

The Child Death Review Process for County Durham and Darlington Annual Report

2019/20



Introduction

This year's report contains the summary of activity carried out by the County Durham and Darlington Child Death Overview Panel (CDOP) which seeks to drive improvements improve the health, safety and wellbeing of children and young people in County Durham and Darlington.

Child Death Review Process

The child death review process covers children under 18 years of age. A child death review must be carried out for all children regardless of the cause of death.

This includes the death of any live-born baby where a death certificate has been issued. In the event that the birth is not attended by a healthcare professional, child death review partners will carry out initial enquiries to determine whether or not the baby was born alive. If these enquiries determine that the baby was born alive the death must be reviewed.

For the avoidance of doubt, it does not include stillbirths, late foetal loss, or terminations of pregnancy (of any gestation) carried out within the law.

Cases where there is a live birth after a planned termination of pregnancy carried out within the law are not subject to a child death review.

Background to the Child Death Review Process

Since April 2008 all deaths of children up to the age of 18 years, excluding still births and planned terminations are to be reviewed by a Child Death Overview Panel (CDOP) to accommodate the national guidance and statutory requirement set out in Working Together to Safeguard Children 2018.

Child Death Review partners, the Local Authorities and Clinical Commissioning Groups for County Durham and Darlington now hold responsibility for the delivery of the Child Death Review Process as set out in the Children Act 2004, as amended by the Children and Social Work Act 2017. The CDOP is multiagency with differing areas of professional expertise. This process is undertaken locally for all children who are normally resident in County Durham and Darlington.

Child Death Review Process

There are three interrelated processes for reviewing child deaths:

1. Joint Agency Response

A co-ordinated multi-agency response (on-call health professional, police investigator, duty social worker), 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 (including 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; *or*
- in the case of a stillbirth where no healthcare professional was in attendance.

2. Child Death Review Meeting

This is the multi-professional meeting chaired by the Designated Paediatrician for Child Deaths and attended by professionals directly involved in the care of that child during life and

those involved in the investigation after death. The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved.

3. Child Death Overview Panel

A multi-agency panel set up by CDR partners to review the deaths of all children normally resident in County Durham and Darlington in order to learn lessons and share any findings for the prevention of future deaths.

The collation and sharing of all learning from Child Death Reviews and the CDOP is now managed by the National Child Mortality Database (NCMD) which became operational on 1 April 2019.

Purpose of Child Death Review

The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If the Child Death Overview Panel identify action that be taken by a person or organisation, they must inform them.

In addition, the Child Death Review Partners:

- Must prepare and publish reports on:
 - what they have done as a result of the child death review arrangements in their area, *and*
 - how effective the arrangements have been in practice;
- may request information from a person or organisation for the purposes of enabling or assisting the review and/or analysis process - the person or organisation must comply with the request, and if they do not, the child death review partners may take legal action to seek enforcement
- may make payments directly towards expenditure incurred in connection with arrangements made for child death reviews or analysis of information about deaths reviewed, or by contributing to a fund out of which payments may be made; and may provide staff, goods, services, accommodation or other resources to any person for purposes connected with the child death review or analysis process.

The Child Death Overview Panel

The Child Death Overview Panel (CDOP) is a joint sub-group of Durham Safeguarding Children Partnership and Darlington Safeguarding Partnership. The Child Death Overview Panel meetings are held on a bi-monthly basis and there has been consistent organisational commitment since the Panel was established in 2008 (membership can be found at Appendix 1).

The Panel has two distinct elements:

1. Case reviews

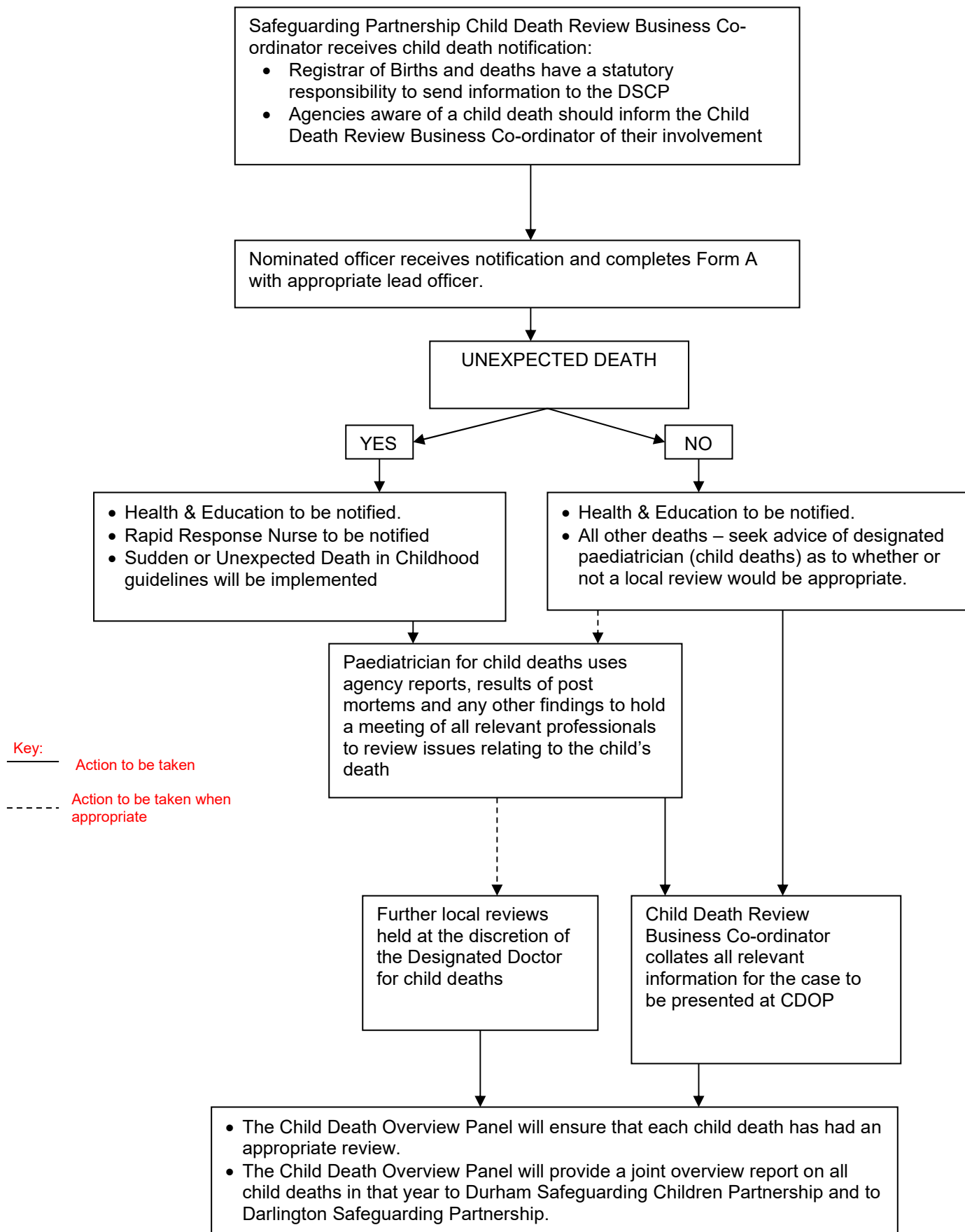
The Panel categorise a likely/cause of death, identify any environmental, extrinsic, medical or personal modifiable factors that may have contributed to the death and consider any agency, strategic, regional and/or national recommendations to prevent future deaths.

2. Business

The Panel considers the business arising from case reviews and the other responsibilities and statutory functions of CDOP.

The role of the Designated Doctor (child deaths) is carried out by a Consultant Paediatrician and the Joint Agency Response process is carried out by a team of senior nurses to manage and deliver the process for sudden and unexpected deaths. This ensures their active involvement at the onset of the review process in line with Government guidance. The Joint Agency Response process augments the local review of all unexpected deaths and ensures that parents are engaged and received appropriate support during the process.

Child Death Review Process Flowchart

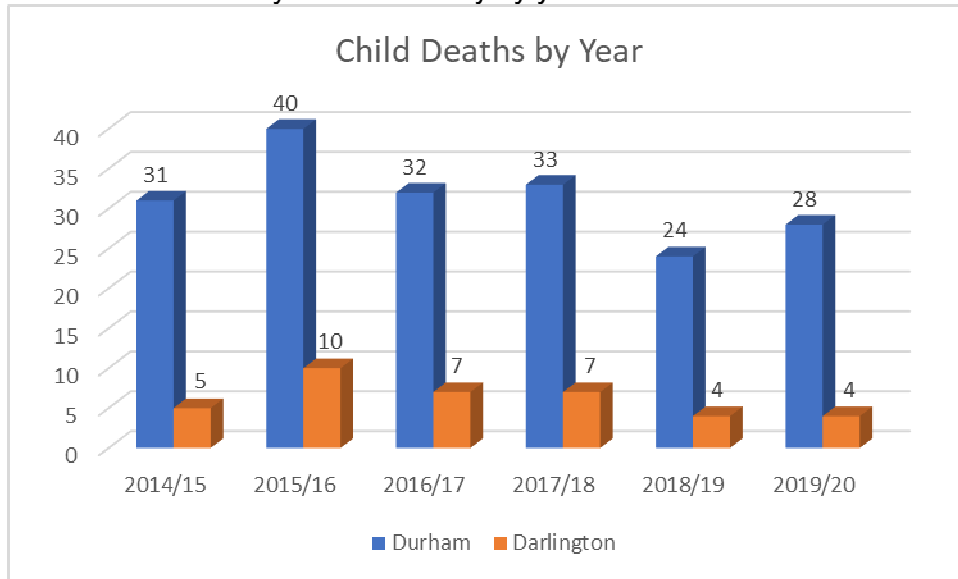


Child Death Review Activity

Child Death Review Notifications

28 children living in Durham and 4 children in Darlington died between 1 April 2019 and 31 March 2020.

Figure 1: The number of child deaths by Local Authority by year



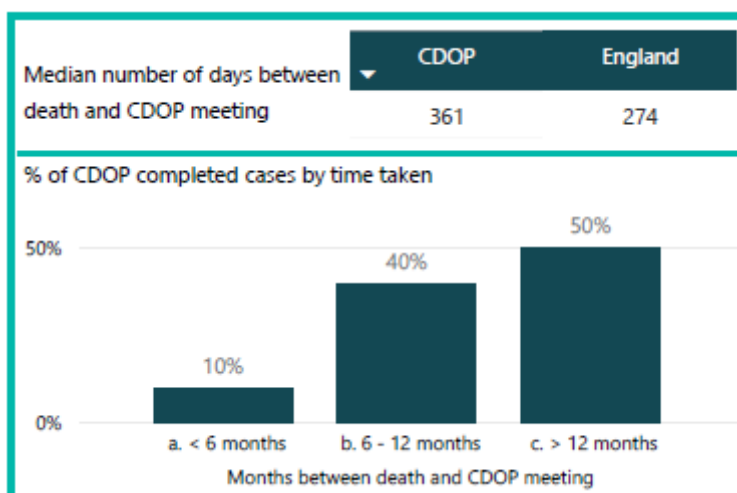
Child Death Overview Panel Performance

Between April 2019 and March 2020 there were three Child Death Overview Panels in which 20 cases were reviewed.

The Panel does not review cases until all information is gathered and other processes have been completed such as Serious Incident Reviews, Root Cause Analysis, criminal proceedings and Serious Case Reviews. At each Child Death Overview 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.

Timescale for Child Death Review Completion

Figure 2: % of CDOP completed cases by time taken



Out of 20 completed reviews, 10% were completed in less than six months. Possible reasons for those taking longer than six months to complete include 11 cases subject to other proceedings. The Child Death Overview Panel has agreed to not complete a Child Death Review until all relevant information has been received. A monitoring system has been built into the Child Death Database to specifically identify the reasons for this as well as an escalation process to address agency report forms not submitted within a timely manner.

46 child death reviews are ongoing; 19 of which cannot be completed until other proceedings have been concluded. This has been compounded following the COVID-19 pandemic towards the end of the financial year. A decision was reached that all face to face meeting would be suspended and future Child Death Overview Panel meetings would be held virtually. Some key members of the Child Death Overview Panel were also redeployed in response to COVID-19 and interim arrangements are in place.

Figure 3: Timeline between Child Death Notification and Completion

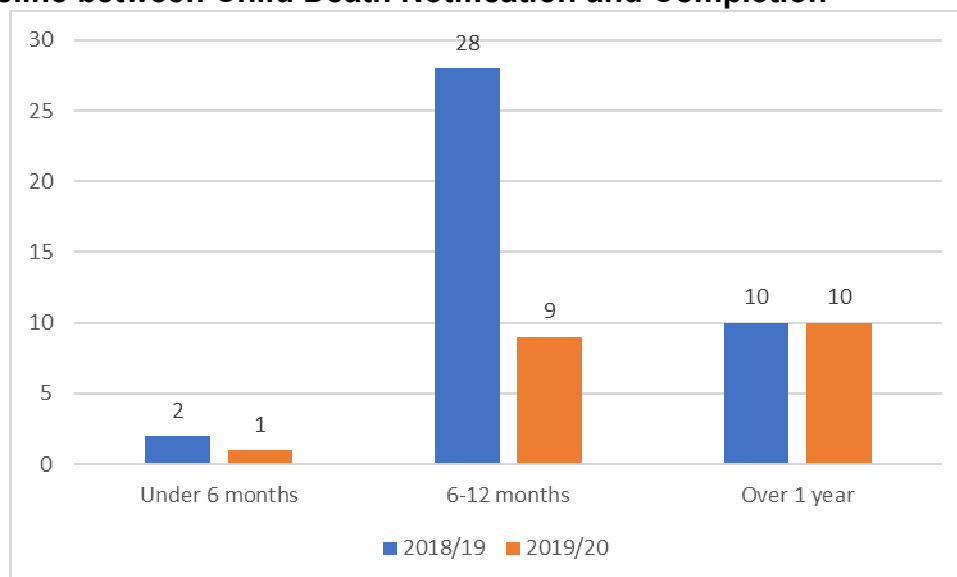
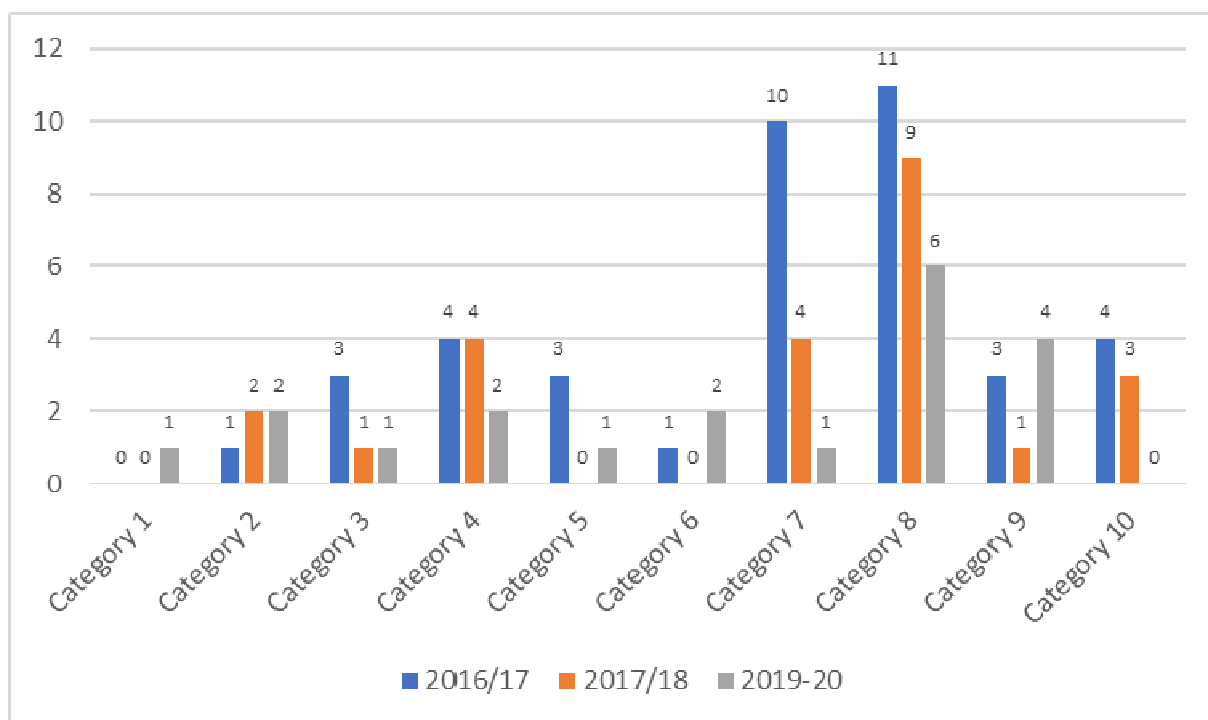


Figure 4: Category of Deaths

Categorisation is nationally determined and a glossary regarding the categorisation is found at Appendix 2.

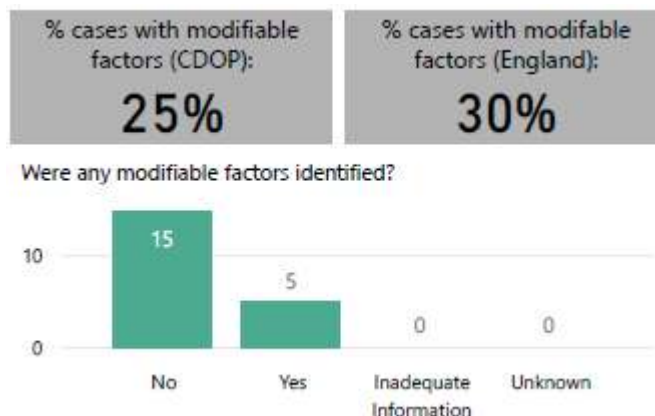
The majority of deaths relate perinatal/neonatal deaths which has consistently been the highest categories since the data has been collected.



Category 1	Deliberate inflicted injury, abuse or neglect	Category 7	Chromosomal, genetic and congenital anomalies
Category 2	Suicide or deliberate self-inflicted harm	Category 8	Perinatal/neonatal event
Category 3	Trauma and other external factors	Category 9	Infection
Category 4	Malignancy	Category 10	Sudden unexpected, unexplained death
Category 5	Acute medical or surgical condition		
Category 6	Chronic medical condition		

Chart 5: Modifiable Factors

Modifiable factors are factors that may have contributed to the death of the child and which, by means of locally or nationally achievable interventions could be modified to reduce the risk of future deaths.



Modifiable factors were identified in 5 deaths (25%) reviewed in 2019-20. Locally this is a 10% increase compared to 2018-19. Modifiable factors included management of illness leading up to death; chronic self-management of diabetes; neglect; cumulative risk; co-sleeping; parental cannabis use; parental awareness of sepsis and surgical procedure.

Learning from Child Death Reviews

The aggregated findings from all child deaths informs local strategic planning including the joint strategic needs assessment, on how to best safeguard and promote the welfare of children in the area. This annual report will assist in ensuring that learning from CDOP is shared with partners and informs the wider Durham Safeguarding Children Partnership and Darlington Safeguarding Partnership annual reports

Chart 6: Where the child was at the time of death

The majority of deaths considered by the Child Death Overview Panel during the reporting period occurred at home (30%).

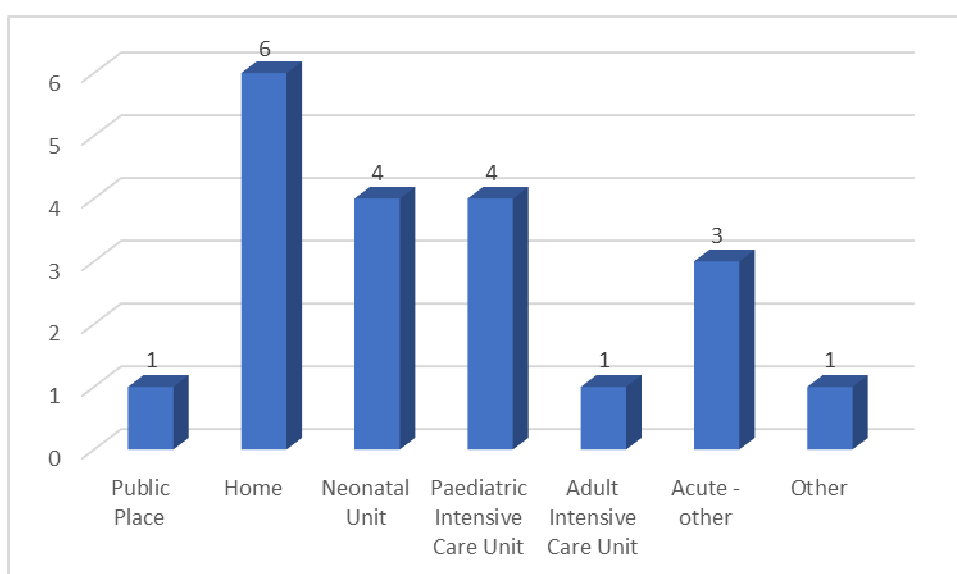


Chart 7: Ages of Children

The deaths of children under one year old (neonatal and post-neonatal) account for around 55% of all child deaths.

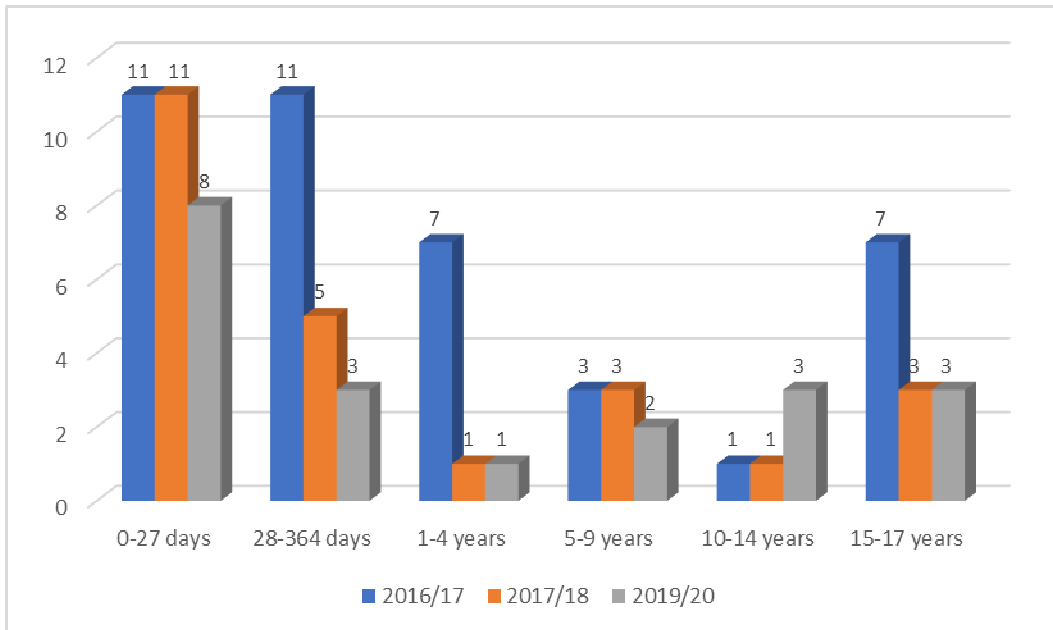
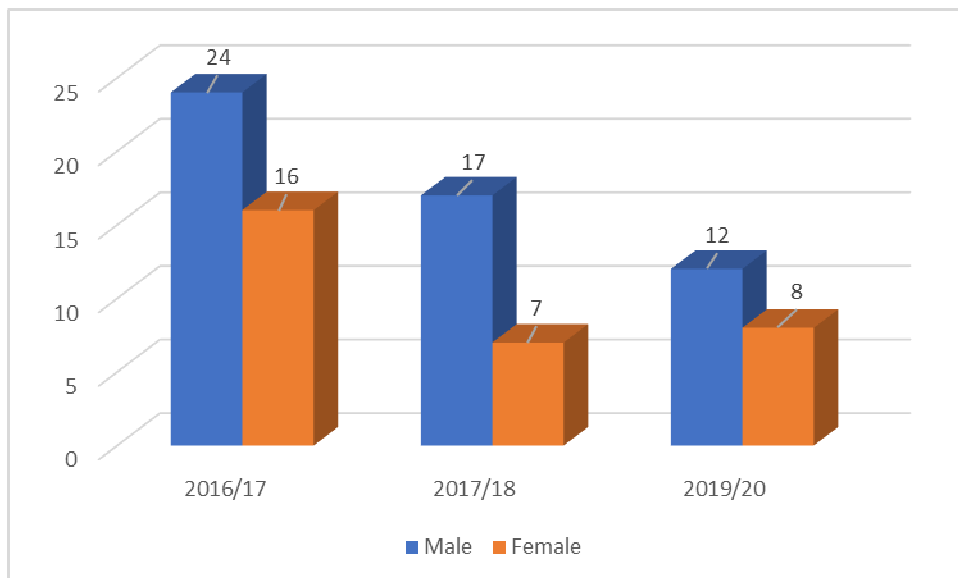


Table 8: Gender

The reporting period demonstrates 60% of completed cases being in relation to male deaths which is slightly higher than last year.



National and Regional Information

The Child Death Overview Panel has been reviewed and is compliant with new Working Together to Safeguard Children guidance 2018. Membership has been reviewed to include a GP at each meeting.

County Durham & Darlington Child Death Overview Panel have engaged with the data sharing processes launched via the National Child Mortality Database and arrangements are in place to input information from the Child Death Notification form within 48 hours of being notified of the child's death and updated following completion of the Child Death Review at the Child Death Overview Panel.

County Durham & Darlington Child Death Overview Panel now has access to the LeDeR Project and arrangements are in place to share information following a child death where the child has a learning disability.

The availability of neonatal cots in the North East region have been explored and as a result funding has been secured to commission an additional three neonatal cots, all of which are to be made available by early 2020.

Analysis of Key Learning

Key Issues & Learning Points from Child Death Reviews completed during 2019/20

Raising Awareness regarding Signs & Indicators of Acute Illness in Children

One case was subject to a Learning Lessons Review and the learning and recommendations will be robustly monitored by the relevant Safeguarding Partnership and the action plan shared with the Child Death Overview Panel once complete.

Community Health Services are utilising Child Safety Week 2019 to raise parental awareness on how to recognise and respond to children showing signs of an acute illness.

Children with Chronic Medical Conditions

Once case was subject to a Serious Case Review and the learning and recommendations will be robustly monitored by the relevant Safeguarding Partnership and the action plan shared with the Child Death Overview Panel once complete.

Accidental Deaths

Local initiatives such as Child Safety Week, Bikewise, etc. are to be engaged in raising awareness targeting teenagers regarding bike safety. Work is also ongoing with the Durham Safeguarding Children Partnership Young People's Commissioner, which is a new post created to engage with children and young people in County Durham, to see if this was appropriate in terms of her ongoing role in engaging with children and young people

Areas of Good Practice

One Serious Case Review recognised that the work of the Paediatric Diabetic Team as being an area of good practice which was acknowledged by the Child Death Overview Panel and feedback was shared with the team concerned.

Developments during 2019/20

A select number of 0-19 Service practitioners have completed training around bereavement support for children. Following the COVID-19 restrictions, Harrogate & District NHS Foundation Trust has extended this training provision for all 0-19 Service practitioners.

The 0-19 Service is also working with a charity to develop online bereavement training to supplement the above training provision.

CDOP Identified Developments for 2020/21

Greater links to be made with the Public Health Intelligence Team to provide input regarding any themes from the broader child mortality data.

Appendix 1

CDOP Membership as at 31 March 2019	
Gill O'Neill (Chairperson)	Deputy Director of Public Health Durham County Council
Jacqui Doherty	Business Manager, Durham LSCB
Amanda Hugill	Business Manager, Darlington SCB
Emma Maynard	Admin Co-ordinator, Durham LSCB
Julie Potts	Named Nurse Child Protection Harrogate & District NHS Foundation Trust
Dr Nnenna Cookey	Designated Paediatrician for Child Deaths County Durham & Darlington NHS Foundation Trust
Dr Nicola Cleghorn	Designated Paediatrician for Safeguarding County Durham CCG
Catherine Hodgkiss	Rapid Response Manager County Durham & Darlington NHS Foundation Trust
Anne Holt	Associate Director of Nursing – Family Health County Durham & Darlington NHS Foundation Trust
Detective Superintendent Dave Ashton	Force Lead for Safeguarding Durham Constabulary
Chris Ring	Strategic Manager – Safeguarding & Professional Practice Durham Children & Young People's Service
Chris Bell	Head of Service – Early Intervention & First Contact Darlington Children's Services
Nichola Howard	Named Lead Professional for Safeguarding North East Ambulance Service NHS Foundation Trust
Heather McFarlane	Designated Nurse Safeguarding & Looked After Children County Durham CCG
Karen Agar	Associate Director of Nursing & Governance Tees, Esk & Wear Valleys NHS Foundation Trust

Appendix 2 – Glossary re Child Death Categorisation

Name & description of category
<p>Deliberately inflicted injury, abuse or neglect This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.</p>
<p>Suicide or deliberate self-inflicted harm This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.</p>
<p>Trauma and other external factors This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Excludes Deliberately inflicted injury, abuse or neglect. (category 1).</p>
<p>Malignancy Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.</p>
<p>Acute medical or surgical condition For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.</p>
<p>Chronic medical condition For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. Includes cerebral palsy with clear post-perinatal cause.</p>
<p>Chromosomal, genetic and congenital anomalies Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.</p>
<p>Perinatal/neonatal event Death ultimately related to perinatal events, eg sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It includes cerebral palsy without evidence of cause, and includes congenital or early-onset bacterial infection (onset in the first postnatal week).</p>
<p>Infection Any primary infection (ie, not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.</p>
<p>Sudden unexpected, unexplained death Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. Excludes Sudden Unexpected Death in Epilepsy (category 5).</p>