Tees

child death overview panel

ANNUAL REPORT 2019-2020

Hosted by Redcar & Cleveland Council
on behalf of Tees Valley CCG, Hartlepool Council,
Middlesbrough Council and Stockton Council

Contents

1. Introduction

1.1 This report covers the period from 1 April 2019 to 31 March 2020 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.

1.2 The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity. Families experiencing such a tragedy should be met with empathy and compassion. They need clear and sensitive communication. They also need to understand what happened to their child and know that people will learn from what happened. The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths.

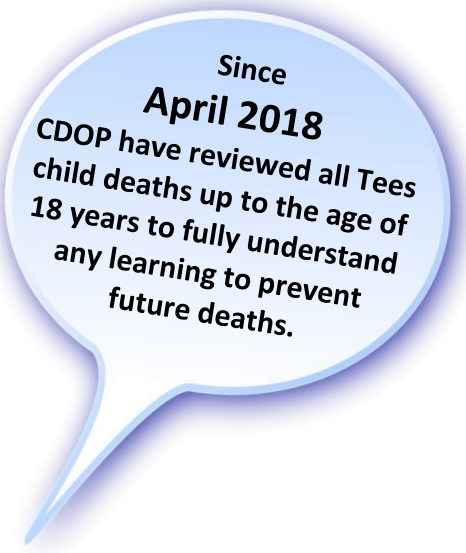
1.3 The death of a child is a tragedy and by reviewing the circumstances surrounding the death of a child we can:

- Identify any changes in practice that might help to prevent similar deaths in the future
- Share any learning with colleagues, locally, regionally and nationally to have a wider impact
- Analyse trends to deliver a response

1.4 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.

1.5 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.
- **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.



2. Membership and Panel Meetings

2.1 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.

2.2 In 2019/2020 the Director of Public Health South Tees (Middlesbrough & Redcar and Cleveland) resigned from the role as Chair and whilst waiting the appointment of a successor to the post of Chair, the Vice Chair stepped up in the interim.

2.3 The Panel comprises of a fixed core membership of senior professionals drawn from organisations with flexibility to co-opt other relevant professionals to discuss certain issues as and when appropriate.

2.4 The Tees CDOP met 6 times in 2019/20 reviewing an average of 3.3 deaths per meeting. The Tees CDOP core membership is detailed below:

Organisation	Title
Public Health	Director of Public Health (Chair)
Tees Valley Clinical Commissioning Group	Designated Paediatrician for Child Death
	Designated Nurse for Safeguarding & Looked After Children (Vice Chair)
North Tees and Hartlepool Hospital NHS Foundation Trust	Consultant Neonatologist, University North Tees Hospital
South Tees Hospitals NHS Foundation Trust	Consultant Neonatologist, James Cook University Hospital
Police	Detective Superintendent, Head of Specialist Crime Cleveland Police
Midwifery	Patient & Safety Lead, Women's & Children's Services, North Tees and Hartlepool NHS Foundation Trust
Nursing Representative	Associate Director of Nursing, Community Care Centre, South Tees NHS Foundation Trust
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	Inclusion Lead, 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

*Some Local Authorities commission this service. Harrogate and District NHS Foundation Trust is commissioned by Stockton and Middlesbrough Council. The CDOP member represents the Tees.

3. Child Death Review Process (CDRP)

The CDRP consists of the following processes:

Immediate Decisions – Within 1-2 hours if possible, senior professionals with responsibility for the child at the end of his/her life should identify the available facts about the circumstances of the child's death;

- determine whether the death meets the criteria for a Joint Agency Response, and if so, contact the on-call representatives for the police, children's social care and health to initiate the joint agency response
- determine whether an MCCD can be issued, if not, consider whether the death should be referred to the coroner
- determine whether an issue relating to health care or service delivery has occurred or is suspected and therefore whether the death should be referred to the coroner and/or a serious incident investigation
- identify how best to support the family
- determine whether any actions are necessary to ensure the health and safety of others, including family or community members, healthcare patients and staff .

In all deaths, these discussions should be recorded on a relevant proforma. The outcome of these discussions should also be fed back to the family.

Joint Agency Response (JAR) (Previously known as Rapid Response Meetings) – usually held within 48 hours of a sudden and unexpected child death, with the exception of neonatal deaths. A Joint Agency Response should be triggered if a child's death:

- is or could be due to external causes
- is sudden and there is no immediately apparent cause (incl. SUDI/C)
- occurs in custody, or where the child was detained under the Mental Health Act
- where the initial circumstances raise any suspicions that the death may not have been natural
- in the case of a stillbirth where no healthcare professional was in attendance

Key professionals from all agencies involved with the child are expected to attend the meeting.

Child Death Review (CDR - previously known as 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 is shared with the coroner, where appropriate, and the relevant CDOP, to inform the child death review.

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.

4. Total Reported Tees Child Deaths: 2019 - 2020

Total Number of Reported Child Deaths 2019/20

Table 1 below shows the **total number of reported expected and unexpected child deaths** (numbers in brackets are total number of unexpected deaths) in each Local Authority area across the Tees in 2019/20:

Table 1 - Tees Child Deaths 2019/20	
	Total
Hartlepool	4 (2)
Middlesbrough	10 (3)
Redcar & Cleveland	5 (3)
Stockton	14 (9)
Tees Total	**33 (17)**

During 2019/20 the CDOP process was amended and Rapid Response meetings were changed to Joint Agency Response (JAR) meetings as described in page 5. JAR meetings are only held for unexpected child deaths and they are not held for neo-natal deaths. The number of rapid response/JARs for the Tees is as follows:

- Hartlepool 2
- Middlesbrough 4
- Redcar & Cleveland 2
- Stockton on Tees 6

Table 2 below shows the total number of reported child deaths in each Local Authority across the Tees from 2015/16 to 2019/20:

Table 2 - Total Child Deaths by Local Authority 2015—2020						
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**Total**
Hartlepool	7(4)	11(8)	5 (2)	2 (1)	4 (2)	**29 (17)**
Middlesbrough	16(8)	13(2)	14 (8)	9 (5)	12 (5)	**62 (26)**
Redcar & Cleveland	8(4)	9(4)	7 (3)	13 (7)	5 (3)	**42 (21)**
Stockton	12(6)	16(8)	12 (6)	12 (3)	14 (9)	**66 (32)**
Tees Total	**43(22)**	**49(22)**	**38 (19)**	**36 (16)**	**33 (17)**	**199 (96)**

Table 2 demonstrates that the total number of child deaths in 2019-20 has slightly decreased and across the last 3 years Tees child deaths have continued to decrease. The number of unexpected deaths has very slightly increased compared to 2018-19, but remains in line with 40 - 60% of the total deaths for each year. It is of note however that the number of unexpected deaths has fluctuated in recent years and there is nothing to suggest that there is statistical relevance to this fluctuation.

5. Tees Child Deaths Reviewed: 2019 - 2020

PLEASE NOTE: The total number of child deaths reported in 2019/20 will be different to the total number of deaths reviewed by CDOP in 2019/20 because cases can take in excess of 6 months to be reviewed by CDOP therefore:

- **some child deaths reviewed in 2019-20 will have occurred in 2018/19 or earlier, and**
- **some child deaths which occurred in 2019-20 may not be reviewed until 2021/21.**

In 2019 – 20, 61% of the total child deaths were reviewed compared with 75% child deaths being reviewed in 2018 – 19. There are various reasons why the number of deaths reviewed has decreased which may include:

- Delays in receiving Post Mortem reports (this is a national issue).
- Increased number of investigations e.g. police, Serious Case Reviews, Learning Reviews, Serious Incidents. Child deaths cannot be reviewed by CDOP until these investigations have been completed.
- The impact of Covid 19 pandemic.

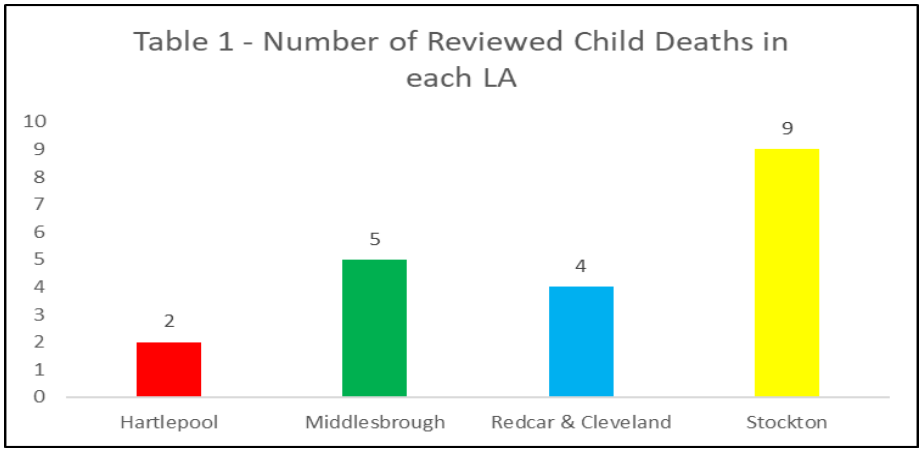


Table 1 above clearly identifies that the most deaths reviewed in 2019-20 were from Stockton (9).

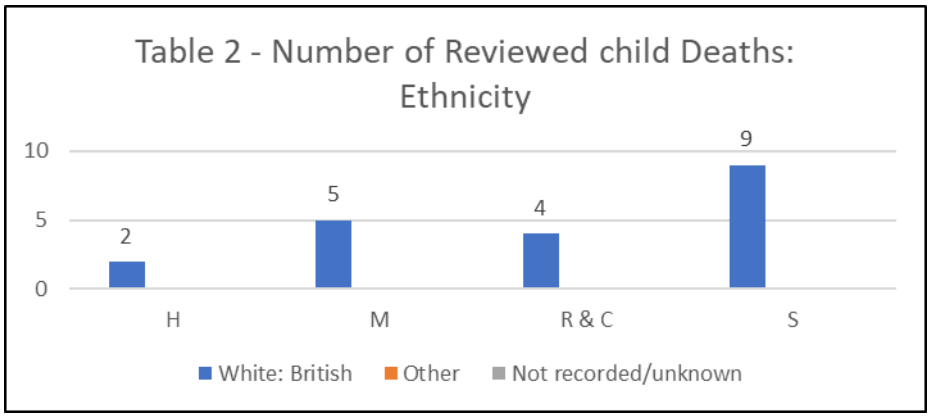
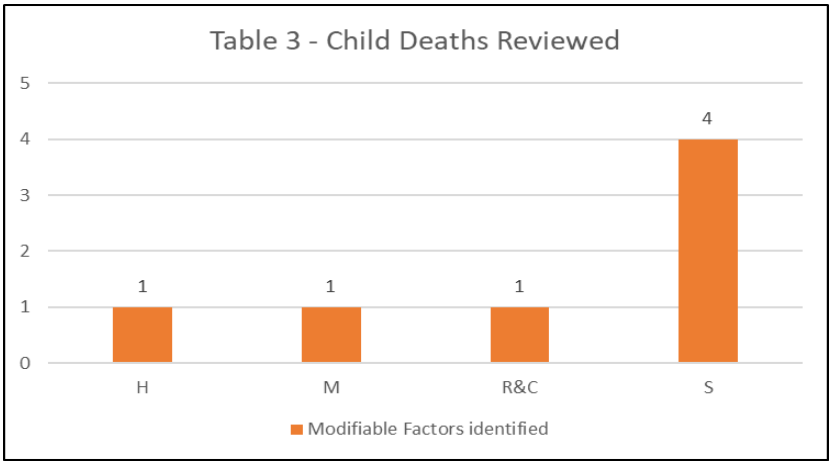


Table 2 above illustrates that all 20 child deaths reviewed were children who were White and British. This is similar to that of previous years of Tees child deaths reviewed.

Table 3 opposite shows the child deaths reviewed with Modifiable Factors. These are defined as 'those where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced'.

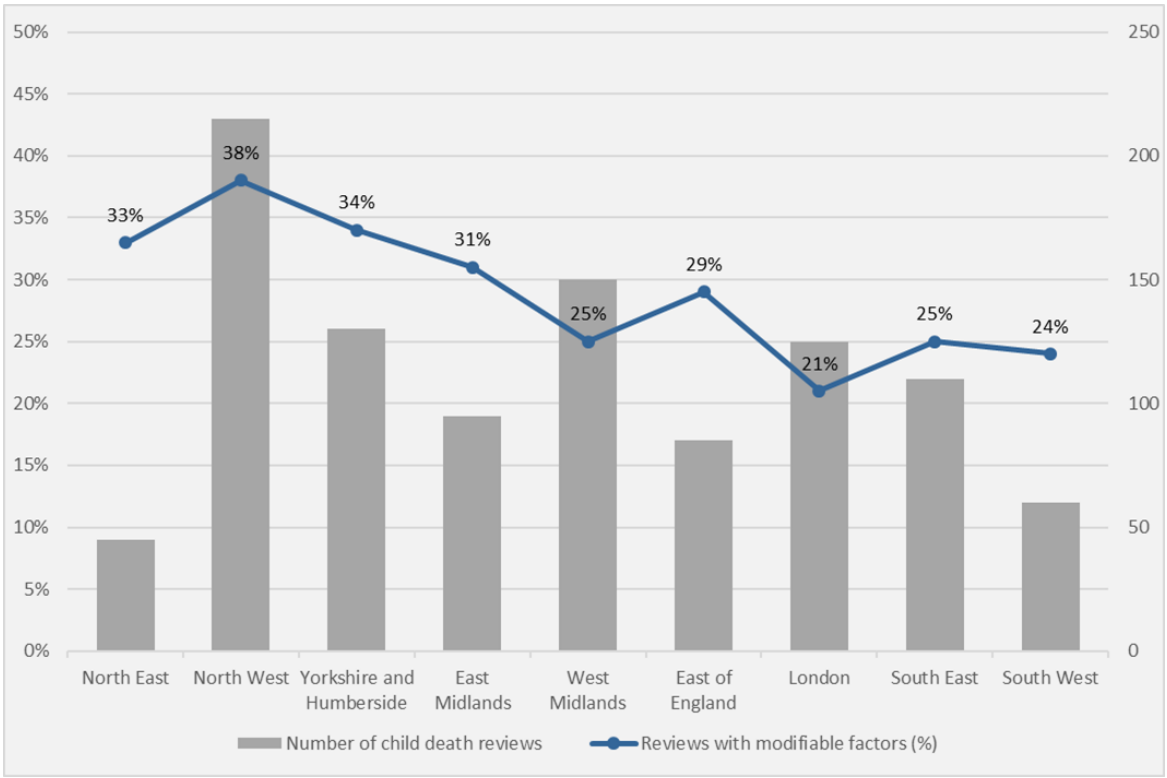


When Tees CDOP reviews a death, they will identify and agree any modifiable factors that may have prevented the death. In 2019 – 20, 7 (35%) out of the 20 deaths reviewed had identified modifiable factors compared with 25% in 2018-19, 33% in 2017-18. Some of these included risk factors such as:

- Smoking in parents
- Alcohol/substance misuse by parent or child/young person
- Co-sleeping
- Chronic illnesses in mothers
- Sepsis diagnosis in children with complex needs

Where modifiable factors are identified, the Panel has taken action to address these where appropriate (please see page 12, outcomes and actions).

Tees CDOP appears to be in line with the percentage of deaths reviewed with modifiable factors. The North East Region (12 Local Authorities) also appears to be in line with the other regions in respect of the percentage of child deaths reviewed with modifiable factors (33%) as the graph highlights below:



Location of child deaths

From the 20 child deaths reviewed only 2 occurred outside of a hospital or medical facility. This data is consistent with previous years for the Tees area.

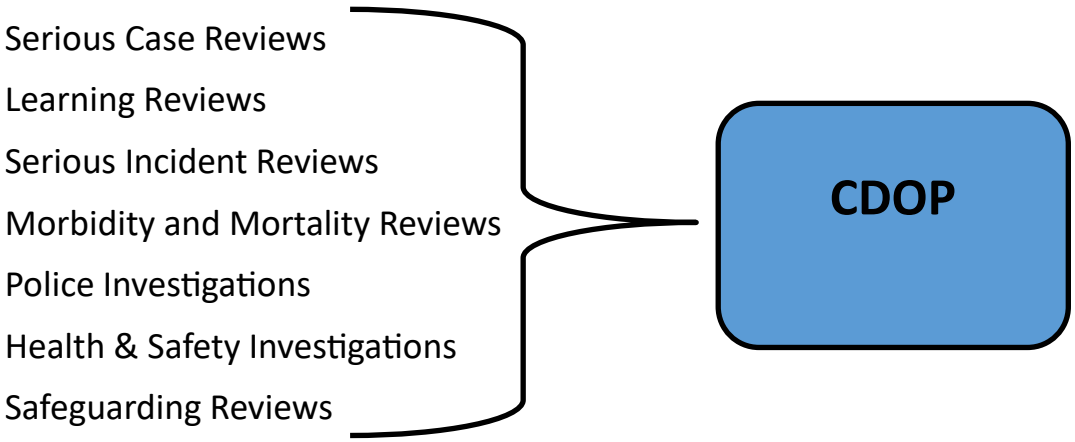
Category of deaths

The table below highlights that from the 20 child deaths reviewed, the highest number of child deaths were categorised as perinatal/Neonatal event. This coincides with the Tees data from 2018/19 and also with national data.

Categories of Death	H	M	R	S
Deliberately inflicted injury, abuse or neglect				
Suicide or deliberate self-inflicted harm		2		
Trauma or other external cause		1		1
Malignancy			1	
Acute medical or surgical condition	1			
Chronic medical condition				
Chromosomal, genetic or congenital anomalies				3
Perinatal/neonatal event		2	3	4
Infection	1			
Sudden unexplained, unexpected death				1
Unknown				

Other Reviews/Investigations

It is important for other reviews/investigations, when completed, are fed into CDOP to ensure informed discussions are held before the child death can be closed.



Children with a Learning Disability

Deaths of children with learning disabilities are reviewed as part of the Disabilities Mortality Review (LeDeR). This programme "*supports local areas to review all deaths of people with learning disabilities, aged 4 years and over. Reviews are completed to identify good practice and what has worked well, as well as where improvements to the provision of care could be made".* The LeDeR review is more of a holistic approach. Of the 20 deaths reviewed, 1 death was reviewed as part of LeDeR.

6. Reported Tees Child Deaths: 2015-2020

The tables below provide a breakdown of child deaths reported each year for each Local Authority over a five year period. This gives a better understanding of the local data.

Table 1 below details the ages of the children when they died for each Local Authority for the 5 years:

Year	2015/16				Total	2016/17				Total	2017/18				Total	2018/19				Total	2019/20				Total
Age / Authority	H	M	R	S		H	M	R	S		H	M	R	S		H	M	R	S		H	M	R	S	
1 - 4 weeks*	4	7	4	6	21	2	3	2	4	11	4	5	2	3	14	0	2	4	8	14	0	6	3	6	15
4- 52 weeks	0	6	3	3	12	1	5	3	4	13	0	5	2	1	8	2	1	5	3	11	2	1	0	2	5
1 - 4 years	1	0	1	1	3	1	1	1	3	6	1	1	1	5	8	0	0	0	1	1	0	0	1	0	1
5 - 9 years	0	1	0	0	1	3	0	1	1	5	0	2	1	2	5	0	2	0	0	2	0	0	0	3	3
10 - 14 years	1	1	0	1	3	0	1	0	2	3	0	0	0	0	0	0	1	3	0	4	2	1	1	2	6
15 - 17 years	1	1	0	1	3	4	3	2	2	11	0	1	1	1	3	0	3	1	0	4	0	2	0	1	3
Total	**7**	**16**	**8**	**12**	**43**	**11**	**13**	**9**	**16**	**49**	**5**	**14**	**7**	**12**	**38**	**2**	**9**	**13**	**12**	**36**	**4**	**10**	**5**	**14**	**33**

Over the 5 years, the most prominent age for expected and unexpected child deaths in the Tees is 1-4 weeks old (neo-natals) which is consistent with national statistics.

Table 2 below details the categories of death for each Local Authority for the 5 years:

	2015/16				Total	2016/17				Total	2017/18				Total	2018/19				Total	2019/20				Total
Categories / Authority	H	M	R	S		H	M	R	S		H	M	R	S		H	M	R	S		H	M	R	S	
Deliberately inflicted injury, abuse, neglect												1	1		2									
Suicide or deliberate self-inflicted harm									3	**3**				1	1		3	1		4		1			**1**
Trauma or other external cause	1	3	1	1	**6**	7	1	2	2	**12**		1		1	2		1			1		1		1	**2**
Malignancy	1	1	1	1	**4**		3	1		**4**								1		1					
Acute medical or surgical condition				1	**1**		2	2	4	**8**		1	1	1	3	1			1	2	1				**1**
Chronic medical condition		1	1	1	**3**		3			**3**		2	1	3	6		1	1	1	3		1	1		**2**
Chromosomal, genetic/congenital anomalies	2	4		1	**7**	2	2	2	4	**10**	2	3	1	4	10		1	3	4	8					
Perinatal/neonatal event	3	5	3	4	**15**	2	2	1	2	**7**	1	3	2	2	8	1	2	3	6	12	1	6	2	3	**12**
Infection				1	**1**						2	3			5		1			1				1	**1**
Sudden unexplained, unexpected death		2	2	2	**6**			1	1	**2**			1		1			3		3				1	**1**
Unknown category																		1		1	2	1	2	8	**13**
TOTAL	7	16	8	12	**43**	11	13	9	16	**49**	5	14	7	12	**38**	2	9	13	12	**36**	4	10	5	14	**33**

This table shows the highest number of deaths are categorised as Perinatal/neonatal event which is also consistent with national statistics. However it must be noted that the 13 deaths categorised as unknown are because these have not yet been reviewed at CDOP therefore the category of death is awaiting confirmation.

Table 3 below details the number of deaths in each Local Authority by male and female over the 5 years:

	2015/16				Total	2016/17				Total	2017/18				Total	2018/19				Total	2019/20				Total
Authority	H	M	R	S		H	M	R	S		H	M	R	S		H	M	R	S		H	M	R	S	
Male	5	9	4	9	**27**	7	9	5	8	**29**	3	10	5	7	**25**	2	5	9	4	**20**	3	5	1	10	**19**
Female	2	7	4	3	**16**	4	4	4	8	**20**	2	4	2	5	**13**	0	4	4	8	**16**	1	6	3	4	**14**
TOTAL	7	16	8	12	**43**	11	13	9	16	**49**	5	14	7	12	**38**	2	9	13	12	**36**	4	10	5	14	**33**

Again the statistics in the above table are consistent with national statistics as nationally there are more male child deaths than females however there appears to be no reason for this.

National Data

Child mortality rate (1-17 years) 2016 - 18 — Directly standardised rate - per 100,000

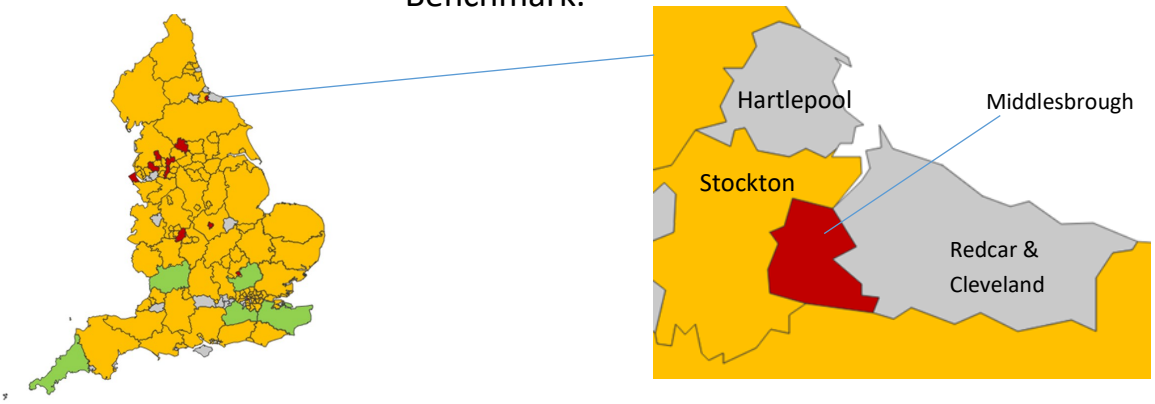
Export table as image Export table as CSV file

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	3,671	11.0	10.6	11.3
North East region	–	187	12.6	10.8	14.5
Middlesbrough	–	18	20.1	11.9	31.9
Stockton-on-Tees	–	20	16.1	9.8	24.9
Newcastle upon Tyne	–	25	15.2	9.8	22.5
North Tyneside	–	14	12.1	6.6	20.3
Sunderland	–	18	11.7	6.9	18.6
Gateshead	–	13	11.3	6.0	19.3
County Durham	–	31	11.0	7.4	15.6
Northumberland	–	16	9.5	5.4	15.5
Darlington	–	8	*	-	-
Hartlepool	–	8	*	-	-
Redcar and Cleveland	–	9	*	-	-
South Tyneside	–	7	*	-	-

Source: Office for National Statistics (ONS)

The table above, from Public Health England, provides the number of child deaths for the North East Region for 2016 -2018. It highlights that compared with the England Benchmark Middlesbrough has higher child deaths and Stockton is similar compared to the other areas in the region. Hartlepool and Redcar & Cleveland cannot be compared due to the low number of child deaths.

The map below shows there are 9 areas that are categorised as worse when compared with the England Benchmark.



7. Local Learning Outcomes and Actions from Child Death Reviews

Issue	CDOP Action	Response
Child deaths from Road Traffic Accidents	To liaise with LSCBs/ Safeguarding Children Partner-ships and the Tees Casualty Reduction Group to raise awareness of child deaths from road traffic accidents	Work commenced with the Tees Casualty Reduction Group Chair and the Tees Road Safety Officers. LSCBs are considering how to raise awareness of road safety to prevent further deaths. A Public Health Childhood Prevention Injury Group is being established and CDOP will link into this.
Palliative Care role across the Tees	To gain clarification in respect of the future of this role.	Ongoing communication between CDOP and North East & Cumbria CCG to ensure this role is fulfilled across the Tees and updates are provided.
Bereavement Support for families and professionals	To fully understand what bereavement support is available.	Work completed by Child Bereavement UK included a mapping exercise to compile a bereavement support directory. Bereavement training sessions available to professionals. Bereavement Group established for siblings of children who have died.
Learning from Child deaths	CDOP submits referrals to LSCBs / Safeguarding Partnerships to review deaths to identify any additional learning.	2 referrals were submitted to LSCBs for Learning Reviews.
External investigations of child deaths	CDOP to ensure they have sight of relevant external investigations of child deaths to aid in the consideration of when CDOP can review the deaths and to also scrutinise any learning and ensure actions are completed.	All SCR's, LR's, Serious Incidents, Police investigations and LeDeR child deaths are now recorded and monitored by CDOP. Regular updates and final reports are provided to CDOP to ensure multi agency information informs the re-view discussions before deaths are closed.
Non-compliance of teenage pregnant mothers with chronic illnesses	Letters sent to both Tees Trusts to gather an understanding of the scale of this problem and any measures in place in respect of non-compliance.	Information was provided identifying that there is an increase in this issue. However, assurance was also provided in respect of the services/clinics available for mothers to access/attend. Midwives and diabetic nurses attempt direct contact with those who do not engage, to provide support and advice. Pregnant mothers with chronic illnesses are closely monitored during pregnancy.
Response to the emerging issue of MDMA and identifying the presentation of young people when MDMA taken	Letter to North East Ambulance service to seek assurance that those professionals who have first contact with young people who have taken MDMA fully un-derstand how they might pre-sent.	NEAS provided assurance that both national and local guidance has been amended to highlight learning from this death in respect of the importance of getting the patient to hospital as soon as possible, raising awareness of specific risks associated with MDMA overdose through training.

9. CDOP Achievements in 2019/20

- CDOP raised awareness of the ICON programme:
  I— Infant Crying is normal
  C – Comforting methods can help
  O—It OK to walk away
  N—Never, ever shake a baby
  The CCG and Tees Health Visiting Services implemented this programme which provides advice, intervention and support for professionals to share with parents/ carers to cope with infant crying.
- A new process has been established with the Child Health Information Service to ensure they are notified of all child deaths.
- Links with Education have been established to ensure that schools/colleges where the child/young person attended is informed of the death and are invited to the JAR, if necessary.
- Links with schools/colleges where siblings attend have also been improved to ensure that appropriate support can be offered.
- As part of the JAR, identified specific services are contacted to clarify whether the child was open to them to ensure there is a multi agency response to the death.
- Relationships have developed with Obstetric colleagues to ensure representatives are invited to child death meetings, if required, and all relevant information is available before the review can take place.
- Work has been completed with professionals in respect of the completion of CDOP forms to ensure all information is readily available at CDOP meetings.
- Bereavement sessions have been held for professionals involved in the care of a child prior to the death.
- The Suicide Prevention officer for Public Health is now involved in all reviews of child death suicides.
- The introduction and use of the National Child Mortality Database which collates data for all child deaths in England.
- Tees CDOP promoted The Lullaby Trust's Safe Sleep Campaign.

10. Priorities and Challenges for 2020 - 21

10.1 Priorities

- To ensure that families are at the forefront of the Child Death Review Process.
- Provide a consistent CDOP leadership to ensure the commitment of all CDR partners and relevant professionals to the process.
- Ensure a CDR business unit is in place to co-ordinate child deaths.
- Provide relevant training to professionals to ensure the new Child Death Review Process is fully embedded into practice.
- Further Develop working relationships with the Coroner.
- Work with neighbouring CDOPs to improve the identification of any patterns or trends in child death data.
- Continue to work closely with Child Bereavement UK to ensure bereavement support is available for families and professionals.

- Develop a mechanism to wider disseminate learning from Tees child deaths.
- Improve and work closely with the Learning Disabilities Mortality Review (LeDeR) programme area lead to ensure a co-ordinated approach to reviewing deaths of children with learning disabilities.
- Continue to promote local and national campaigns to prevent future child deaths.
- To identify an Obstetric Representative to join CDOP to provide valuable information.
- To encourage awareness to families of the Child death process.
- To work closely with the Injury Prevention Group, South Tees Public Health

10.2 Challenges

- The impact of the Covid 19 pandemic on delivering the Child death process.
- Funding constraints within Local Authorities and CCGs to fulfil the statutory requirements of the Child death process.

11. Feedback from CDOP members

This section provides valuable feedback from CDOP members in respect of the importance of CDOP, the process, multi agency working and learning from child deaths.

CDOP enables me to share any learning or relevant information with Teeswide Assistant Director colleagues.

CDOP gives me to have access to detailed multi agency information to inform learning or factors that could prevent future deaths of children.

CDOP allows good networking across agencies and an opportunity to raise the issues of Mental Health in the whole family and the impact this has

Membership of CDOP has been valuable in circulating information to training offers, as well as understanding the bereavement support offers available to families who have experienced the death of a child.

As a lay person on CDOP I bring the lay community view to the panel.

Thank you to CDOP members and external agencies for their commitment and contribution to CDOP in 2019-20.

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Tees
child death overview panel