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

2018/2019

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 2018 to 31st March 2019 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.

It is of note that the Child Death Review Process is changing following a review and a revision of statutory requirements as set out in Working Together 2018. A summary of these changes is included at Section 8.

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 2018/2019 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.

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 1	Independent Lay Member

The administration of the CDOP process is hosted by Redcar and Cleveland Safeguarding Children Board and is funded jointly by 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 2018 TO 31 MARCH 2019

4.1 Total Number of Child Deaths 2018/19

Table 1 shows the number of child deaths reported in each Local Authority area across the Tees in 2018/19:

Table 1 - Child Deaths 2018/19					
	H	**M**	**R & C**	**S**	**TOTAL**
Total Number of Males	2	5	9	3	**19**
Total Number of Females	0	4	4	9	**17**
Total Number of Child Deaths in each local authority	**2**	**9**	**13**	**12**	**36**

4.2 Expected / Unexpected Child Deaths 2014/15 to 2018/19

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 2018/19						
	2014/15	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**Total**
Hartlepool	9(4)	7(4)	11(8)	5 (2)	2 (1)	**34 (19)**
Middlesbrough	13(5)	16(8)	13(2)	14 (8)	9 (5)	**65 (28)**
Redcar & Cleveland	7(3)	8(4)	9(4)	7 (3)	13 (7)	**44 (21)**
Stockton	12(0)	12(6)	16(8)	12 (6)	12 (3)	**64 (23)**
Tees Total	**41(12)**	**43(22)**	**49(22)**	**38 (19)**	**36 (16)**	**207 (91)**

A total of 11 Rapid Response meetings were held in respect of unexpected deaths occurring in 2018/19. Rapid Response meetings did not take place in respect of 5 unexpected deaths as they were neonatal cases which do not routinely require a Rapid Response meeting to be held.

The tables above demonstrate that:

- Both the total number of child deaths in 2018/19 and the unexpected number of child deaths have both slightly decreased in 2018/19 from 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 decrease.
- **PLEASE NOTE: The total number of child deaths reported in 2018/19 is different to the total number of deaths reviewed by CDOP in 2018/19 because cases can take in excess of 6 months to be reviewed by CDOP therefore:**
  - **some child deaths reviewed in 2018/19 will have occurred in 2017/18 or earlier, and**
  - **some child deaths which occurred in 2018/19 may not be reviewed until 2019/20.**

The remainder of this report is in respect of Child Death's reviewed in 2018/19

5. TEES CHILD DEATHS REVIEWED BY CDOP IN 2018/19

During 2018/19 the Tees CDOP reviewed 27 child deaths making a total of 416 reviewed over the 10 years of operation. This is a decrease from the 38 cases reviewed in 2017/18. The Tees panel met 5 times during this year and reviewed an average of 5 cases per meeting.

(6) 22% of child deaths reviewed during 2018/19 year were finalised within less than 6 months of the child's death. (17) 63% of child deaths reviewed during 2018/19 were finalised within 12 months of the child's death. During this time (4) 15% of cases took more than a year to review.

Delays in reviewing cases beyond 1 year have been due to the following factors:

- Designated Doctor for Child Death post vacancy.
- 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 2018/19 by LSCB Area:

Table 3 - Child Deaths Reviewed in 2018/19			
	Neonatal	**Older Children**	**Total**
Hartlepool	1	2	**3**
Middlesbrough	5	5	**10**
Redcar and Cleveland	2	5	**7**
Stockton	2	5	**7**
Total	**10**	**17**	**27**

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

Table 4 - Age Range of Deaths Reviewed in 2018/19							
	Neonatal Deaths <4weeks	**4-52 weeks**	**1-4 years**	**5-9 Years**	**10-14 years**	**15 up to 18 years**	**Total**
Hartlepool	1	1	0	0	1	0	**3**
Middlesbrough	5	2	0	2	0	1	**10**
Redcar & Cleveland	2	3	0	1	0	1	**7**
Stockton	2	1	2	1	0	1	**7**
Tees Total	**10**	**7**	**2**	**4**	**1**	**3**	**27**

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

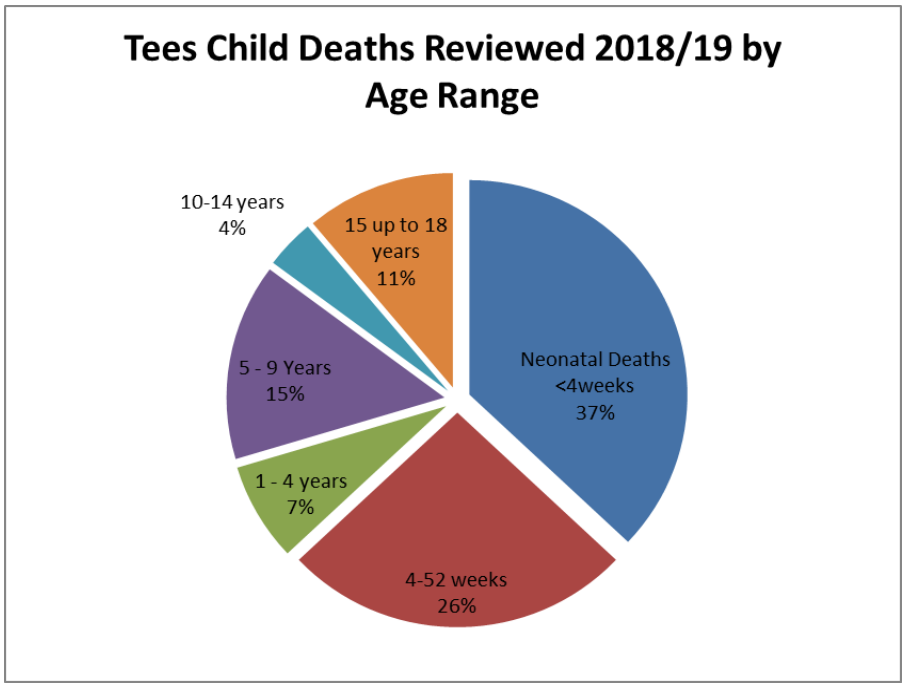

Table 5 below details the ethnicity of children whose deaths were reviewed in 2018/19 as recorded on returned CDOP forms.

Table 5 - Ethnicity of Children Whose Death was Reviewed in 2018/19					
	H	**M**	**R&C**	**S**	**Tees**
White: British	3	8	7	5	**23**
Mixed/multiple ethnic groups: Any other mixed/multiple ethnic background	0	2	0	2	**4**
Not recorded/unknown	0	0	0	0	**0**
Total	**3**	**10**	**7**	**7**	**27**

Table 6 details the location of the child's death of those cases reviewed in 2018/19

Table 6 - Location of Death or Fatal Event 2018/19					
	H	**M**	**R&C**	**S**	**Tees**
Number at home of normal residence or other family home	0	1	1	0	**2**
Number in hospital or medical facility	3	9	5	6	**23**
Number in educational establishment	0	0	0	0	**0**
Number in public place (including roads, railways, parks, restaurant, beaches, waterway etc.)	0	0	1	1	**2**
Total	**3**	**10**	**7**	**7**	**27**

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 2018/19						
		H	**M**	**R&C**	**S**	**Tees**
1	Deliberately inflicted injury, abuse or neglect	0	0	1	0	**1**
2	Suicide or deliberate self-inflicted harm	0	0	0	1	**1**
3	Trauma or other external cause	0	0	0	0	**0**
4	Malignancy	0	0	0	0	**0**
5	Acute medical or surgical condition	0	0	1	0	**1**
6	Chronic medical condition	0	2	0	3	**5**
7	Chromosomal, genetic or congenital anomalies	0	1	2	1	**4**
8	Perinatal/neonatal event	2	5	1	2	**10**
9	Infection	1	2	0	0	**3**
10	Sudden unexplained, unexpected death	0	0	2	0	**2**
11	Unknown category	0	0	0	0	**0**
	TOTAL	**3**	**10**	**7**	**7**	**27**

Table 8 provides additional information in respect of child deaths reviewed by CDOP in 2018/19

Table 8 - Additional information 2018/19					
	H	**M**	**R&C**	**S**	**Tees**
Number of deaths that were unexpected	1	5	4	3	**13**
Number of deaths that CDOP deemed to have Modifiable Factors.	1	2	3	1	**7**
Serious Case Reviews	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 27 child deaths that were reviewed in 2018/19, there were 7 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 2018/19:

- The number of child deaths reviewed in 2018/19 (27) was less than 2017/18 (45), the reasons for which are detailed above.
- There has been a significant decrease of child deaths in the age group of 15 up to 18 years from nine in 2017/18 to three in 2018/19.
- In 2018/19 the main cause of death was as a result of perinatal or neonatal. This is consistent with previous years with the exception of 2017/18 when the main cause of death was reported as Chromosomal, Genetic or Congenital anomalies.
- The number of Sudden Infant Deaths reviewed has remained as that in 2017/18 at 2 cases.
- As in previous years the majority of children died in a hospital or medical setting.
- There was a decrease in the number of child deaths reviewed which occurred in a public place from eight in 2017/18 to two in 2018/19.
- As in previous years the majority of children whose deaths were reviewed were White British.
- Out of the 27 child deaths reviewed in 2018/19 none resulted in a Serious Case Review.

6. OUTCOMES AND RECOMMENDATIONS

Positive outcomes in relation to the work of Tees CDOP include:

- **Safer Sleep Campaign** - once again all Tees LSCBs supported the Lullaby Trust's Campaign which took place 11-17 March 2019.

  The campaign included:

  - Promoting safe sleeping
  - Displaying a variety of posters, information cards and leaflets from The Lullaby Trust in public places to support initiatives.
  - Promotion boards being taken to clinics to actively engage parents in discussions.
  - Information from the Lullaby Trust specifically for teenage parents.
  - Thermometers were provided to families.

- **Tees CDOP Safety Leaflet** –This leaflet provides information and guidance to help prevent childhood injuries and deaths and is given to all parents/carers at the first home visit by the Health Visitor.

  10,000 copies were printed and 2500 copies were distributed to each Tees Local Authority.

- **Links with the Coroner** – improved arrangements are in place to ensure greater support and information is provided to bereaved families/carers.
- **Child Bereavement UK**
  A particularly good working relationship has been formed between Child Bereavement UK and James Cook University Hospital who have been receiving Bereavement Awareness training on a regular basis.

7. FUTURE CHALLENGES AND PRIORITIES

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

- **New Child Death Review Processes (CDRP)**
  We will continue to develop processes as set out by Working Together 2018 and detailed in Section 8.
- **Information for Families**
  We will ensure information is available to all families aimed at keeping children safe and highlighting childhood risks.
- **Supporting Families**
  We will continue to work closely with Child Bereavement UK to develop appropriate pathways to ensure support is available for families/carers who have experienced the tragedy of child death.
- **Improving Communication**
  We will consider how to raise awareness with families in respect of CDRP.
- **Learning Lessons**
  We will consider how best to ensure that lessons learned from the review of child deaths is cascaded both locally and, where appropriate, nationally to help prevent further deaths and injuries.
- **Child Bereavement UK**
  We will support the development of a working relationship between Child Bereavement UK and University of North Tees Hospital.
- **Co-Sleeping**
  We will support campaigns aimed at raising awareness of the risks associated with Co-sleeping.
- **Alcohol Consumption**
  We will work with partners to raise awareness of the risks associated with alcohol consumption by parents and carers who have children in their care.

8. CHANGES TO CHILD DEATH REVIEW PROCESS

The Children and Social Work Act 2017 moves the responsibility for ensuring that reviews are carried out when a child dies from Local Safeguarding Children Boards to the Local Authority and CCG. The arrangements to review child deaths have been amended as part of Working Together (2018), Chapter 5 – Child Death Reviews. The key features of what a good child death review process should look like are detailed in the Child Death Review Statutory and Operational Guidance (2018). The processes in these two documents combine best practice with statutory requirements.

The responsibility for ensuring child death reviews are carried out is held by the Child Death Review Partners (CDRPs), who are defined as the Local Authority for an area and any Clinical Commissioning Groups operating within the local authority area (Working Together 2018). Within the new Tees arrangements the CDRPs are:

South Tees Clinical Commissioning Group

- Hartlepool & Stockton Clinical Commissioning Group
- Hartlepool Council
- Middlesbrough Council
- Redcar & Cleveland Council
- Stockton Borough Council

CDR partners have a legal responsibility and must make arrangements to review all the deaths of children normally resident in the local area and if they consider it appropriate, for any non-resident child who has died in their area in agreement with the CDOP area the child would normally reside in.

The Child Death Review Statutory Guidance states that:

- CDRPs must make arrangements to review all deaths of children normally resident in the local area, and if considered appropriate, for any non-resident child who has died in their area.
- CDRPs must make arrangements for the analysis of information from all deaths reviewed.
- The CDRPs for two or more local authority areas in England may agree that their areas are to be treated as a single area.
- CDPRs should ensure that a Designated Doctor for Child Death (DDCD) is appointed to any multi-agency panel. The DDCD should be a senior paediatrician who can take a lead role in the review process.
- CDRPs should ensure a process is in place whereby the designated doctor for child deaths is notified of each child death and is sent relevant notification.

From the 29th June 2019, Local Authority areas must begin their transition from Local Safeguarding Children Boards (LSCB) to Child Death Review Partner arrangements. The transition must be completed by 29 September 2019.

Work in ongoing to develop appropriate processes across the Tees in line with Working Together 2018.

APPENDIX 1 - TEES CDOP BUDGET

Income/Expenditure 2018-2019	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
Other expenditure: Hosting of the CDOP website Printing – CDOP Safety Leaflet		90 1000
TOTAL EXPENDITURE		21,790
BALANCE	£3,430	

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 Doctor for Child Death and associated administrative support.

APPENDIX 2 - ATTENDANCE AT TEES CDOP MEETINGS 2018-19

Organisation	25.5.18	21.9.18	16.11.18	18.1.19	22.3.19	Meetings Invited	Total Attended
Director - Public Health - (Chair)	Y	Y	Y	A	Y	5	4
South Tees CCG (Vice Chair)	Y	Y	Y	Y	Y	5	5
UNTH – Paediatrician	Y	Y	Y	A	A	5	3
RCBC Education	Y	Y	Y	Y	Y	5	5
Cleveland Police	Y	X	Y	Y	Y	5	4
Designated Doctor for Child Death	X	Y	Y	Y	Y	5	4
Midwifery Representative	Y	Y	Y	A	Y	5	4
Consultant Neonatologist	Y	X	Y	Y	Y	5	4
NEAS Ambulance Service	A	A	Y	A	Y	5	2
Nursing – JCUH	A	Y	Y	Y	Y	5	4
Children's Services	Y	Y	Y	A	Y	5	4
CBUK - Representative	Y	Y	Y	X	A	5	3
Lay Member	A	A	A	Y	Y	5	2
Tees Esk & Wear Valley NHS Trust	Y	Y	Y	A	Y	5	4
Named GP for Safeguarding	Y	A	A	A	Y	5	2
Health Visitor and School Nursing - HDFT	A	X	A	Y	X	5	1

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