

Child Death Reviews in County Durham & Darlington Annual Report 2010/11

1. Responsibility of the Local Safeguarding Children Board

- 1.1 Working Together to Safeguard Children¹ describes the process to be followed when a child dies in the Local Safeguarding Children Board (LSCB) area covered by a Child Death Overview Panel.
- 1.2 There are two interrelated processes for reviewing child deaths:
1. **Rapid Response** by a group of key professionals who come together for the purpose of enquiring into and evaluating each **unexpected death; and**
 2. An overview of **all deaths** up to the age of 18 years (excluding both those babies that are stillborn and planned terminations of pregnancy carried out within the law) in Durham and Darlington areas, undertaken by a panel.
- 1.3 A Child Death Overview Panel (CDOP) was established by County Durham Local Safeguarding Children Board and Darlington Safeguarding Children Board to ensure that each child death had an appropriate review.
- 1.4 The Child Death Overview Panel is a sub-committee of both Durham and Darlington's LSCB. It is responsible for reviewing the available information on all child deaths and is accountable to the LSCB Chair.
- 1.5 The disclosure of information about a deceased child is to enable the LSCBs to carry out its statutory functions relating to child deaths. The LSCBs use the aggregated findings from all child deaths, to inform local strategic planning on how best to safeguard and promote the welfare of children in Durham and Darlington.
- 1.6 The CDOP must make a decision about whether or not a death was preventable. Government guidance defines preventable child deaths as those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.
- 1.7 The designated doctor (child deaths) is a Consultant Paediatrician and has acted as the designated doctor since May 2008.

¹ Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children March 2010

- 1.8 A Rapid Response process commenced in August 2009 with the appointment of six senior nurses to manage the rapid response rota. This ensures their active involvement at the onset of the review process in line with government guidance. The rapid review process augments the local review of all unexpected deaths and ensures that parents are engaged and received appropriate support during the process.

- 1.9 A relationship has been established with the Coroner for Durham and Darlington and the Registrar Superintendent in Durham. Meetings have taken place with the Coroner to establish the relationship.. A relationship has been established with the Registrar Superintendent. The registrars of births and deaths are required by the Children and Young Persons Act 2008 to supply LSCBs with information which they have about the deaths of persons aged under 18 years. This relates only in respect of deaths occurring on or after 1 April 2009.

Notification To Designated Officer for Child Deaths

Child Death Review process

Notification to LSCB designated officer via Child death Admin Coordinator Tel 3834065

- RSMO are contracted to provide information to LSCB
- Registrar of Births and deaths have a statutory responsibility to send information to the LSCB
- Agencies aware of a child death should inform the LSCB of their involvement

Rapid Response

Nominated officer receives notification and forwards Form A to appropriate contact/lead officer.

UNEXPECTED DEATH

yes

no

- Rapid Response Nurse to be notified – 01388 455126
- SUDIC guidelines will be implemented

- All other deaths – seek advice of designated paediatrician (child deaths) as to whether or not a local review would be appropriate.

Paediatrician for child deaths uses agency reviews, results of post mortems and any other findings to hold a meeting of all relevant professionals to review issues relating to the child's death

Local child death review

Further local reviews held at the discretion of the Paediatrician for child deaths

Case presented to CDOP for Overview of child's death

Additional child death review for specific cases

- The Child Death Overview Group will ensure that each child death has had an appropriate review.
- The Child Death Overview Group will provide an overview report on all child in that year to County Durham Local Safeguarding Children Board for deaths in County Durham, and to Darlington Safeguarding Children Board for deaths in Darlington.

Child Death Overview Group

Child Death Review Process

Child Death Overview Panel

The Child Death Overview Panel is a sub group of Durham and Darlington Local Safeguarding Children Boards. The LSCB has a statutory duty to review all child deaths of children under the age of 18 years that normally reside in Durham and Darlington.

The Child Death Overview Panel considers all outstanding reviews and agrees action to progress chase. On average six child death reviews are completed at each meeting.

The Child Death Overview Panel collates of actions and learning from Child Death Reviews into an action plan which is reviewed and updated at each Child Death Overview Panel meeting. This process increases accountability and provides written evidence of progress and completed actions with the facility to monitor deadlines. Experience has shown that over time it is possible to identify hotspots or recurrent themes.

Rapid Response

The national arrangements for a joint agency “rapid response” to unexpected child deaths and a review of all child deaths are a major step forward in helping to ensure that each bereaved family receives a thorough yet sensitive investigation of their child’s death and that professionals from all agencies will respond appropriately when a child dies unexpectedly. A joint agency approach has been in place in County Durham and Darlington since October 2009.

To support a joint agency approach to investigate unexpected child deaths a dedicated nursing service has been commissioned to jointly work with other agencies.

Nursing Service

A senior nurse/manager has been appointed to provide in-depth specialist expertise in the field of unexpected child deaths and respond quickly to the unexplained death of a child and undertake reviews/investigations that are highly sensitive. In addition a key component of the role is to provide bereavement support for parents.

The post-holder provides the majority of hours for the service. However, this is supplemented with a small team of dedicated nurses to provide an on-call rota between 0700 and 2200 hours seven days per week including bank holidays. They are available to respond rapidly within adequate time and flexibility.

The nurses are all experienced and have extensive knowledge of working with children and families. The nurses have undertaken specific additional training both through courses and through an apprenticeship model of getting involved in individual cases together with one of the more experienced members of the team.

The role of the rapid response nurse encompasses:

- Ensuring notification to the coroner.
- Early and continuing multi-agency liaison.
- Detailed and thorough history taking, including a careful review of the 24 hours preceding death and production of detailed reports following each death.
- Make immediate enquiries into and evaluate the reasons for and circumstances of death.
- Collection of relevant information about the circumstances of the death, including clinical details, analysing it and compiling a report for the pathologist carrying out the post mortem examination.
- Undertake joint home visit with the Police.
- Maintain contact at regular intervals with family members and other professionals who have ongoing responsibilities for other family members, to ensure they are informed and kept up to date with information about the child's death.
- Attend Police briefings to jointly update colleagues.
- Together with the designated doctor for child deaths give feedback to parents on the findings from local case discussion.
- Ongoing bereavement support for the family following the conclusion of the child death investigation.

Durham and Darlington are one of only a few LSCBs that have been able to establish a robust rapid review process.

The contact telephone number for the rapid response service is **01388 455156**. This telephone number will automatically connect to the nurse on call.

The Child Death Review Panel fully acknowledge the benefits of the rapid response process with specific emphasis on joint agency involvement following a child's death. This approach enables a robust investigation into the cause and circumstance of a death with a sensitive approach to supporting families in their grief. Families have expressed gratitude to the local teams involved, commenting on the sensitive way in which investigations have been carried out and the feedback they receive on the progress of the investigation.

Local case discussions

The Child Death Review process collects information about all child deaths including those in children with life-limiting conditions whose death was expected, since there may be lessons to learn to improve the care of the child and support for the family in future expected deaths.

For most unexpected deaths a local case discussion takes place when all the information has been gathered, including return of all requested Agency Report Forms (Form B) and the final post mortem report together with the results of all tests taken at the time of the child's death. All agencies involved with the child and family before and at the time of their death are invited to the meeting. We have found that the best way to facilitate attendance by general practitioners is to hold the meetings at GP's surgeries.

We aim to carry out Local Case Discussions as soon as possible ideally within 6 months. We continue to experience delays in receiving some agency reports, and delays caused by long waits for final autopsy reports and difficulties experienced in bringing together large numbers of professionals to attend review meetings. The longest delay between a child's death and a local case discussion being held was nine months. Our local experience is in keeping with those of CDOPs in other parts of the country where similar long delays are occurring.

Child Death Review Activity

Child Death Review Notifications

35 children resident in Durham and 9 children in Darlington died between 1 April 2010 and 31 March 2011.

Of the 44 child deaths:

- 15 deaths resulted in a Rapid Response being instigated.
- 14 deaths have been or will be considered at a Local Case Discussion meeting.
- 4 deaths are subject to Sudden Unexplained Infant/Perinatal meetings.
- 3 child deaths are subject to a Serious Case Review.

Child Death Overview Panel

The Child Death Overview Panel met on five occasions in 2010/11. At each Child Death Review Panel, the Designated Doctor for Child Deaths presents the circumstances of each death to the multi-agency panel. The case is reviewed in detail and recommendations/actions logged for monitoring purposes.

40 Child Death Reviews have been completed. 17 child deaths occurring in 2010/11 were completed (15 from Durham and 2 from Darlington). 22 child deaths occurring in 2009/10 were reviewed in 2010/11 (18 in Durham and 4 in Darlington). One death occurring in 2008/9 was reviewed in 2010/11 following a significant delay in receiving an Agency Report from a key professional.

25 child deaths remain outstanding and will be brought forward to 2011/12. The LSCB has taken action to address delays in receiving the information from agencies involved in the process and improvements are reflected in the increased number of child death reviews that are completed by the Child Death Review Panel within 6 months. Further work is necessary to achieve continual improvement.

The CDOP were of the view that there were six deaths in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths. These are further discussed in the analysis section of this report.

Local Case Discussion

Out of the 40 Child Death Reviews completed, 5 Local Case Discussions were presented at the Child Death Overview Panel.

- . The delays are due to several factors:-
 - Long delays in receiving completed agency report forms from professionals involved with the child and their family
 - A wait of at least 3 months before the final autopsy report is available
 - Where specialist pathological opinions are sought the wait for a final report may be many months and in one case more than a year
 - The difficulties in finding a date in the diaries when all the relevant people are free to attend a case discussion.
 - 3 case discussions were put on hold pending the outcome of serious case reviews.

Table 1: Cases discussed and completed 2010/11

| | County Durham | Darlington |
|---|---------------|------------|
| No. of child deaths which occurred in 2008-09 where the review was completed in 2010-11 | | 1 |
| No. of child deaths which occurred in 2009-10 where the review was completed in 2010-11 | 18 | 4 |
| No. of child deaths which occurred in 2010-11 where the review was completed in 2010-11 | 15 | 2 |

Timescale for Child Death Review Completion

Out of 40 completed reviews, 50% were completed in less than six months. This is partly due to the delay in receiving agency reports, however it also reflected the robustness of the panel in ensuring that all relevant information was available before Child Death Reviews were completed.

Chart 1: Timeline between Child Death Notification and Completion

2010/11

2009/10

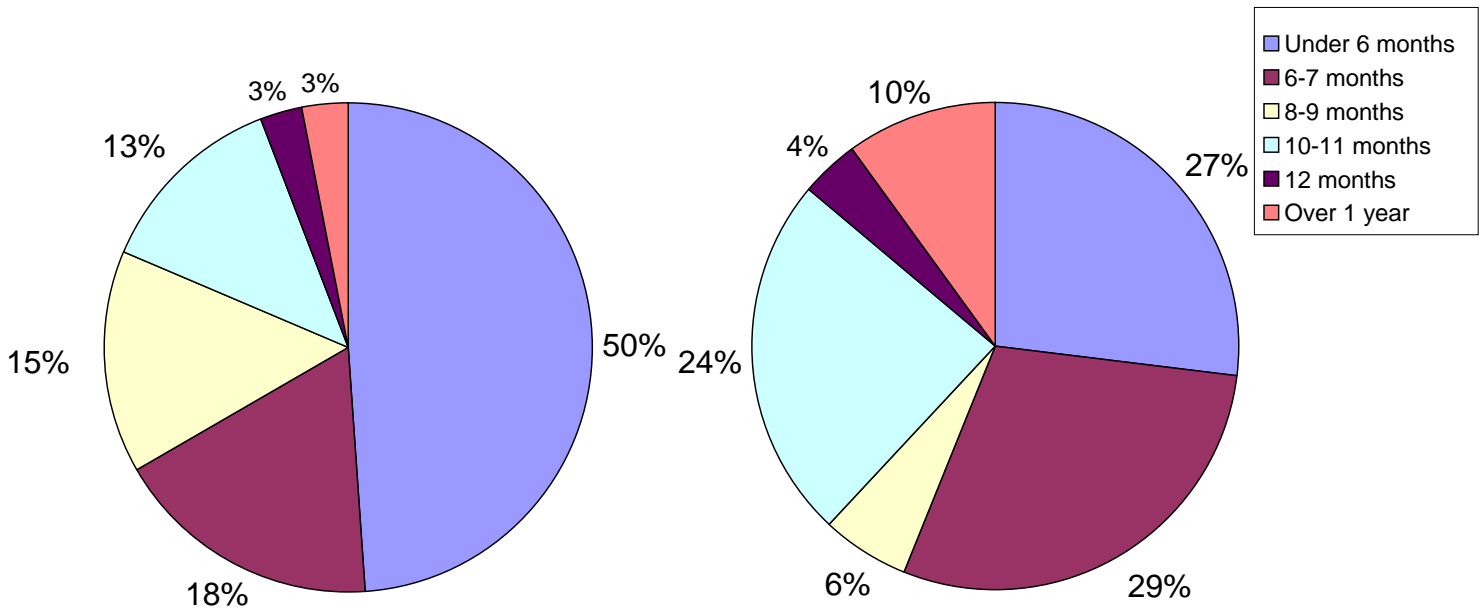
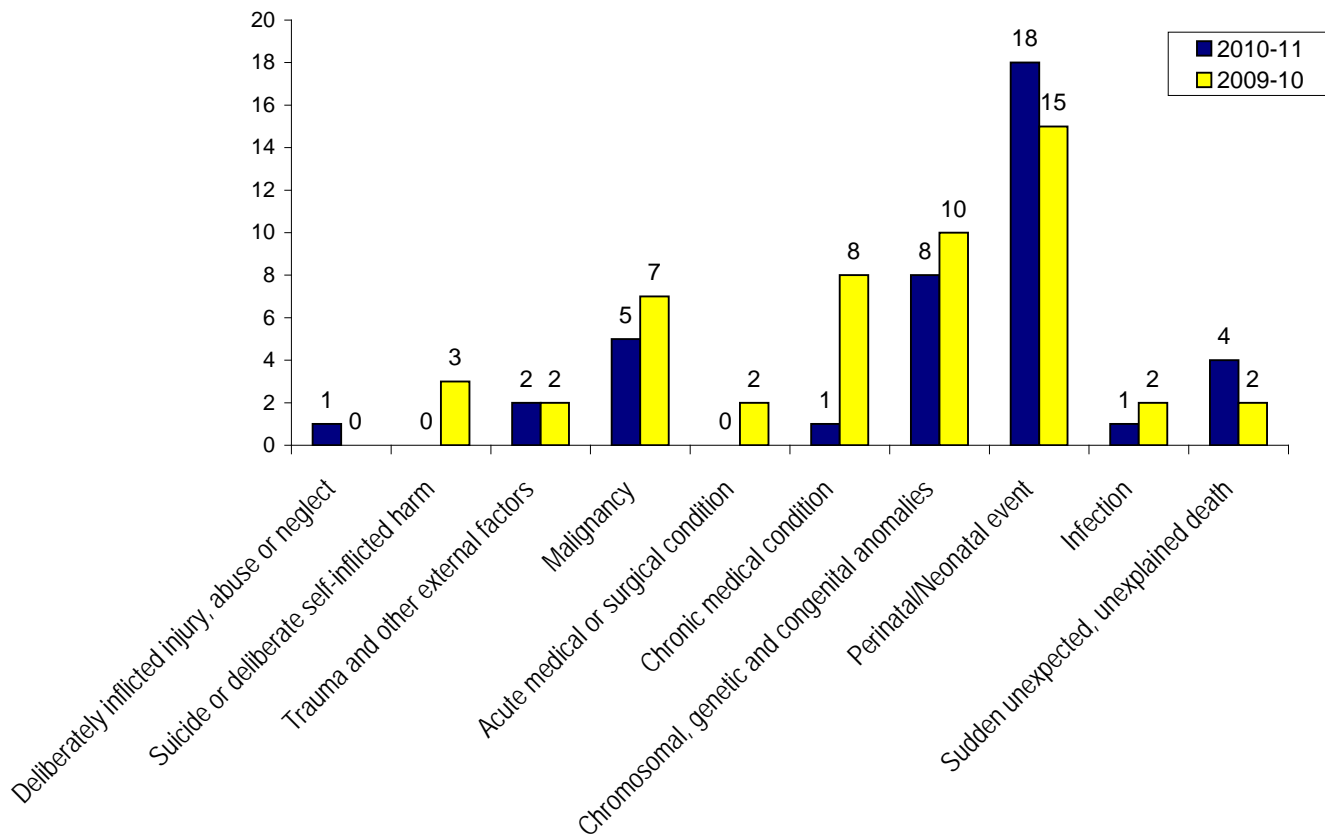


Chart 2: Category of Deaths



The vast majority of deaths reported to the Child Death Review Panel are perinatal or neonatal events where a child has lived for a very short period of time as a result of complications resulting from extreme prematurity. The next largest category is those children who have died as a result of congenital anomalies, many of these children having lime limiting conditions. There has been a reduction in the number of children who have died as a result of chronic medical conditions however due to the small number of overall deaths of children across Durham and Darlington it is impossible to say if this is a significant.

Chart 3: Where the child was at the time of death

The high number of children dying in Neonatal and Paediatric Intensive care reflects the number of deaths of premature babies.

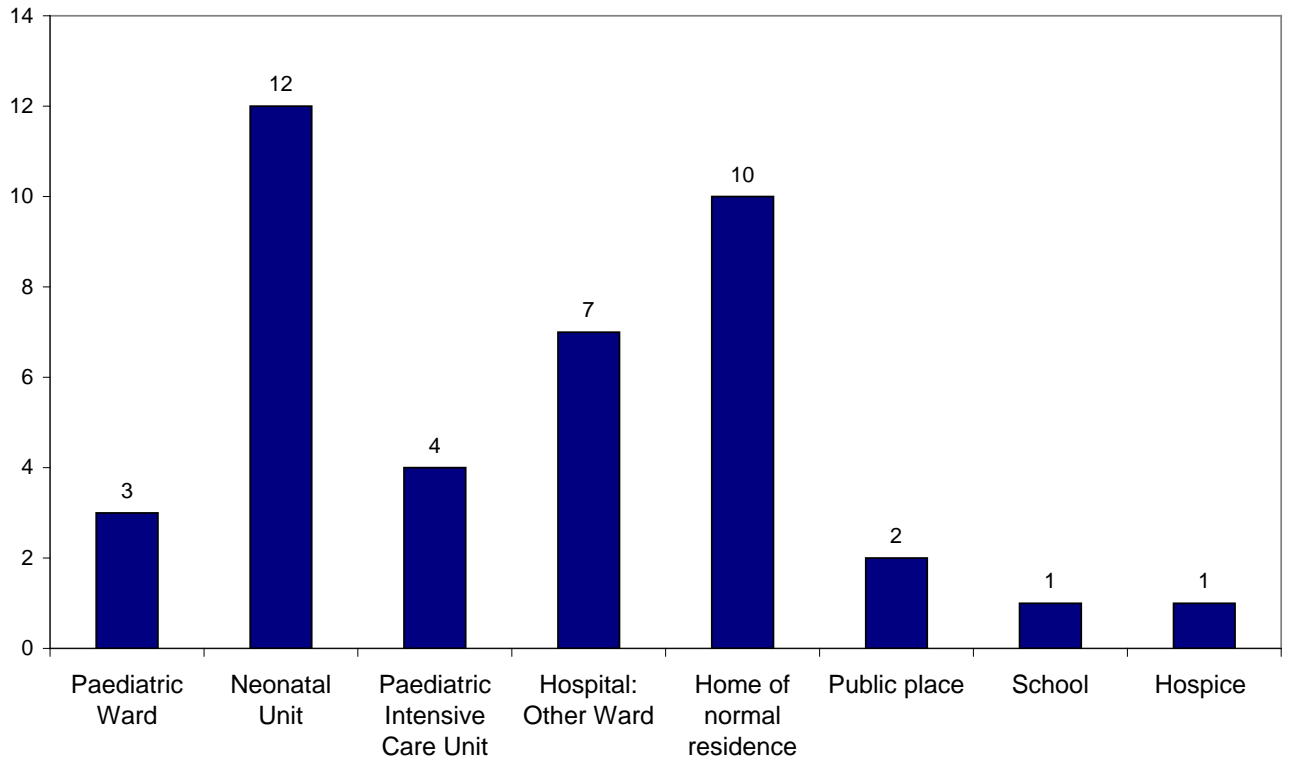


Chart 4: Ages of Children

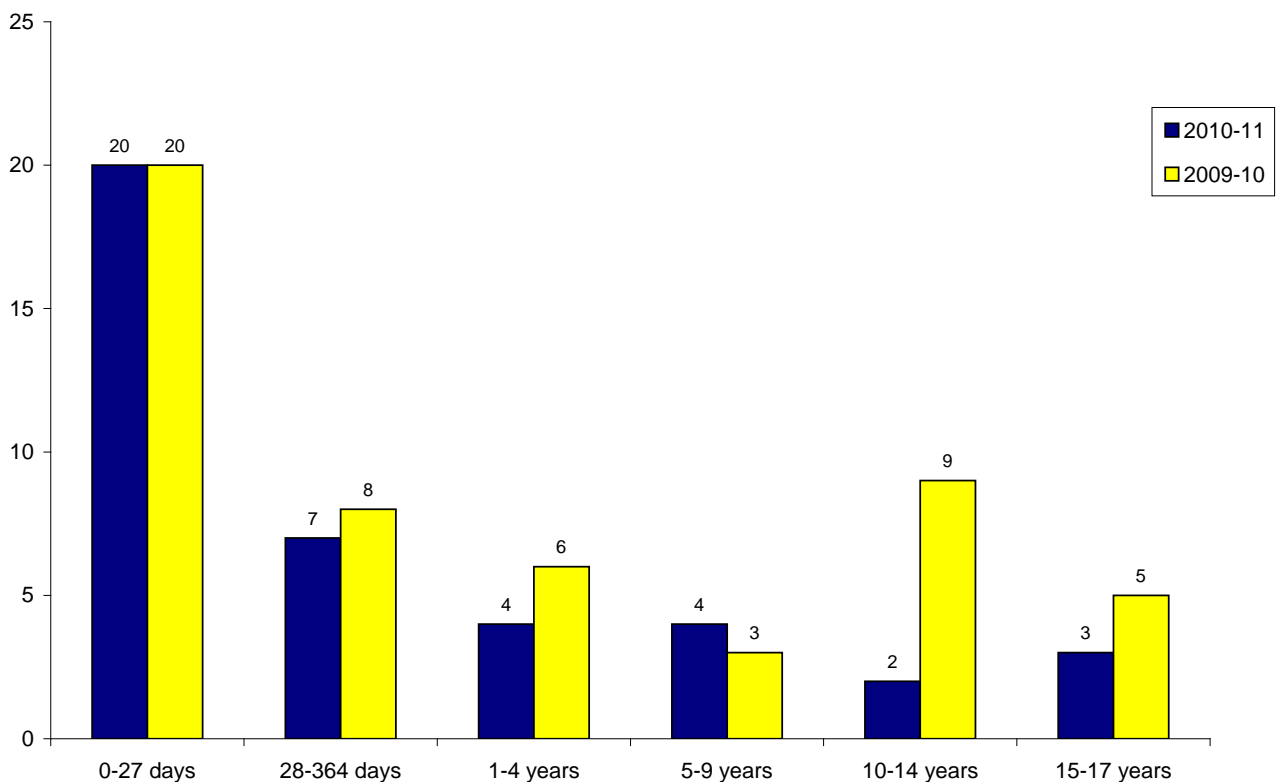
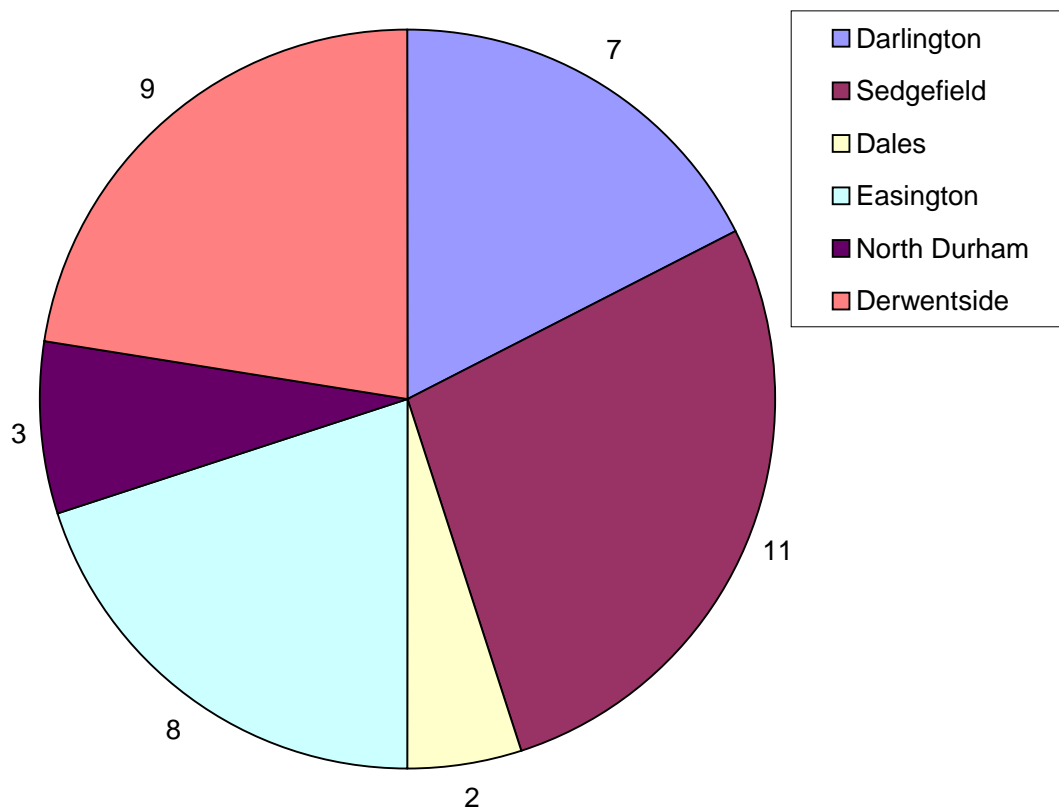


Table 3: Gender

| | 2010/11 | 2009/10 |
|---------------|-----------|-----------|
| Male | 20 | 32 |
| Female | 20 | 19 |

Chart 5: District according to child's residence



DCSF Data Returns

A DCSF data return is submitted at the end of May each year to the Department for Education.

INVOLVEMENT OF PARENTS

Unexpected deaths

The Rapid Response Nurses and Designated Paediatrician strive to ensure that parents are kept informed at all stages of the investigation after an unexpected death, and have the opportunity to ask questions, have input into the case discussion and to hear the outcome of discussions and any recommendations made. This process begins as soon as the Rapid Response Nurse meets the family. The Child Death Review process is explained to parents and an information leaflet offered, although parents may find this information hard to take in at such a difficult time. The Rapid Response Nurse liaises closely with Police colleagues and the pathologist, and visits parents as soon as possible after the autopsy to feedback preliminary results. When the full autopsy report is received the Rapid Response Nurse and Designated Paediatrician visit the family together to explain the report, answer questions and ask about issues that the family would like to be discussed at the Local Case Discussion. After the case discussion they visit again to give feedback. Alongside these visits the Senior Rapid Response Nurse offers bereavement support to the family and remains in contact by telephone, text and by visits according to the family's wishes.

Expected deaths

All children who die from a life-limiting condition are under the care of a paediatrician, and usually community paediatric nurses and other palliative care staff are participating in the care for the child and family. These deaths do not require a rapid response but the Senior Rapid Response Nurse is available to offer bereavement support to the family if requested by their paediatrician. The Designated Paediatrician has educated her colleagues about the Child Death Review Process and they are aware of the need to explain to the child's parents that the death will be considered by Child Death Overview Panel. The Paediatrician is requested to give the Child Death Review Process leaflets (both the local one and that produced by the FSID) to the family. Sometimes parents have issues about their child's care or the support they received that they wish to discuss and in those cases it may be appropriate to hold a Local Case Discussion. This has happened in two cases to date.

Analysis of Key Learning

A recurring theme in case reviews of full-term babies who have died following complications during labour is that potential warning signs from foetal heart rate monitoring were not acted upon, either because of disagreement between health-care professionals over their significance, or because a “wait and see” approach was adopted inappropriately. Hence following each such death the action plan includes a recommendation that training is improved for midwives and obstetric doctors in interpretation of this foetal monitoring. This is now included in mandatory training for all the midwives on a monthly basis, and is also included in the obstetric department weekly clinical meetings.

Another action recommended after a congenital anomaly was missed on an antenatal scan was to improve the quality assurance mechanisms of the antenatal ultrasound scans. Regular meetings take place between the sonographers, obstetricians and the foetal medicine specialists to review scans and to improve the training and experience of antenatal staff.

Some colleagues in psychiatry were unaware of the advice that mothers taking medication should not share a bed with their baby because of the increased risk of sudden infant death. Following a case discussion this information has now been disseminated to psychiatrists who are able to counsel their patients accordingly.

After the death in the bath of a child with special needs the consultant paediatricians were all requested to explicitly discuss bathing arrangements with families of such children to ensure safe practices were adopted in the home.

Communication

Several case discussions have highlighted problems in communication, both within a team and between primary and secondary health care, or between health care staff and professionals in other agencies which may have compromised the care of that child and their family. Examples include a baby’s health visitor having received no information that there had been previous child protection concerns in the family and that parents had a history of substance misuse, and problems with liaison between two specialist nursing teams caring for a child with a terminal illness. In some cases, community services such as school nurses were not receiving copies of correspondence and were therefore unaware that a child had defaulted from appointments.

Process issues

As we all become more familiar with the Child Death Review Process and the role of the Rapid Response team areas where practice could be improved are recognised. These involve all agencies. Several recommendations have been made to change aspects of Police procedures. In the first year of operations for the Rapid Response team, they were not informed of several deaths, including one which was initially treated as potentially suspicious. During the year 2010-11 the Rapid Response team were notified of all unexpected deaths including those that were suspicious, as health care and Police colleagues became more aware of their role.

The role of the Designated Paediatrician remains an interesting and challenging one. The work of the Rapid Response nurses and especially the lead nurse is an enormous help to the Designated Paediatrician. Their diligence in collecting information, co-ordinating information-sharing, liaison with various agencies particularly Police, and bereavement support to families is invaluable and has been widely appreciated and praised. The Child Death Review Panel was delighted to be told that the County Durham and Darlington Health Trust Chief Executive's Team of the Year Award was given to the Rapid Response Team in November 2010. The Rapid Response team is funded by the outgoing PCT until October 2011. Much work has been undertaken by the Designated Paediatrician to convince the incoming commissioners of the immense value of the service and the need for continue funding.

Progress against actions 2010/11

Further work was undertaken with the registrar superintendent of births and deaths and the coroner for Durham and Darlington to ensure clarity regarding the role of the Child Death Overview Panel, Rapid Response and Local Case Discussion processes.

Further debate is required regarding the relationship between the child death process and Medical Examiners and the CPS to review working arrangement in line with government guidance.

The LSCB Child Protection Procedures in relation to the reviews of child deaths were reviewed and amended in accordance with government guidance

Monitoring processes have been reviewed to ensure that all learning is actively used to improve services. This process will be the subject of continual review.

The panel have committed and experienced membership and we have not found the need to engage further expertise. Further debate is required as to how the use of designated panels may assist the effectiveness of the panel. The issue of designated panels will be discussed as part of the 2011/12 work programme

The chair of the panel has recently moved on with chairing responsibility passing to Dr Mike Lavender, Consultant in Public Health, NHS County Durham.

Work Plan 2011/12

1. To resolve the funding of the designated doctor and rapid response service and address any related process issues.
2. To continue to increase the number of children whose deaths are reviewed within a six month period.

3. Recommendations

The two safeguarding boards are asked to accept the findings of the Child Death Review Annual Report

Dr Mike Lavender
Chair, Child Death Overview Panel