 22,100 25,220	
Salaries (inc. on-costs): RCSCB Business Manager (1 day per week) RCSCB Administrator (2 days per week)		20,700
Expenditure – Hosting of the CDOP website Website Domain Registration		110 40
TOTAL EXPENDITURE		20,850
POTENTIAL C/F 2019/20	£4,370	

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

In addition to the staff posts funded directly by the CDOP budget the NHS Hartlepool and Stockton on Tees CCG and NHS South Tees CCG also fund the cost of the provision for the Designated Paediatrician for Child Death and associated administrative support.

APPENDIX 2 - ATTENDANCE AT TEES CDOP MEETINGS 2017-18

Organisation	26.5.17	21.7.17	15.9.17	17.11.17	19.1.18	23.3.18	Meetings Invited	Total Attended
Director - Public Health - (CHAIR)	Y	Y	Y	Y	Y	Y	6	6
South Tees CCG (Vice Chair)	Y	Y	Y	Y	Y	Y	6	6
UNTH – Neonatologist	Y	X	Y	A	X	Y	6	3
UNTH – Paediatrician	X	Y	X	X	X	Y	6	2
RCBC Education	Y	Y	Y	Y	Y	Y	6	6
Cleveland Police	Y	Y	Y	Y	Y	Y	6	6
Designated Paediatrician for Child Death / JCUH – Paediatrician	Y	Y	Y	Y	Y	Resigned	5	5
Coroner	A	A	X	Resigned			3	0
Midwifery Representative	A	Y	A	Y	Y	A	6	3
JCUH - Consultant Neonatologist	A	Y	A	Y	Y	Y	6	4
NEAS Ambulance Service	X	X	X	X	A	A	6	0
Nursing – JCUH	Y	Y	Y	Y	Y	Y	6	6
Children's Services	A	Y	Y	A	Y	Y	6	4
CBUK - Representative	X	Y	X	X	Y	Y	6	3
Lay Member	A	A	A	Y	Y	Y	3	3
Tees Esk & Wear Valley NHS Trust	Y	Y	Y	Y	Y	Y	6	6
Named GP for Safeguarding	N/A	N/A	A	A	Y	Y	4	2
Health Visitor and School Nursing - HDFT	N/A	N/A	N/A	N/A	Y*	Y	2	2

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

*This was the first meeting the Health Visitor and School Nursing Representative was invited to.