

## Child Death Reviews in County Durham & Darlington Annual Report 2009/10

### **1. Responsibility of the Local Safeguarding Children Board**

- 1.1 Working Together to Safeguard Children<sup>1</sup> 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 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 LSCB to carry out its statutory functions relating to child deaths. The LSCB 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.

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<sup>1</sup> 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. The Coroner also receives copies of the review summaries following each CDOP meeting. 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.
- 1.10 The government has recently produced a list of all child deaths in Durham and Darlington to enable the CDOP to monitor the notifications by the Registrar and ensure we are aware of all child deaths in the area.
- 1.11 The new government guidance provides the LSCB with an opportunity to review and further strengthen these arrangements.

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 a quarterly basis on all child deaths occurring cumulatively to date 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

## **2. Child Death Reviews 2009/10**

### ***Rapid Response***

- 2.1 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.
- 2.2 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***

- 2.3 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.
- 2.4 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.
- 2.5 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.
- 2.6 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.

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

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

2.9 It is our perception that by engaging in a joint agency approach from the beginning it is possible to carry out 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.

2.10 Ten cases in Durham and two cases in Darlington resulted in the instigation of the rapid response process between August 2009 and February 2010. The service was not informed about two other cases.

### ***Local case discussions***

2.11 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. Although we would wish to carry out the local case discussion as soon as possible, and ideally before three months have elapsed, in practice this is proving difficult. The principal delays in the process are the very long delays before some agency report forms are returned, long waits for final autopsy reports, and the difficulties in finding dates when several busy professionals are free to meet. The longest delay between a child's death and a local case discussion being held was 11 months. Our local experience is in keeping with those of CDOPs in other parts of the country where similar long delays are occurring.

2.12 37 children resident in County Durham have died between 1 April 2009 and 31 March 2010 and of these local case discussions have been held for 6. Case discussions are planned for a further four, but data is incomplete and final autopsy reports are still awaited. One child's death was considered preventable because he had a known, treatable condition and could have been treated effectively if he and family had sought help sooner. Several reasons why this did not happen were identified and recommendations made. None of the other children's deaths were considered preventable, although in all cases way in which care and/or communication could be improved were identified.

2.13 Of the seven children who died from Darlington, one local case discussion is planned but reports are still outstanding.

### ***Child Death Overview Panel***

2.14 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.

2.15 The CDOG met on seven occasions in total in 2009/10.

2.16 34 child deaths (28 in Durham and 6 in Darlington) were brought forward from 2008/9 which were reviewed in 2009/10. A further 37 deaths were notified in 2009/10 bringing the number of deaths to be reviewed 2009/10 to 71.

2.17 51 reviews have been completed during 2009/10. 41 Durham cases and 10 Darlington cases.

2.18 18 Durham cases are outstanding; the earliest death occurred in May 2009, this review was delayed due to resistance by the obstetrician to complete an agency report for a child under 24 weeks gestation, which some obstetricians consider to be a late miscarriage. Other delays relate to difficulties in obtaining agency reports.

2.19 The LSCB has taken action to address delays in receiving the information from agencies involved in the process.

2.20 Each Child Death Overview Panel averages four hours in duration, and on average 10 cases in addition to the cases to be completed will be discussed at each meeting.

2.21 The agenda consists of:

- Progress reporting by designated person for child deaths of all cases not completed;
- Presentation of new cases by Designated Doctor for Child Deaths. When full information is available, the case is reviewed in detail and recommendations/actions logged for monitoring purposes.
- Practice and development issues.

2.22 Experience has shown that the majority of the meeting is taken up by robust review of the cases with often little opportunity to concentrate on development issues. This will be subject to review in 2010/11.

2.23 Durham and Darlington CDOP gave permission for the Safeguarding Advisor Government Office to attend the Child Death Overview Panel in January 2010 to gain an understanding as to how the child death process is handled in Durham and Darlington. She was impressed with the robustness of the panel discussion regarding individual cases. She also experienced at first hand the complex nature of the cases and the difficulty using some the forms to adequately document the decisions.

**Table 1: Cases discussed and completed 2009/10**

Date	County Durham		Darlington	
	Discussed and Deferred	Discussed and Completed	Discussed and Deferred	Discussed and Completed
27/04/09	1	4	3	4
01/06/09	1	5	0	1
31/07/09	1	6	0	1
30/09/09	3	7	0	1
30/11/09	3	6	0	0
25/01/10	1	5	0	1
12/03/10	1	8	0	2

### **3. Overview findings**

- 3.1 The CDOP were of the view that four 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.
- 3.2 There were a further four cases with potentially modifiable factors:
- 3.3 Out of 51 completed reviews, 15% were completed within timescale. 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 and local reviews were completed. In addition deaths of children under 24 weeks gestation were not reviewed from the start of the CDOP process. Clarification from DCSF confirmed that all children other than still born should be subject to review. As a result all previous cases were reviewed which significantly impacted on deadlines for completion.

Factors for those which took over six months to complete include:

- 4 case deferred pending a local case discussion
- 1 case deferred pending a Sudden Unnatural Incident Review
- 9 cases the delayed were due to outstanding agency reports and information from key professionals. 2 cases resulted in a letter of complaint being submitted to the Chief Executive of the Trust
- 3 cases delayed due to ongoing Police investigations
- 1 case deferred pending Coroners Inquest
- 1 case deferred pending toxicology results
- 2 case deferred pending Serious Case Review Panels
- 6 cases were relating to children under 24 weeks gestation and confirmation was required from Government Office as to whether the Child Death Overview Group should consider these cases
- 1 case was deferred pending the completion of a Serious Case Review
- 1 case was deferred pending the completion of a YJB Serious Incident Review

#### ***DCSF Data Returns***

- 3.4 A DCSF data return was submitted in May for the preceding year. The figures differ from the figures in this report as they refer only to those cases that have been completed.

## ***Learning***

3.5 There were three key learning points from the review of child deaths in 2009/10 and these are as follows:

- Chronic medical conditions in childhood. There was a recurrent theme of children with severe chronic medical conditions becoming lost to medical follow-up with no one professional taking overall responsibility for the child's condition. There appears to be a need to review and develop the process whereby children with chronic medical conditions are managed to ensure the identification of a lead clinician who has responsibility for ensuring regular follow-up and maintaining regular contact with both the child and the parent/carer.
- Asthma management. There is a need to ensure that children with asthma are managed according to national guidance to reduce the risk of severe and potentially fatal asthma attacks.
- Clinical procedures. The Child Death Review highlighted the need for secondary care clinical procedures to be continually reviewed and updated in both paediatric and obstetric care.

## ***Issues***

### 3.6 The following issues remain to be addressed:

- The process is still too slow. This is still in part due to delays in provision of information from some agencies. This is still a new process and there has been a clear improvement in responsiveness over the last 12 months but more must be done to continue to speed-up the review process.
- In 08/09 a review of the reported deaths in that 12 month period was completed in 14 out of the 48 cases (29%) whereas in 09/10 a review was completed in 18 of the 37 deaths notified that year (49%).
- The rapid response team was established in August 2009 and provides a widely-acclaimed service.
- There is a need to continue the development of a monitoring process and thematic process for learning lessons.
- There is a need to increase the percentage of cases completed within the DCSF timescale of 4/6 months.

## Monitoring

- 4.1 The CDOP has recognised that there needed to be a more robust process for monitoring. As a result a thematic tool has been developed to capture this information, adopting a similar approach to that used by Durham LSCB to monitor Serious Case Review actions.<sup>2</sup>
- 4.2 The use of colour coding groups issues from each case into one master document. Experience has shown that over time it is possible to identify hotspots or recurrent themes.
- 4.3 This process increases accountability and provides written evidence of progress and completed actions with the facility to monitor deadlines.
- 4.4 This process will be further trialled and reviewed in 2010/11.

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<sup>2</sup> Publicised as an example of good practice Understanding Serious Case Reviews and their Impact – A biennial Analysis of Serious Case Reviews 2005-07 DCSF

## 5 Funding

### *Funding for 2009/10:*

County Durham PCT	£113,000
Darlington PCT	£20,000
<b>The total income in 2009/10</b>	<b>£133,000</b>

### *2009/10 Expenditure*

Designated Doctor for CDOP plus PA support	£2,199 per month
Rapid Response Nurses (In place from August 2009)	£9,375 per month
Training costs for rapid response nurses	£8,000
<b>Total expenditure</b>	<b>£98,480</b>

5.1 The role of nominated child death officers for Durham and Darlington and administration officers were added to the roles of the LSCB Business Managers and Administrators; this cost was met by the overall contributions to the Board by all partner agencies.

5.2 Government grant funding continues until 2011/12. CDOP are currently examining the availability of mainstream funding.

## **6 Work Plan 2010/11**

- **Further work to be undertaken with the Registrar Superintendent of births and deaths, the Coroner for Durham and Darlington, Medical Examiners and the Crown Prosecution Service to review working arrangements in line with government guidance<sup>3</sup>**
- **Review and finalise Child Death Review Procedures in accordance with Government Guidance**
- **Review process recently adopted to monitor actions following the review of the child death**
- **Review the effectiveness of the Child Death Review process in learning lessons and bringing about change**
- **Review the effectiveness of the Rapid Response process in learning lessons and bringing about change**
- **Introduce the use of designated panels and engage appropriate expertise where appropriate**
- **Review the process to ensure that lessons learned are disseminated to all relevant organisations**

## **7 Recommendations**

7.1 The two safeguarding boards are asked to:

- Note the development of the child death review process including the progress in establishing a rapid response team.
- Note the overview findings.
- Note the issues raised.

**Dr Ian Davidson**  
**Chair, Child Death Overview Group**

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<sup>3</sup> Working Together to Safeguard Children March 2010 DCSF